BIRMINGHAM CITY COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM AND SOLIHULL)

THURSDAY, 10 JUNE 2021 AT 14:00 HOURS
IN ON-LINE INFORMAL MEETING, [VENUE ADDRESS]

A G E N D A

1 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

2 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's Internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

3 **APOLOGIES**

To receive any apologies.

4 **TERMS OF REFERENCE**

1 - 4

For information.

5 **MINUTES**

5 - 12

Draft minutes of the meeting held on 9th March 2021 for information. To be agreed at the next formal meeting of the Joint Health Scrutiny Committee. (1400-1405hrs)

13 - 30

6 **UHB NHS TRUST'S PERFORMANCE DURING THE COVID-19 PANDEMIC AND RECOVERY OF SERVICES**

Jonathan Brotherton, Chief Operating Officer, UHB NHS Foundation Trust.
(1405-1430hrs)

31 - 50

7 **BIRMINGHAM AND SOLIHULL SYSTEM OPERATIONAL PLANNING 2021/22**

Harvir Lawrence, Director of Planning and Delivery; Lesa Kingham, Head of Planning and PMO, Birmingham and Solihull CCG.
(1430-1455hrs)

51 - 56

8 **BIRMINGHAM AND SOLIHULL ICS FINANCIAL PLANNING 2021/22**

Paul Athey, Chief Finance Officer, Birmingham and Solihull CCG; David Melbourne, System Finance Lead.
(1455-1510hrs)

57 - 72

9 **POST COVID SYNDROME ('LONG COVID') REHABILITATION**

Jo Williams, CEO, The Royal Orthopaedic Hospital (ROH); Clare Underwood, Deputy Chief Nurse (Birmingham and Solihull CCG); Rebecca Lloyd, Deputy Director of Strategy (ROH); Alicia Stanton, Transformation Manager (ROH).
(1510-1535hrs)

73 - 82

10 **GOODREST CROFT SURGERY**

Paul Sherriff, Director of Partnerships in Primary Care; Simon Doble, Senior Commissioning Manager; Michelle Williams, Operational Team Manager; Jennifer Weigham, Senior Communications and Engagement Manager.
(1535-1600hrs)

11 **DATE AND TIME OF NEXT MEETING**

To agree a date and time.

12 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chair are matters of urgency.

Joint Health Overview and Scrutiny Committee (Solihull and Birmingham)

Terms of Reference

June 2021

1 Rationale

1.1 Following its inception to examine proposed variations of maternity services at Solihull Hospital, which had implications for patients across Birmingham and Solihull, the scope of the Joint Committee was extended through updates to its Terms of Reference in 2010, 2011, 2012, 2013, 2014, 2015, 2016. 2019 to include: -

- The monitoring of related issues, such as quality of care across the former Heart of England NHS Foundation Trust, Birmingham and Solihull Mental Health Trust sites, as necessary.

- The scrutiny of activity particularly with regards to any change to clinical pathways.

- To consider proposals coming forward from Clinical Commissioning Groups (CCGs) that affect Birmingham and Solihull.

1.2 Following the establishment of Birmingham and Solihull Clinical Commissioning Group (BSol CCG); merger of University Hospital Birmingham with the former Heart of England Foundation Trust in 2018 to form a greater University Hospitals Birmingham (UHB) (including the Queen Elizabeth Hospital, Heartlands Hospital, Good Hope Hospital and Solihull Hospital); and the Birmingham and Solihull Sustainability and Transformation Partnership (STP) as it transitions towards an Integrated Care System, a Joint Health Scrutiny Committee needs to continue to exist. It should consider the above, scrutinise and maintain an oversight of health service developments and substantial variations taking place in across Birmingham and Solihull and maintain an overview of key issues such as: -

- Finances and performance (provider / commissioner)
- Quality of care
- Consultation and engagement activity

2 General Terms of Reference

2.1 The primary role and purpose of the Joint HOSC is to consider:

- Whether as a statutory body, the Joint HOSC has been properly consulted within the consultation process;

- Whether in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;

- Whether a proposal for changes is in the interest of the local health service.

2.2 The primary role will be in respect of proposed service changes and quality of care issues affecting the provider bodies such as UHB and Birmingham and Solihull Mental Health Foundation Trust and the BSol CCG over proposed changes to care pathways.

2.3 The JHOSC would also scrutinise and have oversight of joint issues / plans emerging from the BSol STP and Health and Wellbeing Boards across Birmingham and Solihull.

2.4 The Joint HOSC will have regard to the four requirements for lawful consultation in reaching its conclusions on service changes.

- At the formative stage, the consulting body must have an open mind on the outcome;
- There must be sufficient reasons for the proposals, and requests for further information should be supported;
- Adequate time should be allowed for consultation with all stakeholders;
- There should be evidence of conscientious consideration of responses by the consulting body.

2.5 The joint response to the consulting Healthcare Body will be agreed by the Joint Health Overview and Scrutiny Committee and signed by both Chairmen.

2.6 No matter to be discussed by the Group shall be considered to be confidential or exempt without the agreement of both Councils and subject to the requirements of Schedule 12A of the Local Government Act 1972.

3 Timescales & Governance

3.1 The Joint Health Overview and Scrutiny Committee will continue whilst proposed services changes that affect both areas are contemplated.

3.2 The responsibility for chairing meetings will alternate between Birmingham and Solihull, the Health Scrutiny Chair of the hosting authority to chair the meeting. The location of meetings is to rotate between the two authorities. In the absence of a meeting Chairman, the Chairman of the other Authority, if present, takes the chair, and in the absence of both Chairmen, a Chairman will be elected from those members present at the meeting.

3.3 Meetings of the Joint HOSC will be conducted under the Standing Orders of the host Local Authority (i.e. the Local Authority chairing the meeting and providing democratic services support)

4 Communication with Media

4.1 Should a press statement or press release need to be made by the Joint Health Overview and Scrutiny Committee, this will be drafted by the host Local Authority on behalf of the Committee and will be agreed by both Chairmen.

5 Membership

5.1 Membership of the Joint HOSC will be nominated by the Birmingham City Council and Solihull Metropolitan Borough Council.

5.2 Membership of the Joint Scrutiny Committee will reflect the political balance of each local authority. Membership of the Joint Scrutiny Committee will reflect the political balance of each local authority. For a committee of ten members the ratio for Solihull is (3:2) and for Birmingham it is (3:1:1).

5.3 The quorum for meetings will be four members, comprising two members from each authority.

5.4 Healthwatch Birmingham and Solihull should be given an opportunity to contribute to the meetings as and when necessary to do so.

6 Support Arrangements / Resources

6.1 The work of the Joint HOSC will require support in terms of overall co-ordination, setting up and clerking of meetings and underpinning policy support and administrative arrangements.

6.2 Venues for meetings are to be rotated between Solihull MBC and Birmingham City Council with associated administrative costs to be borne by the respective Authority. Responsibility for administrative/ policy support and clerking arrangements is also to be alternated between the two Authorities.

6.3 The support officers for the JHOSC will need to work together to support the development and co-ordination of a JHOSC work programme.

6.4 These terms of reference would have regard to the following statutory guidance: -

Health Scrutiny Guidance (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

Statutory Overview and Scrutiny Guidance (2019)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

Approved by:

Councillor
Solihull HOSC Chairman

Councillor
Birmingham HOSC Chairman

On behalf of the Joint Health Overview and Scrutiny Committee

Date approved.

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 9 March 2021

MINUTES

Present:	Councillors: K Blunt, Brown, Donaldson, Fowler, Mrs D Holl-Allen MBE, D Howell, L McCarthy, Pocock, R Sexton and Tilsley Councillor K Grinsell – Solihull MBC Cabinet Member for Adult Social Care and Health
Officers:	Joe Suffield – Democratic Services Officer (Solihull MBC) Gail Sadler – Scrutiny Officer (Birmingham City Council)
External Representatives:	Jeremy Brown – Integrated Emergency and Urgent Care Director, West Midlands Ambulance Service Jason Evans - Acting Chief Officer for West Midlands Integrated Urgent and Emergency Care (IUEC) Service, Sandwell and West Birmingham CCG Karen Helliwell – Deputy Chief Executive, Birmingham and Solihull CCG Helen Kelly - Associate Director of Integration, Birmingham and Solihull CCG Harvir Lawrence – Director of Planning and Delivery, Birmingham and Solihull CCG Michelle Rayner – Associate Director of Finance for Sustainability and Transformation, Birmingham and Solihull CCG Dr William Taylor – Chair, Birmingham and Solihull CCG

1. APOLOGIES

No apologies were received.

2. DECLARATIONS OF INTERESTS

There were no declarations of interest.

3. QUESTIONS AND DEPUTATIONS

No questions or deputations were received.

4. MINUTES

The minutes of the meeting held on 16th December 2020 were presented to the Board.

Member requested that an item on Long COVID was included at a future meeting.

RESOLVED
The minutes of the meeting held on 16th December 2020 were approved.

5. URGENT CARE UPDATE AND NHS 111 FIRST

The Acting Chief Officer for West Midlands Integrated Urgent and Emergency Care Service introduced the item and drew Members attention to:

- The NHS 111 offer continues to be delivered by West Midlands Ambulance Service (WMAS) in Dudley. It has developed into a frontline patient service, with a number of clinicians to support the calls.
- It was noted that 999 and 111 call handlers within the West Midlands would soon be integrated seamlessly. This would enable 999 calls to benefit from the expertise of 111 clinicians and reduce ambulance conveyance.
- Since the COVID-19 pandemic, there had been increased demand on the service, as the public had been encouraged to use the 111 service. This had not significantly impacted on regional performance against KPIs. Other factors which increased demand included:
    - The introduction of NHS 111 First in December 2020.
    - Staff sickness and absence rates.
    - National contingency support to other 111 providers in England.

The Integrated Emergency and Urgent Care Director, WMAS highlighted the following points to Members:

- WMAS took over as the NHS 111 provider for the Greater West Midlands region in November 2019. A considerable amount of work had been undertaken to improve the service. From March 2020, there were significant changes in the activity of the service and how users accessed the health service. This was unlikely to ease in the immediate future.
- There appeared to be less of a reliance to contact GP surgeries and instead residents would choose to contact NHS 111.
- They continued to try to reduce the number of people who unnecessarily contacted 999 or attended Emergency Departments. This was part of a shift to support patients in their own home, and for them to access the most appropriate local service.
- They aimed to completely integrate the 999 and 111 service into a single call queue. This would improve outcomes for patients as they would be able to seamlessly access alternative pathways when appropriate.

Members made comments and asked the following questions:

- A Member asked about which services NHS 111 users attended instead of Emergency Departments. The Integrated Emergency and Urgent Care Director confirmed that the information was available and this highlighted that patients would primarily be directed to Primary Care services, local pharmacies and other similar provision. In response, the Member sought clarity whether this created an additional burden on Primary Care services, and whether there was additional funding to support this. It was stated that the data would not support this, and less patients were sent through to their own GPs.
- A Member queried whether there was information to show that fewer people would attend Emergency Departments if they contacted NHS 111. The Integrated Emergency and Urgent Care Director explained

there were not larger numbers of patients referred to Emergency Departments after they contacted NHS 111. They worked closely with partners to make sure referrals were followed up; as they were able to book appointments.

- A Member asked whether there had been any significant events as a result of residents who had contacted 111 instead of going to an Emergency Department, and if residents were still able to turn up to these sites to be treated without a booking. It was confirmed there had not been any events and they were able to turn up to these sites.
- A Member enquired what the longest time taken to answer a call was. The Integrated Emergency and Urgent Care Director explained that in the early stages of the pandemic there was activity which far exceeded predicted call volumes, as a direct result of the lockdown. A large number of these people were the “worried well”, who were people concerned about the implications of the lockdown. It was unlikely that this volume of activity would be replicated.
- A Member probed about the equality impact assessment in reference to the safe discharge measures, especially for those who were vulnerable, and what steps were in place to support these people. The Associate Director of Integration, Birmingham and Solihull CCG explained that there was an integrated discharge hub with health and social care partners to ensure that people were on the correct discharge process and were discharged safely. The Member also asked whether a consultation and monitoring plan mentioned in the equality impact assessment had been produced. The Associate Director of Integration confirmed this had been produced and could be shared.
- A Member asked how the triage process was assessed to ensure that the correct pathway for patients had been taken, and how this information was used. The Integrated Emergency and Urgent Care Director responded that they evaluated and audited call assessors and handlers. They aimed to stick to the same care pathway, but it was noted that there could be some exceptions, such as to prevent patients being sent to Emergency Departments unless absolutely necessary. Alongside this, they linked in with other areas to ensure that the outcomes for patients were effective.
- A Member requested further information whether if a patient contacted NHS 111 it would be included on their records. It was confirmed that the details would be passed through to their GP and attached to their records. Call handlers were able to access some patient information.
- A Member sought clarification about the geographical and demographics of the patients who accessed the service. The Acting Chief Officer confirmed there was performance and service level data which could be shared with the Board.
- A Member also enquired about whether this service acted as a displacement from a GP call and if this was funded by NHS England. The Acting Chief Officer confirmed that it was a national mandated service which had local considerations factored in and was consolidated by the Black Country CCG for the West Midlands. They also explained that there had not been displacement.

- A Member asked if it was clear to call handlers if the patient had dialled 999 or 111. The Integrated Emergency and Urgent Care Director reassured Members that the call takers were aware where the call stemmed from and would respond appropriately. Another Member queried whether that there could be detrimental outcomes if services were streamlined for those with communication difficulties. The Director explained there were a number of tools in place to support these patients, which included a triage system called NHS Pathways.
- A Member questioned whether this service would lead to increased demands on paramedics. The Integrated Emergency and Urgent Care Director highlighted that activity on both 999 and 111 continued to increase. This had not explicitly translated to increased demands on paramedics.
- A Member stated that there needed to be clinical excellence to support the integration of 111 and 999. The Integrated Emergency and Urgent Care Director responded that there had been significant developments in 111, which would make the service better and more accessible.

RESOLVED
The Board **NOTED** the presentation.

6. BRIEFING ON BIRMINGHAM AND SOLIHULL STP WAVE 2 UPDATE

The Director of Planning and Delivery, Birmingham and Solihull CCG, introduced the item and provided the following update on the Birmingham and Solihull service response to COVID-19:

- Since the last update, there had been significant changes in the previously reported position, as a result of the latest COVID-19 wave. The rate of COVID-19 had dropped a lot, however remained high. Similarly, hospital admissions remained high, and patients had been transferred out of Birmingham and Solihull Hospitals to manage demand.
- They were due to re-enter the restoration and recovery phase, and plans were being drawn up to prepare for this. Primarily this would focus on maximising capacity within the system for priority 2 and 3 patients. This would be a system wide approach, with a single waiting list across Birmingham and Solihull providers, which would mean that resources would be pooled.
- An elective coordination hub would be led by University Hospitals Birmingham (UHB). Decision making would take place at Chief Executive level in relation to the order that critical services would be restored. Where service changes would be made permanent, due process would be followed.
- The 2021/22 planning round had been deferred by NHS England and Improvement to Quarter 1 of 2021/22. They still awaited the national planning guidance and financial allocation for 2021/22. There was steps to identify the baseline financial position for the next financial year.

Members made comments and asked the following questions:

- A Member asked in what order services would be stood back up. The Director of Planning and Delivery explained that it would be decided on clinical priority, which was a process undertaken by clinicians.
- A Member queried how many staff were absent from work because of mental health problems and what support was available and accessed. Other Members flagged similar concerns. The Deputy Chief Executive, Birmingham and Solihull CCG, highlighted that there was a health and wellbeing programme of work and a “peoples” Board. Sickness and absence was monitored through this forum and information on this would be shared with the Board. The offer had been promoted to support staff mental health; it was recognised that this would need to be in place for a prolonged period of time.
- Members requested clarity about whether Solihull Hospital still had COVID-19 patients. The Director of Planning and Delivery confirmed that it no longer had COVID-19 patients, these were restricted to the Queen Elizabeth, Good Hope and Heartlands Hospitals. Strict measures to prevent cross infection remained in place.
- A Member questioned how people with degenerative diseases were prioritised. The Director of Planning and Delivery explained that all patients would be included and considered on the single waiting list.
- A Member sought clarification on the backlog of patients for the priority groups, how long it would take to work through this list and the process for this. The Director of Planning and Delivery noted that the figures for the priority lists shifted frequently, and information would be shared with the Board. There was detailed modelling work which would consider different scenarios of how capacity was managed to decide the priority list. The modelling would need to be completed before further information, such as time frames, could be shared.
- A Member requested further information on how junior doctors were used during the pandemic. The Deputy Chief Executive confirmed that this was a temporary measure at Solihull Hospital which provided additional support to a small amount of wards with patients were almost ready to be discharged. The learnings from this could be shared.
- A Member queried about the reduction of endoscopy services and whether this programme continued. The Director of Planning and Delivery explained that there was additional capacity for endoscopies put into the system at Solihull Hospital, and should be live in the near future.
- A Member stated that they had spoken to NHS staff who had given mixed reviews of the psychological support available. They asked whether anonymous feedback could be given on the support and what evaluation of the support had taken place to ensure it met their needs. A response would be provided on this.
- A Member noted that the there was a shortage of female mental health inpatient beds, and asked what the consequences of this were, what was done to manage this and had there been any adverse events. The Director of Planning and Delivery highlighted that there was a national shortage of mental health beds prior to COVID-19, which as a result led to out of area placements. They would then aim to repatriate these patients back into the area if an appropriate setting became available.

The Deputy Chief Executive noted that these problems were high on their agenda, and would be worked through as quickly as possible.

- A Member asked whether the vaccine programme had started to take effect for care home residents and staff. The Deputy Chief Executive confirmed that the number and severity of infections was reduced; this was monitored on a weekly basis. It would still take time to see the full impact of the virus on these figures.
- A Member sought clarity on how the vaccination campaign could continue to be supported while other services were restarted. The Director of Planning and Delivery explained that a number of staff had been redeployed to support the vaccination campaign across a variety of sites and this would be factored into the modelling for restoration and recovery.
- A Member queried whether national guidelines were followed when services were paused and restarted, in particular referrals for some types of lymph node biopsies. In response the Director of Planning and Delivery highlighted that national guidance was followed and adhered to alongside the clinical advice. More information was be provided on lymph node biopsies.
- A Member requested further information on the current situation with the Nightingale Hospital in Solihull. The Director of Planning and Delivery noted that this was a nationally commissioned service, but that it had not been used to date.
- A Member asked how successful partner organisations had been to support vaccine delivery. It was confirmed that GP surgeries and other partners played a pivotal role in the vaccine delivery programme.
- A Member questioned how they would create shared services and policies as the restart and restoration work was undertaken. In response, the Director of Planning and Delivery explained that they had cemented and reinforced close partnership working as a result of COVID-19 and the ICS status. This would continue to be pursued in the future.
- A Member sought feedback on how different communities had accessed the vaccine. The Director of Planning and Delivery outlined that there had been considerable work with faith leaders and community representatives to reinforce the benefits of the vaccine with the communities who may be resistant. This work had received positive comments.

RESOLVED
The Board **NOTED** the presentation.

7. BIRMINGHAM AND SOLIHULL STP FINANCE UPDATE 2020/21

The Associate Director of Finance for Sustainability and Transformation provided the following update:

- The system had an agreed system trajectory of £19.2m deficit. The current forecast at month 10 was a £31.7m deficit, which included a £22.3m increase in annual leave accrual. There were indications that

there would be additional funding to cover some of this. The balance without the annual leave accrual was a £9.4m deficit.

- There were some risks in the financial position in relation to the elective incentive scheme which had specific targets that had not been met. There would have been a charged levied for this, but national indications suggested that they would not be applied.
- Guidance continued to be circulated on how to treat COVID-19 related costs at the end of the financial year. As this was released, forecasts would be reviewed and updated.
- The system has a capital envelope which had to be operated within. If one partner had some slippages on their capital programme, this would be managed across the system.
- The cash position was better than planned, due to a national system whereby block payments to providers were paid a month in advance and therefore they had the benefit of an additional month's cash within the system.
- The planning round had been paused and it was likely that financial arrangements for the latter half of 2020/21 were due to roll over into the first quarter of the 2021/22 financial year. The funding envelope available for health was still to be confirmed.
- Nationally there had been £1.5bn set aside for recovery and restoration work. There would be guidance on what these additional funds would look to cover. They had made some high level estimates about the costs of restoration and recovery, which would total around £50m. This continued to be assessed and may be reduced. Upon a fair shares basis it would be likely that the allocation would amount to £20m. The allocation was expected to be circulated around the end of March.

Members made comments and asked the following questions:

- A Member raised concerns that to clear the backlog would potentially cost £50m, while there was likely to only be £20m of funding available. They asked how long it would take to clear the backlog based on the £20m figure and how the money would be used. The Associate Director responded that it would be determined by the funds available and would be a collaborative effort to pool resources to decide it would be most effectively used. The discussions on allocations remained ongoing and would form part of the planning round. It was requested that an update on this would be included at the next meeting.
- A Member asked how the additional allocations were split between trusts. In response, the Associate Director confirmed that the allocations were given to systems to manage across partnerships to enable the allocations to be clinically prioritised.
- A Member queried whether the current deficit included the CRES savings. It was confirmed that this did include any efficiency savings which had been made.

RESOLVED
The Board **NOTED** the presentation.

8. GOODREST CROFT SURGERY

Councillor Pocock raised the issue of the closure of Goodrest Croft Surgery. It was requested that the information received by Birmingham Councillors was shared with Solihull Members, as the GP surgery may have Solihull residents.

RESOLVED

Members asked that a report was bought to the next meeting which covered the procedure for the closure of the GP surgery, and the consultation that took place prior to the decision.

The meeting finished at 8.05 pm

University Hospitals Birmingham
NHS Foundation Trust

REPORT ON UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST'S PERFORMANCE DURING THE COVID-19 PANDEMIC AND RECOVERY OF SERVICES

Presented by: Jonathan Brotherton, Chief Operating Officer

1. Executive summary

As the most impacted Trust in the country, this report looks at the key issues that have affected the Trust since the start of the COVID-19 pandemic.

It describes the pressures that the Trust has been under in specific areas of the organisations, such as: ED, inpatient areas, cancer, critical area and outpatients.

It then considers the remarkable progress that has been made in key areas, under very challenging circumstances, acknowledging the momentous efforts of our staff and the contribution of the wider health system.

In conclusion, the paper describes the work that is actively on going to restore and recover services across the Birmingham and Solihull system, and the enabling work streams that are contributing to that.

2. Introduction

Since COVID-19 was first identified in December 2019, it has been an extraordinary journey for University Hospitals Birmingham NHS Foundation Trust (UHB), the UK and the world at large.

During this period, the NHS in Birmingham and Solihull has faced unprecedented challenges, with UHB being the hardest-hit Trust in the country, treating nearly 14,000 COVID-positive inpatients and 114,000 beds days occupied by COVID patients.

Despite the monumentous efforts of our staff, 1,500 of whom were redeployed from within our Trust and other healthcare organisations in Birmingham and Solihull to help care for the sickest patients, the significant and enduring impact of COVID-19 on our hospitals has significantly impacted UHB's ability to provide consistent access to planned care and treatment care over the past year.

Our most precious resource, our staff, continue to be under pressure and we want to ensure they rest, take time off and take up health and wellbeing support after more than a year of intense pressure, often in unfamiliar healthcare settings.

Theatres and ITU are also a severely constrained resource, and ultimately determine the rate of reduction of the large backlogs of patients now awaiting elective surgical procedures.

All this needs to be balanced against our desire to get back to treating as many patients as we can, as quickly as we can.

We will be living with COVID indefinitely and need to continue to adapt and transform the way we deliver services to ensure we care for our patients in the right place, at the right time, by the right health professional, most effectively using the resources we have at our disposal.

We also need to ensure, wherever possible, that health inequalities are not further impacted and we need to build on our relationships and integration with primary care colleagues, as they will play a key role in supporting our patients and staff.

Most importantly, we need to take the public and our patients with us through the next 12 months, which will likely be more difficult and challenging than the previous ones. It is a mammoth and complex piece of work and the NHS in Birmingham and Solihull has committed to work together, at pace, to deliver it.

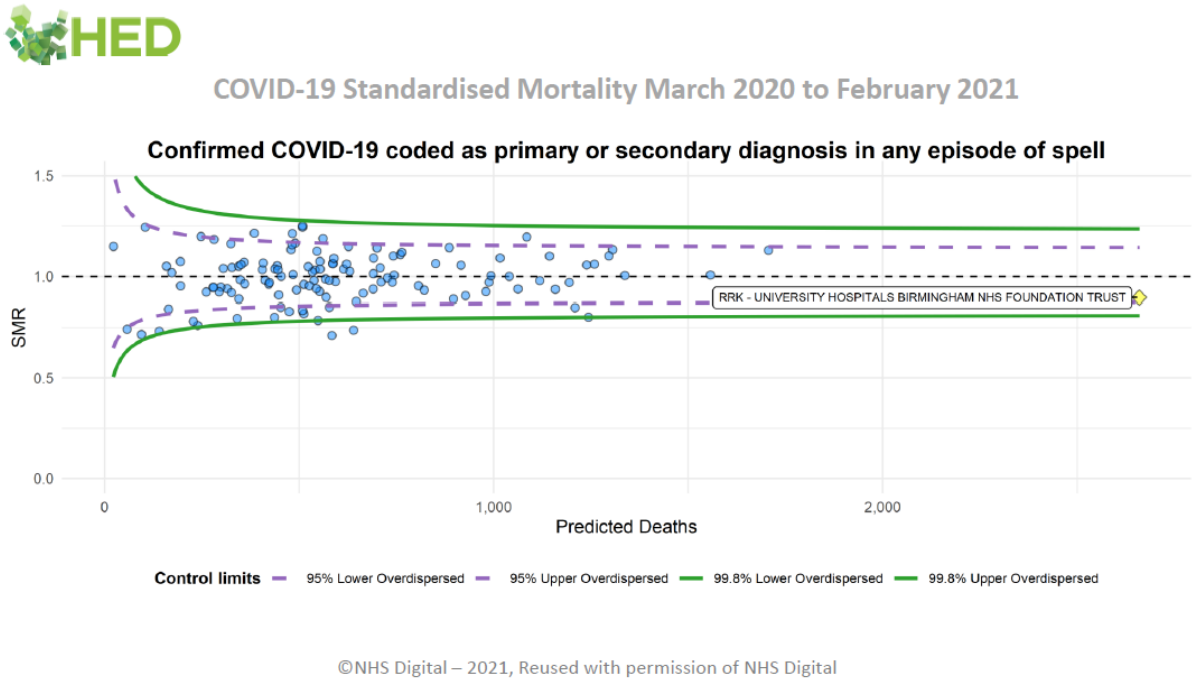
3. The context - UHB activity

The table below shows the highest number that UHB recorded for a number of the key metrics over each of the waves:

		1st Wave	2nd Wave	3rd Wave
Daily inpatients COVID-19	Number	**708**	**469**	**1067**
	Date	10 Apr 2020	24 Nov 2020	24 Jan 2021
Daily deaths COVID-19	Number	**37**	**16**	**27**
	Date	5 Apr 2020	7 Nov 2020	3 Feb 2021
Daily new positives COVID-19	Number	**145**	**103**	**197**
	Date	31 Mar 2020	11 Nov 2020	18 Jan 2021
Total patients on ITU	Number	**171**	**133**	**211**
	Date	17 Apr 2020	26 Nov 2020	21 Jan 2021
Daily COVID patients on ITU	Number	**134**	**51**	**165**
	Date	17 Apr 2020	23 Nov 2020	21 Jan 2021

Figure 1, below, identifies the standardised mortality for all patients confirmed as COVID-19 positive in the primary or secondary diagnosis. This figure identifies that UHB is below the expected level.

Figure 1: COVID-19 standardised mortality – March 2020 to February 2021



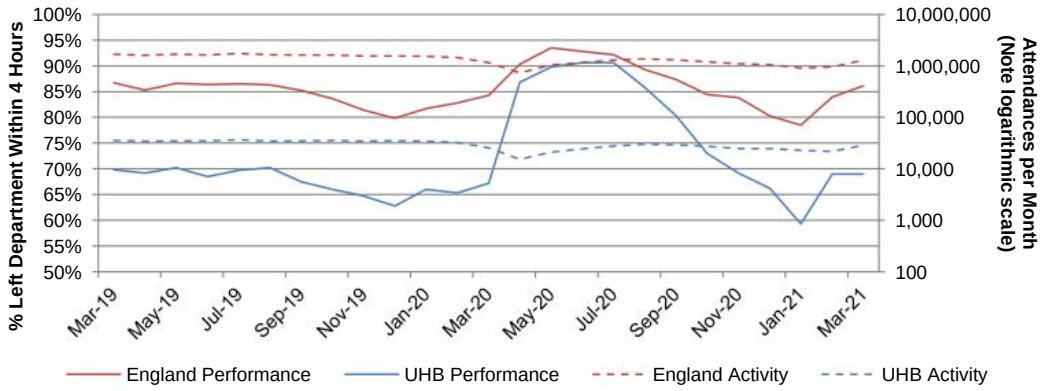
3.1 Emergency Departments

Attendances at the Trust's Emergency Departments (EDs) are back up to pre-COVID numbers (c. 1,200) a day.

The requirement for social distancing and infection control has resulted in a reduction in ED capacity (75% less seating in waiting rooms), with patient separation into COVID and non-COVID areas and the requirement for COVID testing also reducing throughput.

England's performance, and UHB's performance, has followed a similar trend and are broadly at the same levels now as they were two years ago (Figure 2, below).

Figure 2: ED attendances and four hour performance

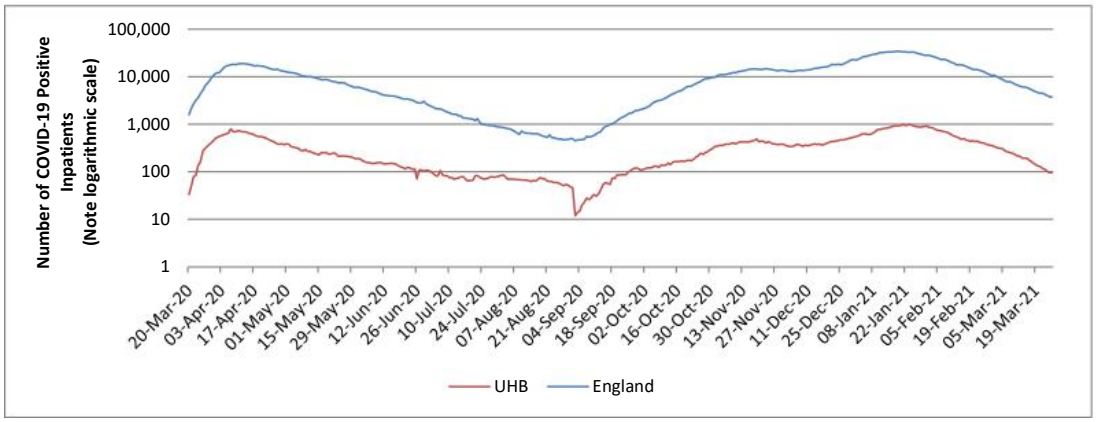


3.2 Inpatients

During the peaks of each wave, the NHS has seen a significant proportion of its available beds occupied by patients with COVID-19. Figure 3, below, shows the number of beds occupied each day at UHB and for England as a whole; it can be seen that UHB's pattern of occupancy is very similar to that of the NHS as a whole.

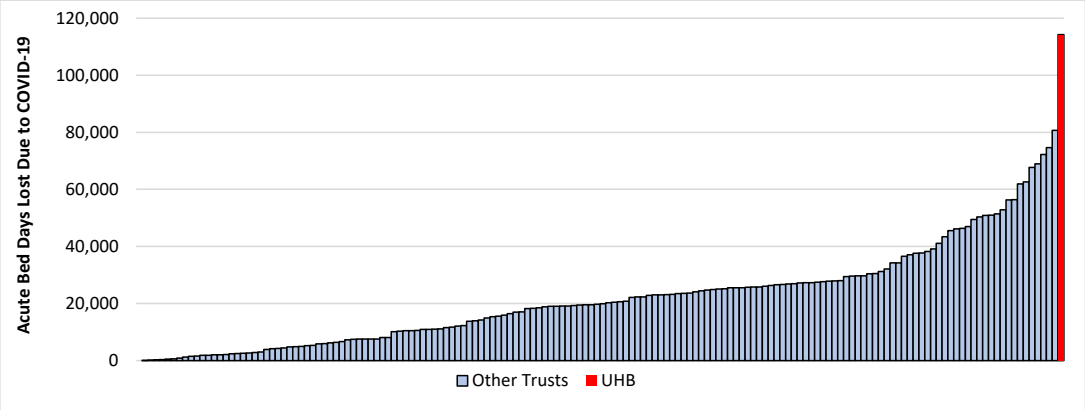
It should also be noted that in the year from 20 March 2020, UHB had the highest number of COVID-19 positive patients on 209 days. Over that period the NHS as a whole had nearly 3.7 million bed days occupied, with UHB contributing nearly 129,000, or 3.5% of this.

Figure 3: Daily bed occupancy by COVID-19 patients



When comparing the number of acute bed days consumed by COVID-19 occupancy, as shown in Figure 4, the impact on UHB was greater than any other trust in England. UHB had 41% more bed days consumed than the next most affected trust.

Figure 4: Acute bed days consumed due to COVID-19 occupancy



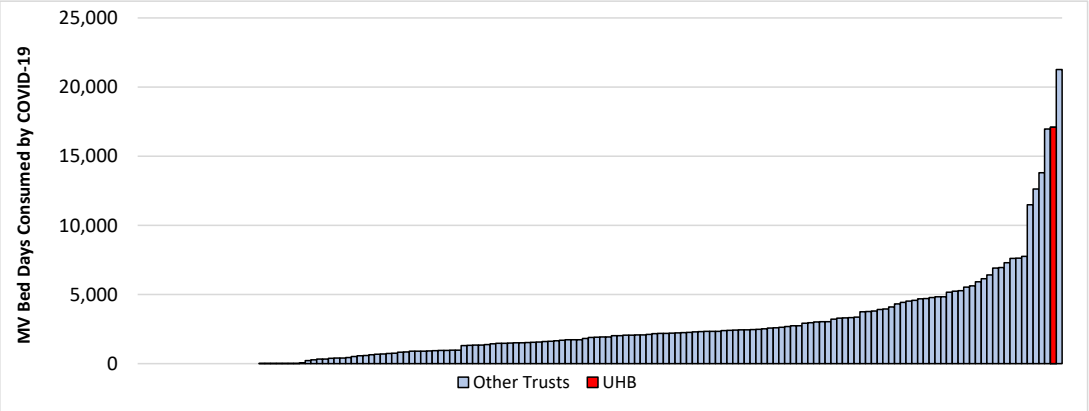
3.3 Critical care

The Trust has cared for 13,773 COVID-positive and 115,098 non-COVID patients during the pandemic; with 211 patients in its ITUs at the peak. Over 1,500 staff from UHB and organisations across Birmingham and Solihull were redeployed from their substantive clinical and non-clinical roles to support ITUs and other acute areas.

Of those reservists, nearly 100 wish to keep up their new ITU skills and will work a day month on UHB's units to maintain their competencies.

UHB was amongst the trusts to see the highest demand for mechanical ventilation during the pandemic, with 17,087 bed days occupied by COVID positive patients, as of 7 April; see Figure 5 below:

Figure 5: Bed days consumed due to COVID-19 mechanically ventilated occupancy - 2 April 2020 - 7 April 2021



To create additional critical care capacity 'surge' and 'super surge' plans were put in place to expand the physical available space, equipped number of beds and

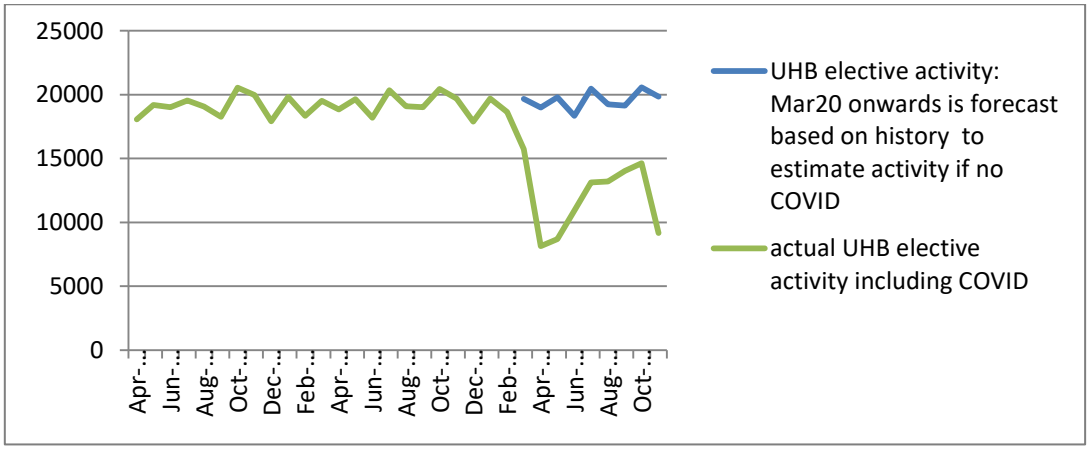
workforce by 250%, to enable us to care for our sickest patients. Meeting this requirement eliminated almost all elective treatment, for patients requiring access to operating theatres.

3.4 Waiting lists and RTT performance

Due to the cancellation of elective inpatient admissions and outpatient appointments during the pandemic, there has been rapid growth in the Trust's waiting lists and a deterioration in waiting time performance with significant numbers of patients now waiting longer than 52 weeks from referral to treatment.

Further on in the paper (section 11), the situation and measures being taken to reduce the elective waiting lists are described in greater detail.

Figure 6: UHB elective activity - April 2018 to October 2020



During the pandemic, operating capacity in the independent sector was utilised to maintain access to elective surgery. This was prioritised using national guidance and now every patient on an inpatient waiting list is clinically prioritised using guidance from the Federation of Specialty Surgical Associations. The Trust also had to implement a comprehensive pre-operative COVID screening and shielding pathway, to allow it to restore safe elective surgery.

Over the summer, when pressure was lower, Solihull Hospital was established as a cold elective site and cold pathways set up at the other hospitals to try to maintain elective activity. This enabled UHB to provide elective surgical treatment to non-COVID patients for far longer into the second and third waves, than it was able to in the first wave, when those services were essentially suspended far earlier because of the inability to contain the spread of infection and the requirement to redeploy staff providing elective care.

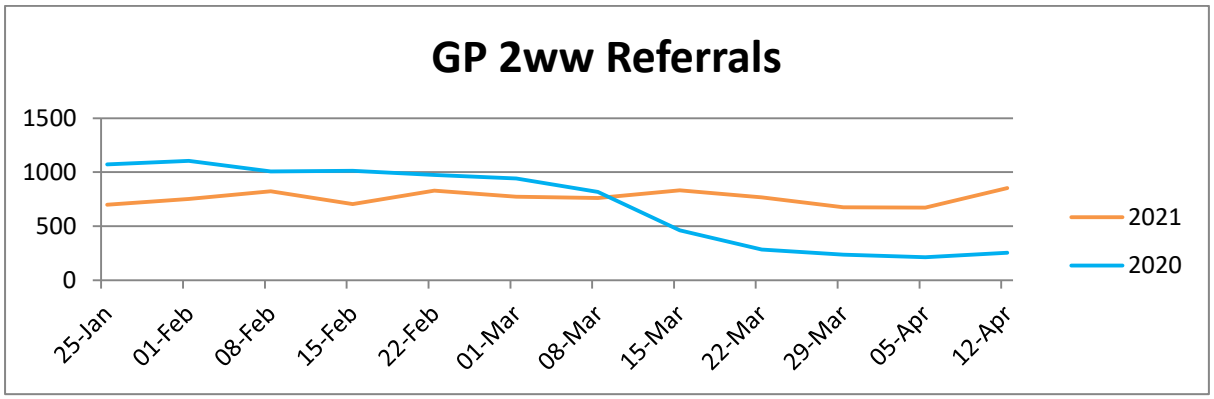
The Trust and CCG have maintained ongoing dialogue with statutory committees e.g. Joint Health Overview and Scrutiny Committee, to ensure they are informed and sighted on the current situation, whilst the NHS and Trust is operating under emergency legislation.

2.5 Effect on cancer performance

The pandemic has had a very significant effect on cancer performance, particularly where surgery was the chosen form of treatment. However, we continue to prioritise emergency and cancer treatments, as we work to recover all services, as well as offering appropriate alternative treatment regimes. Access to rapid two week wait clinics and diagnostics was maintained throughout the pandemic, but not at the same pre-COVID levels, resulting in backlogs of patients awaiting diagnosis.

Overall, two week wait referral demand is currently at around 75% of pre-pandemic levels and rising. Some specialties have seen referral demand above 100% of pre-COVID levels. Two week wait 'first seen' activity has now reached 85%-90% of pre-COVID levels and total first treatment activity (31 day) has now reached 92% of pre-pandemic levels.

Figure 7: GP two week wait referrals – January to April 2020 and 2021



With limited surgical capacity available at times during the pandemic, there has been increased use of chemotherapy as a first line treatment. Likewise, radiotherapy activity increased and excellent access was maintained. In Wave 1, this included all but benign and some prostate work, where alternative treatments were put in place. From Wave 2 onwards, all treatments were maintained, as well as a replacement linear accelerator (LINAC) being installed.

Unfortunately, there has been an increase in the number of patients on the 62 day pathway who have waited 104 days or more for treatment following referral, as shown in Figures 8 and 9, below. The majority of these patients are suspected rather than confirmed cancer cases. A trajectory has been set to reduce this number, which will accelerate with the delivery of two staffed Vanguard theatres at Solihull Hospital. The reduction is already significantly ahead of trajectory largely as a result of the work to reduce the diagnostic backlogs including the opening of two more endoscopy rooms at Solihull Hospital.

Figure 8: Cancer 62 day backlog and trajectory for reduction

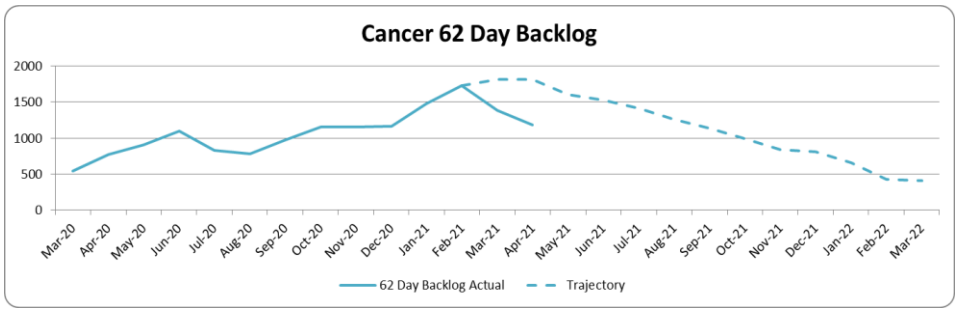
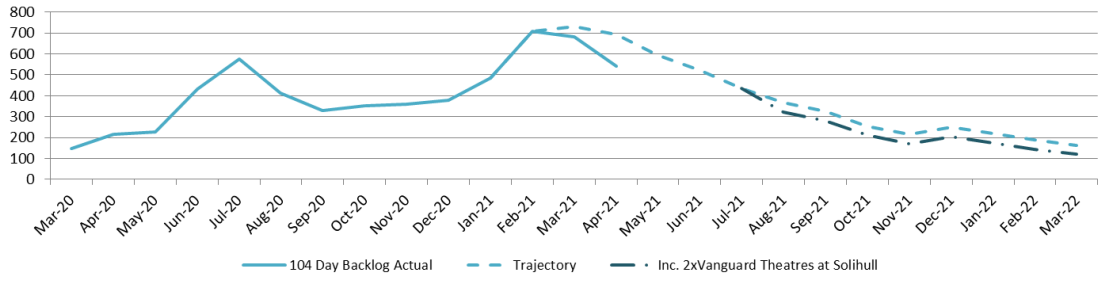


Figure 9: Number of cancer patients waiting >104 days from referral to treatment and trajectory for reduction



A cancer recovery plan has been implemented, in collaboration with commissioners and NHSE/I, which aims to restore cancer diagnostic and treatment services, and reduce the number of long-waiting cancer patients. Everything possible is being done to ensure patients will receive the necessary treatment, as soon as possible, with a point of contact to support them.

There are two new endoscopy rooms at Solihull Hospital, which became operational in March, which are supporting the endoscopy backlog reduction. In addition, the Faecal Immunochemical Test (FIT) pathway in primary care went live from 8 March, with 765 kits already requested and sent out (a total of c.2,000 tests have been delivered since FIT introduced). This reduces the demand on our endoscopy service and provides a timelier outcome to the patients in terms of their diagnosis.

All patients are tracked and monitored, where treatment plans are delayed or otherwise impacted; this is clearly recorded and highlighted to the respective service with all long-waiting patients on a cancer pathway subject to a clinically-led harm review, where their pathway is reviewed by a senior cancer clinician, and any potential harm escalated via the Trust's internal clinical governance arrangements.

The pandemic has also impacted on cancer pathways through patient choice. Among our long-waiting cancer patients, around a quarter chose to delay or defer their pathway and most due to concerns around COVID within the hospital. There is a process in place for a member of the clinical team to contact the patient and do everything possible to persuade them to keep their appointment or treatment date.

2.6 Effect on discharge

In March 2020, the launch of the Early Intervention Community Team (EICT) facilitated the discharge of patients to their homes, as discharging patients to create capacity for COVID-19 patients was a priority. Over the next two months, the Integrated Discharge Hub was established, in partnership with Birmingham Community Healthcare NHS Foundation Trust. National guidance on swabbing patients being discharged from hospital was published in May 2020, with updated COVID guidelines published in October 2020. Additional actions to support effective discharge have included: additional bed capacity; the roll out of the Discharge Hub Management System across the Trust; the redeployment of CCG nurses; and additional admin and operational support.

Despite a steady increase of over 40% of patients being referred to the Discharge Hub, the length of stay for patients following the completion of a Transfer of Care (ToC) has fallen significantly for Birmingham patients, or remained static for out-of-area patients.

3. Staff health and wellbeing

In 2020/21, the Trust recorded an annual average sickness absence across all clinical and corporate divisions of 5.80%.

The increased levels of staff sickness absence in 2020/21 were associated with the pandemic. At the height of the first peak in April 2020, there were 2,622 staff absent due to COVID-19 and a further 720 unavailable staff who were shielding due to age, pregnancy or being clinically vulnerable.

In the second and third waves, staff absence did not reach the same levels, peaking at 1,068 COVID-related absences in January 2021, with a further 141 unavailable shielding staff. The reduction of absence during this time was as a result of a number of factors including:

- Social distancing measures
- Wearing of masks in all areas
- PPE
- Collaborative working with occupational health, infection control and health and safety teams
- Management of risk assessment processes, both environmental risk management and individual risk management
- Introduction of staff testing and household testing
- Home and flexible working
- Introduction of Wellbeing Hubs
- Psychological support for staff
- Issuing of 160 key worker letters to support childcare provision and exemption from quarantine requirements.

The above measures vastly reduced the number of staff that were absent during the second and third waves.

4. Nightingale Hospital Birmingham

UHB was appointed as the host trust for Nightingale Hospital Birmingham (NHB) in March 2020, at the start of the COVID-19 pandemic.

Nightingale Hospitals were established by NHSE/I as temporary, large-scale field hospitals, intended to treat or provide care for patients diagnosed with COVID-19. NHB, located at the NEC Birmingham, was the second Nightingale Hospital to be established in England; after a monumentous effort from UHB colleagues, it was formally opened on 16 April 2020 by the Duke of Cambridge. NHB originally had a maximum capacity of 1188 beds. The clinical model for NHB was a step down facility for patients recovering from COVID-19, or those not suitable for ventilation.

Whilst the first wave of the pandemic proved extremely challenging for the West Midlands region, thankfully there was sufficient hospital capacity to meet demand and NHB entered hibernation on 7 May 2020. During summer 2020, NHB capacity was reduced to 384 beds within a smaller footprint at the NEC. The facility remained on standby until the end of March 2021. It was subsequently decommissioned and handed back to the NEC on 12 April 2021.

5. COVID vaccination programme

The Birmingham and Solihull COVID-19 vaccination service went live on 12 December 2020. The service is being delivered collaboratively across the Integrated Care System (ICS) through vaccination centres, hospital hubs and local vaccination services (GPs and community pharmacies). UHB has been designated lead provider for the system and has responsibility for vaccination centres and the hospital hubs located on UHB sites. To date, the programme has administered over a million vaccinations, with the majority being delivered by local vaccination services.

Throughout the programme to date, responsive interventions have been taken to ensure that the vaccine is available in local communities that need it the most. Good practice examples of vaccination delivery include the roving vaccination model, which takes vaccine to where it is needed most e.g. the housebound, places of worship, the homeless and other vulnerable people. A pop-up vaccination service at Jaguar Land Rover in Solihull reached over 4,500 employees. The service has also led the development of multi-generational household vaccination, which was subsequently adopted nationally.

The programme is being supported by a robust and effective evidence-based communications and engagement approach, which has included deliverables to reach all external and internal audiences, including: a dedicated website; outdoor advertising; household leaflet drops; social media and digital messaging; and tailored communication and engagement for staff.

There has also been a system-wide focus on engagement and health inequalities, which has been facilitated by close partnership working. Several multi-agency initiatives have been implemented to increase uptake in seldom heard communities, communities where there is vaccine hesitancy, and areas where there have been repeated outbreaks, including on-going work with grass-root organisations, such as food banks. There has been extensive and on-going engagement with community

leaders, faith leaders, COVID Champions, third sector organisations and local people, using local GPs and clinical spokespeople. In addition, a series of five well attended locality-based public webinars were co-hosted with the local NHS and Birmingham City Council's Cabinet Member for Heath.

The Birmingham and Solihull COVID vaccination communications and engagement approach has been heralded as best practice nationally by NHSE/I, as well as the Government's Race Disparity Unit.

On behalf of the system, UHB's workforce team led on the recruitment of 4,600 staff, who were rapidly made roster-ready, with a focus on employing those individuals in Birmingham and Solihull who were furloughed or made redundant during the COVID pandemic. The programme has worked closely with St John Ambulance to incorporate volunteers within local vaccination services and the vaccination centres and has the highest uptake of St John Ambulance volunteers in the Midlands; the volunteers have proven to be valuable vaccination team members.

Whole system collaboration has been evident throughout the programme.

6. Mutual aid and collaborative working

The pandemic saw collaborative working in paediatrics across the ICS. During the first wave, Children's ED was located on Ward 14 at Heartlands Hospital, to support the flow of adult emergency patients in main ED and allocate dedicated space for paediatric patients, in conjunction with an ambulance divert for paediatrics. In the second wave, a full paediatric divert for all ambulances was put in place from Heartlands and Good Hope hospitals, to Birmingham Children's Hospital (BCH), from December 2020 to support capacity for adult pathways at UHB. This included the paediatric wards being closed at UHB during January and February 2021, with children's inpatient care being clinically managed at BCH.

Birmingham Women's Hospital (BW) supported gynaecology elective surgery from November 2020 until March 2021, due to the closure of operating theatres in October 2020 at Good Hope Hospital, to support ITU staffing and the use of day surgery beds for medical emergencies.

Ambulatory and hand trauma activity has been carried out at the Royal Orthopaedic Hospital (ROH), with some non-ambulatory trauma during the first wave. In neurosurgery, revised spinal pathways were established; BCHC and ROH partnered with the Trust to provide spinal theatre access and emergency triage. Cranial neurosurgery/oncology patients have received support from Stoke, Cambridge and Bristol.

During the height of the pandemic, we were supported by numerous regional manufacturers including Jaguar Land Rover. The Trust also developed a Midlands PPE Collective with five regional manufacturers who supported the Trust in the manufacturer of surgical gowns and clear face masks. This created over 120 new jobs, deferring 200 staff from furlough.

In the last 12 months, UHB has supported over 111 mutual aid requests, providing over 3 million pieces of PPE to 40 separate organisations that included hospices,

care homes, GP practices, dental services and homeless shelters (including soup kitchens). A further 500,000 pieces of PPE that were unable to be used within a hospital setting were provided to schools and other third sector organisations, to support the continuation of their services.

7. Research

At the beginning of the pandemic, the Trust's research function had to rapidly pivot to support research to develop an evidence base for the treatment of COVID-19. This included recruitment to the 'Recovery' trial, from which an early finding in June 2020 was that dexamethasone reduced mortality in hospitalised patients and more recently that convalescent plasma may have a beneficial effect.

The 'DECOVID' partnership was established to answer clinical questions, using data from data-mature hospitals. The research team also co-ordinated the delivery of antibody testing for staff. The Trust has been a very significant recruiter to the Oxford vaccine trial. Leading the testing of ventilators has also spread knowledge of the role of the Trauma MIC and MD-TEC.

Currently there is a now a balanced portfolio of COVID and non-COVID studies being delivered. Over 85% of COVID-positive admissions that remain inpatients for more than 24 hours, are recruited into a study. The Oxford Vaccine Trial completed recruiting to all cohorts with UHB one of the top recruiting sites. Un-paused and new studies are supporting recruitment and follow up to non-COVID trials, whilst prioritising capacity to support the core COVID team.

8. Digital transformation

Significant progress has been made in digital transformation during the pandemic, with many notable achievements, including:

- Over 2,000 patients going through the world's first artificial intelligence (AI) powered skin cancer pathway, which was deployed in April 2020. 40% of patients have avoided the need for a hospital appointment, with further improvements planned to get to 60%.

- Over 400 medical retina patients using a newly established community ophthalmology pathway where scans and diagnostics are carried out in the community without the need for a hospital appointment, and all information is reviewed by UHB Consultant Ophthalmologists remotely. Volumes are now increasing, with a further 3,000 glaucoma patients to use the pathway.

- A major collaboration has started to enable the fundamental redesign of 16 pathways that are traditionally delivered in an outpatient setting. Modelling suggests that over five years, 77,000 outpatients' appointments per year will not be required.

- The DrDoctor digital platform went live in March 2021, with digital patient letters and a replacement platform for video appointments.

- A pilot has been completed to connect hospital based Consultant Geriatricians to patients in community intermediate care centres; supported by digital stethoscope, ECG and HD camera capability on low latency, high bandwidth 5G connectivity. There are plans to roll this out to remaining intermediate care centres, care homes, domiciliary care, primary and community care.

A number of key IT transformation projects have continued to be delivered during the pandemic, with the launch of Oceano PAS and OPTIMS at Heartlands, Good Hope and Solihull in October 2020 and the continued upgrade to Windows 10. PICS went live successfully at Solihull Hospital, as it transitioned to an elective site and from March 2021 the roll-out will continue at Heartlands and Good Hope hospitals.

9. Recovery and restoration of services

9.1 Working together on recovery and restoration

The ICS Board has given system responsibility to UHB for leading on restoring adult services, and BWC for paediatrics. The Birmingham and Solihull approach to addressing and reducing the elective waiting lists for priority patients, capitalises on effective and close partnership working across the local health system, to ensure that we recover our services as quickly as possible, for all patients in line with their clinical priority. This includes strong partnerships with colleagues in primary care (GPs).

A system-wide clinical prioritisation policy and process has been agreed by the Chief Medical Officers, which means that all patients on our inpatient adult and paediatric waiting lists have been reviewed and prioritised in order of clinical need.

Day-to-day actions are progressed and decisions are underpinned by the System Operational Delivery Group (ODG), chaired by UHB's Chief Operating Officer, which has relevant medical and executive input from provider and commissioning organisations.

Tools and outputs that are supporting this work, to underpin decision making and ensure accountability, include: single inpatient waiting lists, system level demand and capacity modelling, integrated theatre plans, and a range of system metrics to support decision making. As part of our restoration of outpatient services we have also made progress with re-shaping outpatient referral management including the significant expansion of the use of Advice and Guidance, which is an important step in better connecting primary and secondary care clinicians.

9.2 Backlogs of patients who are overdue surgery

A number of work streams have been established to oversee all the recovery programmes, with the initial focus on reducing the backlog of patients on our inpatient waiting lists that have grown significantly during the pandemic.

Work to identify theatre capacity plans and specialty Priority 2 (treatment <30 days) and Priority 3 (treatment <90 days) demand across Birmingham and Solihull is complete and cases being worked through and progress tracked.

A quarter 1 plan has been agreed and actioned, to open theatres to maximal level (based on available staff) with recruitment ongoing to support theatres and perioperative care, including international recruitment of qualified nursing staff. Plans for quarter 2 are being finalised.

Figure 10, below, shows the number of adult patients across Birmingham and Solihull who are waiting longer than the recommended time scale for surgery, along with the current forecast reduction based on the agreed theatre plans. The backlogs reduce quicker with theatre resources being pooled across Birmingham and Solihull, but more capacity is needed in order to deliver a quicker reduction. At this stage, the Trust and system have been unsuccessful in attracting additional funds from the NSHE/I Accelerator Programme. Unless other agreements can be reached, we are therefore reliant on achieving the activity thresholds set out in the NHSE/I Elective Recovery Fund, in order to deliver more activity and reduce backlogs quicker. This will prove challenging given the disproportionate impact on UHB from COVID, as outlined earlier.

Figure 10: Actuals and forecast for quarter 1 (adults)

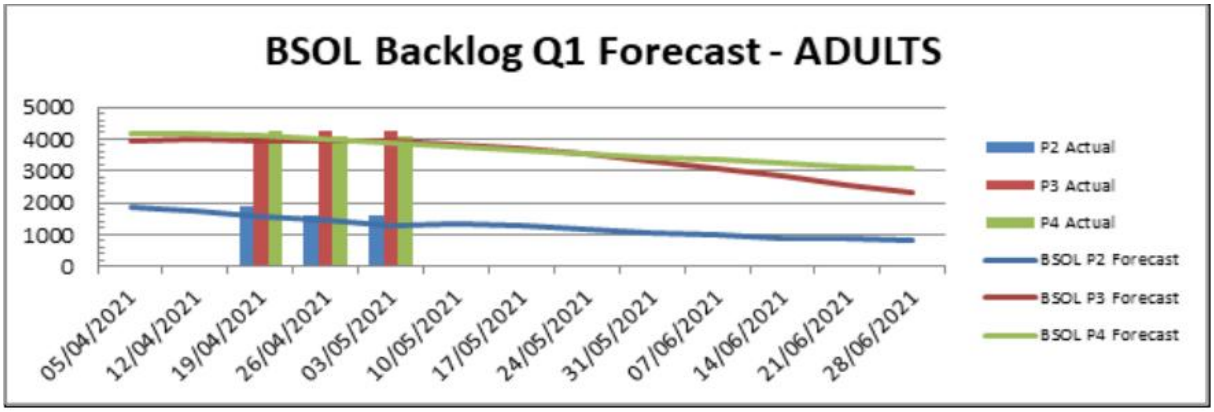
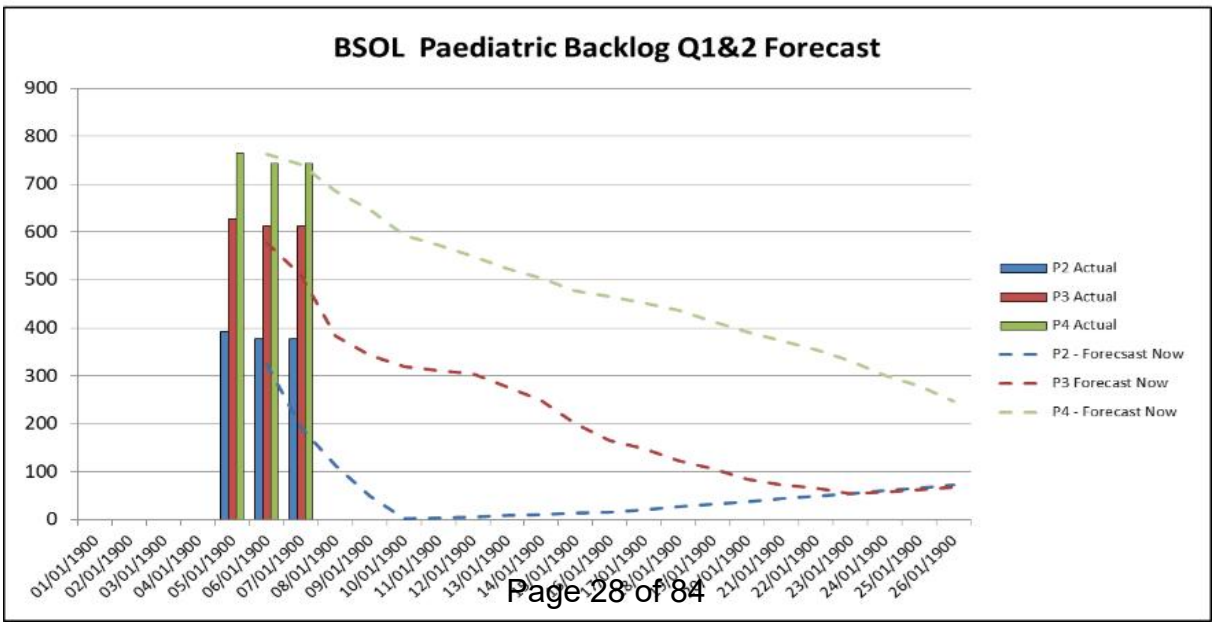


Figure 11: Actuals and forecast for quarter 1 (paediatrics)



P2 and P3 children awaiting surgery at UHB are being referred to BWC. This has included 80 ENT patients; of those 50 have already been treated and plans are in place for the remainder.

Enhanced perioperative care units have been established at the QEHB and Solihull Hospital, delivering 4 to 6 beds each day for elective surgery and this is expected to continue to expand. Nearly 70 cases a week, that would have needed an ITU bed, are currently going through these units.

There is an agreed theatre allocation across the system, rather than by individual organisation, incorporating a speciality approach, workforce solutions and the standardisation of outpatients and diagnostics.

The Health Status Check process, which was launched at BWC in February, is being adopted for some of the adult waiting list at UHB. The DrDoctor system will be used to support the engagement with patients. Final operational processes are being agreed, to help ensure the Trust has an up-to-date view of the status of each patient waiting for admission for treatment. A joint process is also in development for the wider system and for patients awaiting outpatient assessment.

9.3 Long term conditions, outpatients and diagnostics

The model of outpatient care has changed little over recent years and is ripe for reform; returning to a 'pre-COVID normal' will likely see a slower recovery. The pressure on delivery of an effective and timely diagnostic service has also been increased by the COVID-19 pandemic, and reform is required to prioritise diagnostic tests, with innovative pathways to aid such prioritisation.

There is a system-wide programme in place which aims to transform outpatient management, where the patient remains at the centre of care, cognisant of the size of the challenge during recovery to ensure equitable population access to the most appropriate care. Changes in outpatient models during this period of recovery should also look to the future and link with digital transformation models, maximising benefit across the whole population. Co-design across all stakeholders is key to successful, system-owned solutions where pathways are transparent to all patients and healthcare staff and demonstrate clear equity of access.

At the beginning of wave 1, there was a necessary rapid move to reduce face-to-face review with establishment of remote review by telephone and video. Face-to-face capacity has remained lower than pre-COVID levels even within recovery periods, and thus remote review has remained. NHSE/I 2021/22 planning guidance advocates remote review in at least 25% of outpatient appointments, estimating that this will rise to 40% where no outpatient procedure is required. Capacity for face-to-face review must however remain and be used as efficiently as possible to allow safe and effective clinical review where patient attendance is required to facilitate.

It is recognised that some pathways may be associated with a significant wait for secondary care. Effective triage of all referrals is a key element to both ensure urgent review where required and reduce demand on outpatient appointments where

advice can be given. However, demand in some pathways may still be associated with a long wait.

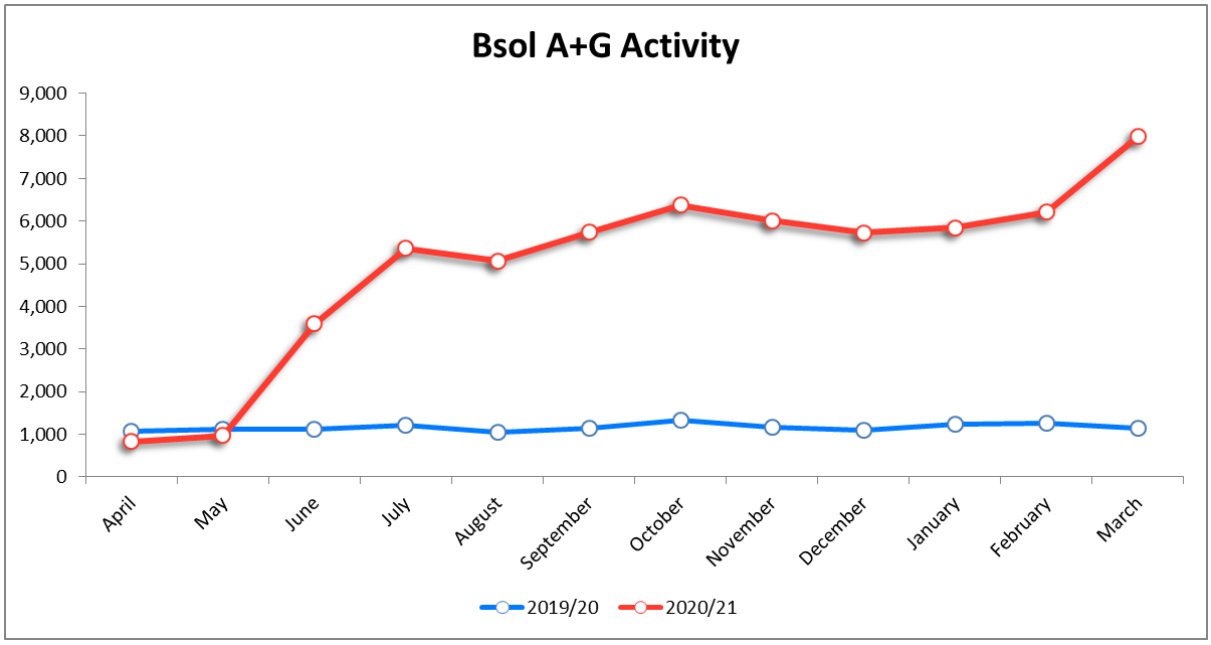
A key component of ensuring patient safety within this wait is the ability to assess for any deterioration in health status during this wait that may need re-prioritisation. Equally, the condition for which a referral has been made may have resolved, such that review is no longer required.

9.4 Advice and Guidance

Advice and Guidance allows consultants to respond to queries from GPs, avoids the need for a referral and consequently the patient coming to hospital; this helps to mitigate the impact of increased waiting times for first outpatient appointments.

Closer working relationships with primary care during the pandemic has facilitated a significant increase in the use of Advice and Guidance and rapid transformation of key critical referral pathways, as demonstrated in Figure 11, up by 400% and the second highest performance in the country.

Figure 12: Advice and Guidance activity for 2019/20 and 2020/21



Advice and Guidance activity is currently being reviewed by GPs, specialities and providers to establish a baseline and aid capacity and resource planning. This includes a 'user' questionnaire, to identify the key learning from the last 12 months and enable continuous improvements.

9.5 Communication and engagement

There is a system communications and engagement plan is place, which supports a fortnightly cycle of activity to keep audiences up-to-date with the latest information.

This includes patient communication, staff communication and engagement, stakeholder briefing and engagement with primary care. Focussed fortnightly online engagement sessions with staff and primary care colleagues are evaluating well. Oversight of the communications and engagement elements of the programme is provided at the System Operational Delivery Group and weekly ICS communications forums, which key ICS partners attend.

The Trust will start to write to all patients clinically classified as P3 and P4 on the inpatient waiting lists imminently, to advise them of the clinical priority their clinician has determined and advice if their condition deteriorates and the next steps. This will be accompanied by a FAQ document to support with common queries. Healthwatch Birmingham and Healthwatch Solihull have provided input into the patient letters. This will also run simultaneously with the Health Status Check, as described above.

A dedicated team is currently being established to manage patient enquiries via telephone and email following the receipt of the letters, to help support patients and reduce pressure on the wider system e.g. primary care.

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System operational planning 2021/22
Stakeholder briefing to Birmingham and Solihull Joint Overview and Scrutiny Committee

Harvir Lawrence, Director of Planning and Delivery
Lesa Kingham, Head of Planning and PMO

10th June 2021

Objectives

- Summarise the current context, challenges and priorities
- Highlight the national requirements for planning for 2021/22
- Highlight Birmingham and Solihull plans for 2021/22
- Seek your views on the plans for 2021/22

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Challenges and COVID impacts

COVID has had a significant impact on our area. Whilst we have worked effectively together to respond to the challenges and delivered excellent work in some areas it has had a negative impact on a range of areas:

- **Widening health inequalities** – negative impacts on our vulnerable and ethnic minority communities plus wider economic prosperity
- **COVID rates and hospital impacts** – comparable rates of infections to other large urban areas but we have experienced a greater level of hospitalisations linked to COVID – treating 11k COVID inpatients, 4k more than the nearest comparable hospital system (Barts in London)
- **Services suspended/changed and our future plans** – we accelerated transformation initiatives to deliver care including digital but a range of services were suspended to release staff to support our most COVID critical patients in hospitals and in the community linked to our hospital impacts
- **Increasing number of people waiting for care** – due to COVID, there are now growing numbers of people waiting for care and people are unfortunately waiting longer (c15k people now waiting 52 weeks and c22k people waiting 42 weeks)
- **Financial challenges** – before COVID, we recognised we needed to become sustainable. COVID has not alleviated these background pressures and there are still challenges regarding affordability
- **Workforce challenges** – before COVID, we had challenges in relation to recruitment, retention and staff shortages. COVID has added to that plus our staff are tired after months of pressure.

DRAFT 21/22 Delivery Priorities

1. **Keep colleagues and citizens safe from COVID19.** Deliver the vaccination programme and maintain organisational IPC and preparedness in the event of further waves of COVID19.
2. **Tackle long waiting times** for care as we come out of the COVID19 pandemic.
3. Transform care pathways based on our **"early help" / "early intervention"** vision
4. Improve the health of people living with **long-term conditions** and tackle inequalities by delivering primary care pathways focussed on prevention. (Priority conditions to be agreed e.g. diabetes, heart failure, respiratory).
5. Deliver **digitally-driven care pathways** building on UHB's digital transformation programme.
6. Establish the ICS partners as **"anchor institutions"** for tackling inequalities through a systematic approach to making good quality public sector jobs available to people from our most disadvantaged communities.
7. Invest in supporting the **health and wellbeing of health and social care colleagues** across the ICS including addressing issues of equality, diversity and inclusion.
8. Build a **system for tackling inequalities** in Birmingham and Solihull bringing together population health management, a locality and neighbourhood operating model and our inequalities strategy
9. Continue to build **an effective Integrated Care System** that will serve the people of Birmingham and Solihull well – establishing the ICS, approach to provider collaboratives, delivering a system financial strategy, designing a system estates strategy, bringing West Birmingham on board.

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Risks to delivering our priorities

Even before COVID, we were managing a number of risks. These risks and associated impacts have largely increased due to COVID:

- **Widening inequalities** – as we restore our services, there may be a continued negative impact from COVID on our ethnic minority, high risk and vulnerable people
- **Long waiting times –** these may worsen in the event of a further surge of COVID and as we recover services. This will widen health inequalities and increase mortality rates. Areas of risk are cancer, elective care, longer waiting times for mental health services, speech and language therapy, physio, OT and specialist assessment services
- **Increased demand for services** – we are likely to see an increased demand for different services e.g. mental health services as the pandemic continues.
- **Long term impacts for children** – we know the pandemic has been hard on children and young people – socially, educationally and through increased poverty levels. These issues may cause long term developmental impacts if we do not act now.
- **Future surges of COVID** – whilst we are planning to mitigate these, further national lockdowns and impacts on hospital will affect our communities both in health and wellbeing but also economically
- **Workforce capacity issues** – whilst we are proactively recruiting and addressing workforce challenges, even before COVID we had insufficient staff numbers. In the event of a surge in COVID infections there may be insufficient workforce resources to manage this and manage many of the services we have been working to restore
- **Funding** – financial constraints could be exacerbated further in 2021/22 which impacts on COVID delivery, restoration, recovery and long term transformation
- **ICS delivery** – there are risks relating to delays of introducing the ICS (due to national government policy, resources, clarity on final arrangements) which could affect how we use resources during this transition year
- **Boundary changes** – there are potential risks relating to changes in boundary for the Birmingham and Solihull ICS.
- **Lack of engagement** – there is a risk that we do not keep stakeholders informed which helps them understand the current operating environment and services available, which impacts on timely access to the most appropriate care.
- **Mitigations** - are in place for all of the risks and challenges. These are being monitored closely by senior leaders in our system.

National planning priorities for 2021/22

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
F. Working collaboratively across systems to deliver on these priorities.

Additional policy and technical guidance has also been provided on:

- System development and ICS establishment
- Elective recovery framework
- Health inequalities
- Maternity and Neonatal transformation priorities.

Birmingham and Solihull's response

Summary

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Health inequalities

Birmingham & Solihull ICS Inequalities Work Programme Priorities 2021/22

Workstream	Priorities 2021/22				
Inequalities as ICS Core Business	Midlands Health Inequalities Toolkit	BSol Inequalities leads Network	HI Priorities for ICS workstreams	HI Priorities for NHS trusts	HI leadership development
Data	NHS activity ethnicity coding	Locality & PCN level data	Mapping access to NHS services	Activity analysis joint with BCWB	Tracking Impact inc ICS OF
Community Engagement	PCN-level prototypes (x2)	Locality stakeholders	BLACHIR – NHS input	Link to Healthwatch Community offer	
COVID Response & Inequalities	Waiting Lists – equality analysis	Vaccination – inequalities grp	Long COVID equity of access	Equality impact of recovery plan	
Prevention	Maternity pathways (BUMP)	Early Years pathways (BFS)	Mental Health pathways	Long Term Condition pathways	
Anchor Institutions	Joint work with the People Board	Recruitment Opportunities	Social Value procurement	Living Wage commitment	
Digital Inclusion	Joint work with the Digital Group	Digital inclusion strategy			
Population Health Management	Led by the PHM programme	Inequalities built into PHM approach			

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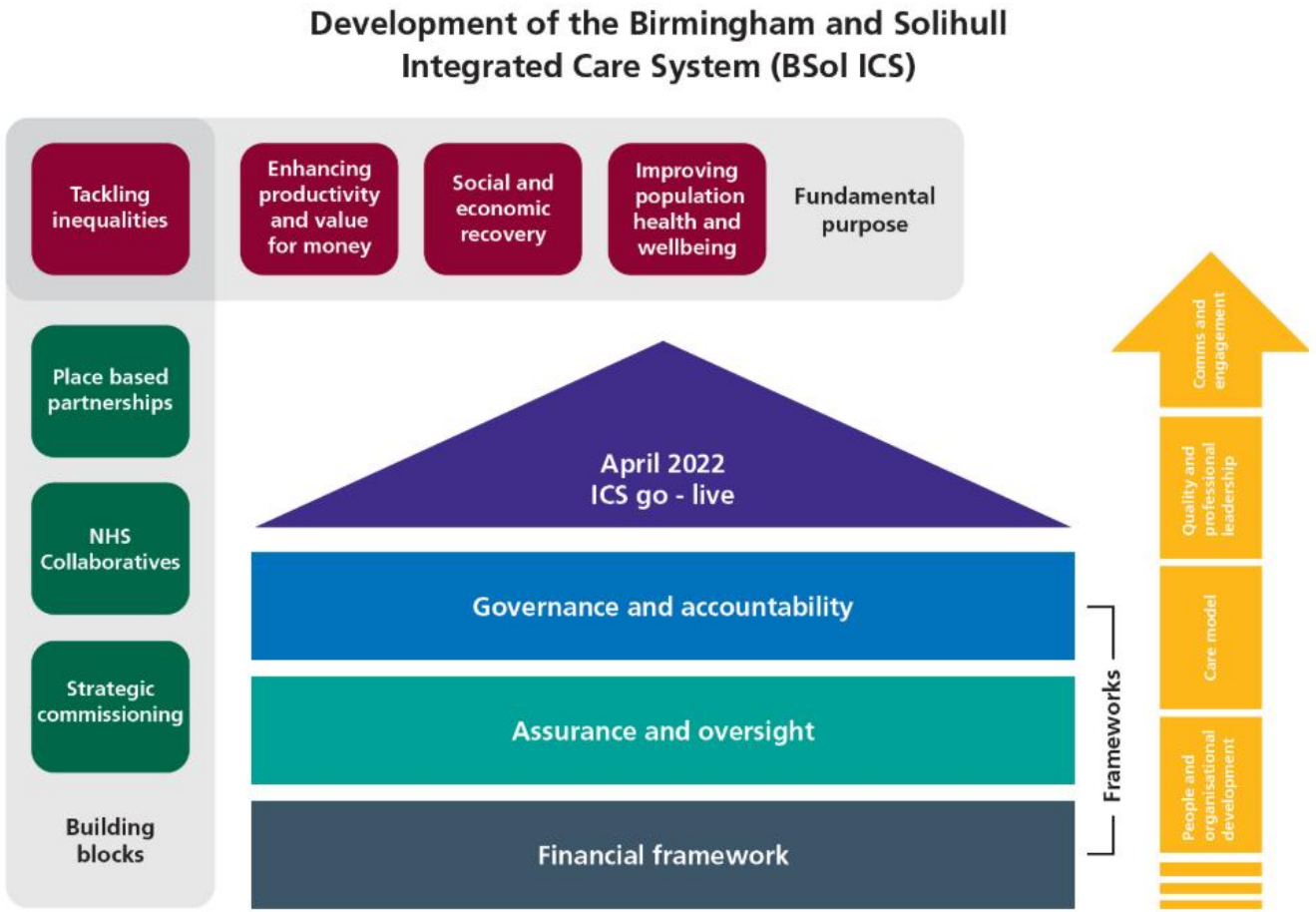
System development and ICS establishment



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A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

- **Continue to roll out and evaluate the enhanced Occupational Health and Wellbeing Offer -** for Staff and the Mental Health Hub to support people to recover from COVID
- **Deliver the objectives within Regional Equality, Diversity and Inclusion Strategy** - 6 High Impact Recruitment Actions and develop a clear action plan to address inclusion within recruitment
- **Review learning from the pandemic** – includes digitalisation, transferability of skills and competencies. and working across organisational boundaries
- **Increase focus on new ways of working** - supports both the mitigation of workforce capacity risks and deliver greater workforce integration and co-operation; includes ICS Bank and Reservist workforce
- **Address workforce gaps** – e.g. through new roles; retention of recently retired clinicians; GP training scheme; working with universities; apprenticeships; Careers Hub to attract hard to reach communities; entry level jobs; expansion in trainee nursing associates, primary care, international recruitment of theatre nurses, health care assistants
- **Work to be employer of choice** – by delivering the above and measuring this via Workforce Race Equality Standard, Workforce Disability Equality Standard and staff survey indicators

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

- **Continue with COVID vaccination management programme** – first dose to adults by end July 2021 and target via local vaccination units low-uptake amongst specific communities
- **Continue to deliver support services virtually and at home for those who are COVID positive** - aim is to prevent admission to hospital, where appropriate
- **Deliver post Covid-19 Syndrome (PCS) rehabilitation** – to be delivered via 2 assessment clinics; integration of teams across all providers for both children and adults; dedicated website; building on current pathways of care
- **Develop health inequalities plan across all pathways** - aim is to ensure equitable access to post COVID assessment and long COVID rehabilitation
- **Develop specialist children post ITU multi-disciplinary team clinics** where required
- **Develop the communications plan for raising awareness of the service** within the local community, working across commercial, charitable and voluntary sector

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (1)

Elective and cancer care

- **Pool resources to deliver the elective recovery programme** – creating a single patient waiting list (one for adults, one for children), supported by a demand and capacity planning tool to maximise efficiency
- **Continue to carry out clinical prioritisation and harm reviews for all patients** – ensuring diagnostics and treatments are expedited as quickly as possible
- **Maximise use of theatres, ITU and high dependency units** and explore triage options to maximise capacity
- **Maintain COVID 19 'green pathways' for elective surgery** – for essential urgent and cancer and spinal services whilst working through the orthopaedic backlog
- **Continue to improve patient flow** e.g. discharge to assess pathways, 'home first' cultures
- **Plan for any surges of COVID activity**
- **Support delivery of Rapid Diagnostic Centres** philosophy
- **Working with providers to ensure 2 week wait referrals are stable**
- **Support patients with advice and guidance and virtual outpatients for faster access** and to free up essential capacity

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (2)

Learning disability and mental health

- **Continue to support all patients with learning disabilities to ensure health checks**
- **Continue to learn from the Learning Disability Mortality Review Programme** and implement 100% of all actions identified
- **Continue to focus on inpatient admission avoidance for adults and children** with a learning disability
- **Continue with development of iThrive model of mental wellbeing and care** for young people up to 25 and increase coverage of 24/7 crisis response services
- **Increase access to IAPT** (improve access to psychological therapies
- **Expand mental health community services for early intervention**, people with serious mental illness
- **Increase diagnosis rate for dementia** and support continued offer of memory assessment clinics

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (3)

Children and young people's services

- **Commence children and young people's inpatient pathways, hospital admission avoidance transformation programmes**
- **Develop a place based approach** for children and young people's services based on transformation initiatives
- **Deliver the actions to improve Special Education Needs and Disabilities (SEND) services,** supporting education and health care plans, reviewing quality and reducing waiting times
- **Deliver the recommendations for the 1001 critical days** (i.e. first 3 years of a child's life)
- **Address health inequalities by reviewing service delivery based on access, data**
- **Support delivery of services for children's chronic illnesses** e.g. respiratory, diabetes, epilepsy to ensure care is delivered closer to home
- **Develop system wide neurodevelopment service** for people with Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder and review assessment processes and pathways to reduce time of referral to diagnosis
- **Focus on clearing the backlog of childhood immunisations due to COVID**

C. Transform the delivery of services based on learning from the pandemic, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services (4)

Maternity and neonatal transformation priorities

- **Deliver Ockenden recommendations for maternity services** including supporting partners to access appointments, supporting women from ethnic minorities via increasing support to at-risk pregnant women, tailoring communications, discussing vitamins and supplements, recording data (postcode, age, co-morbidities, BMI to provide enhanced support, particularly to people in more deprived areas)
- **Increase access to community based specialistic perinatal mental health** and widen the criteria to extend the period of access from 12 to 24 months for new mums
- **Increase access to psychological therapies for pregnant women and new mums**, to include postnatal depression service
- **Complete study into perinatal mental health services from ethnic backgrounds** to inform service delivery
- **Review psychological therapies services** to ensure they are culturally competent.

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

- **Continue to work with Practices, PCNs and GP Providers to review access** - plus support with a range of improvement initiatives to support the backlog of appointments, support long term conditions management and address health inequalities
- **Continue with Local Dental Network and Managed Clinical Networks (MCN)** – these provide clinical forums to support service development and recovery. Some of these such as Urgent Care, Restorative, Paediatrics, Oral Medicine, Secure Settings and Special Care are West Midlands wide whereas there are specific local MCNs to cover Oral Surgery and Orthodontics
- **Continue delivering the Local Maternity System Wide Stop Smoking Service** – to improve smoking cessation rates in pregnancy
- **Ensure focus remains on disease prevention and health promotion across a range of long term conditions**
  - Fully-integrated and system-wide approach to delivering diabetes care and Single Point of Access
  - Embed the Cardiovascular disease (CVD) projects and cardiac rehabilitation pathway. Also include heart failure pathway
  - Gather evidence (as one of 10 sites) to test the Low Calorie Diet Pilot
  - Review Birmingham and Solihull stroke pathway
  - Develop respiratory pathway for patients with COPD, Asthma, Bronchiectasis and Interstitial Lung Disease (ILD).

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

- **Embed Discharge to Assess pathway approach** by focusing on reducing length of stay in hospital; 'home first' approach; reviewing workforce model; development of single hub to expedite decision making; continue daily multi-agency reviews of all patients delayed from discharge; continue with the specialist palliative care and urgent response
- **Ensure community services for intermediate care** – supporting COVID+ patients needing bedded provision
- **Agreed system dashboard for monitoring 2 hour crisis responses**
- **Roll out Discharge Hub Management System** to aid one system view of patient flow
- **Deliver local awareness of NHS111 as a primary route into all urgent care services** in collaboration with national and regional NHS111 marketing campaigns and local targeted communication approaches and reviewing what will be most effective for our area given breadth of different communities and languages spoken
- **Develop a direct line for referrals for same day emergency care assessment areas** to prevent referral delay and expediate the patient journey to the appropriate facility
- **Work closely with all providers (via Birmingham and Solihull Directory of Service lead, monthly working group and Urgent Care Operational Group) to ensure the local Directory of Service is kept fully up to date** with service availability and that service descriptions are clear for NHS 111 staff
- **Establish Task and Finish group to ensure that the data is consistently and correctly recorded to report the new information in compliance with the Emergency Care Data Set requirement -** will involve ED clinicians, Information analysts and Divisional Management to ensure consistency of approach across all sites

Engagement

We will update and inform and engage on the plan with the following:

Partner **Key stakeholders who will work in partnership to help us deliver the activity**	• NHS staff – clinical • NHS staff – non-clinical • NHS England and NHS Improvement • General practice • NHS Birmingham and Solihull CCG • University Hospitals Birmingham NHS FT (UHB) • Birmingham Women's and Children's NHS FT (BWC) • Birmingham and Solihull Mental Health NHS FT (BSMHFT) • Royal Orthopaedic Hospital (ROH) • Birmingham Community Healthcare NHS FT (BCHC) • Birmingham City Council (BCC) • Solihull Metropolitan Borough Council (SMBC)
Involve and engage **Stakeholders who will need to be actively involved and engaged**	• Existing patient networks and forums • Statutory committees e.g. HOSC, HWBB • MPs and Councillors • Third sector – via BVSC (Birmingham) and CAVA (Solihull) • Healthwatch Birmingham • Healthwatch Solihull • Local Medical Committees • Other stakeholders, as appropriate
Inform* **Stakeholders who need to be aware, kept informed and have an opportunity to respond**	• Existing patients • Wider public in Birmingham and Solihull • Local media, inc. radio • Hyper-local media outlets

Next steps

- Start to consider longer term strategic priorities and plans (October 2021-March 2021) and engage on these

- Continue to transition to an Integrated Care System by September (shadow form) and new legal entity (April 2022).

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Questions and discussion points

- Do you think we have captured the challenges effectively?
- Do you agree with the priorities for Birmingham and Solihull?
- How will being an Integrated Care System help us improve health and care, from your perspective?

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Birmingham and Solihull ICS Financial Planning 21/22 - JHOSC June 2021

ICS Financial Performance – October 20 to March 21

The BSOL system originally submitted a plan showing a deficit of £50.4m for the final 6 months of the financial year. Due to movement in assumptions and performance during October and November, the financial plan was revised to a £19.2m deficit.

The year end financial performance, by organisation, is shown below:

	Plan	Actual
Birmingham and Solihull Mental Health	(£2.6m)	(£1.7m)
Birmingham Community Healthcare	£0.8m	£0.1m
Birmingham Women's and Children's	(£3.7m)	£3.8m
The Royal Orthopaedic Hospital	(£2.2m)	(£2.4m)
University Hospitals Birmingham	(£11.4m)	£12.8m
Birmingham and Solihull CCG	£0m	£1.0m
TOTAL	(£19.2m)	£13.6m

The BSOL system finished the year in surplus, largely as a result of additional resources released by NHSE/I in Month 12 to cover shortfalls in non-NHS income and the impact of the backlog of annual leave in NHS organisations.

ICS Financial Planning Process

- ICS finance planning covers the H1 period between April and September 2021.
- Systems received an allocation broadly in line with that received during H2 20/21, therefore including additional funding for ongoing Covid costs.
- Additional funding also allocated for:
  - Elective Recovery Fund – Funding for additional recovery activity over and above historic baselines (70% of 19/20 activity in April, 75% in May, 80% in June, 85% from July onwards)
  - Mental Health Investment Standard
  - Service Development Funding for specific priorities within the Long Term Plan and targeted post-Covid challenges:
    - Mental Health
    - Primary Care
    - Community - Roll out of the two-hour crisis community health response at home
    - Long COVID
    - Outpatient Video Consultation
    - Learning Disability and Autism
    - Ockenden Review of Maternity Services

ICS Financial Plan – April to September 21

The BSOL system submitted a plan to NHSE/I on 6th May showing a deficit of £28m for the H1 21/22, with a range of potential mitigations that could bring the system into financial balance.

The deficit plan, by organisation, is shown below:

	Plan
Birmingham and Solihull Mental Health	(£1.6m)
Birmingham Community Healthcare	(£1.6m)
Birmingham Women's and Children's	(£2.7m)
The Royal Orthopaedic Hospital	(£0.5m)
University Hospitals Birmingham	(£10.2m)
Birmingham and Solihull CCG	(£11.3m)
TOTAL	(£28.0m)

Following additional work to identify and firm up additional mitigations, the ICS has verbally committed to targeting a breakeven position for H1. It is expected that a formal resubmission will be made on or around 15th June.

Key Assumptions within the H1 Financial Plan

- Restoration and Recovery of services:
  - Plans assume funding to deliver the baseline activity targets as per the Elective Recovery Fund (70% of 19/20 activity in April, 75% in May, 80% in June, 85% from July onwards).
  - Plans for BWCH, ROH and the CCG (for the Independent sector) include baseline costs that will deliver activity over and above these activity targets.
  - In total, this additional activity would generate £5.7m of ERF income if overall system activity targets are achieved.
  - Plans for BCHC assume funding to cover the restoration of standard community services, plus additional funding to retain key service developments introduced during Covid.
  - Plans for BSMHT and FTB assume additional funding for mental health surge capacity and the full year effect of expanded services funded through the Mental Health Investment Standard.
- Efficiency Targets
  - There were no explicit efficiency targets placed on NHS organisations in 20/21.
  - H1 allocations assume the continued suspension of efficiency targets until 1st July 2021.
  - For Q2, efficiency targets of 0.55% have been top-sliced from allocations.
  - Systems with an underlying financial deficit (which includes BSOL) have had an additional improvement target applied to their allocation (£2.9m for BSOL).
  - It is expected that savings targets of a minimum of 1.1% will be reintroduced from H2.

Post-COVID Syndrome ('Long COVID') Rehabilitation

Jo Williams, CEO, The Royal Orthopaedic Hospital (ROH)
Claire Underwood, Deputy Chief Nurse (Birmingham and Solihull CCG)
Rebecca Lloyd, Deputy Director of Strategy (ROH)
Alicia Stanton, Transformation Manager (ROH)

Presentation to JHOSC | 10th June 2021

Background

- NHSE and NHSI five-point plan to support people with post-COVID Syndrome (launched Oct 2020)
  - Commitment to establish clinics across England, giving patients access to multi-professional advice
- Prior to this, referral pathway and available treatment options were unclear
- £10 million allocated for the establishment of clinics – funding allocation based on GP registered populations by region
- NHSE/I guidelines published November 2020 and updated April 2021
- NICE guidelines published December 2020
- Increasing evidence that COVID-19 has a disproportionate impact on people in black and ethnic minority groups, and exacerbates existing health inequalities
- The number of patients who need management focusing on recovery and rehabilitation is likely to continue rising

Scope: What is Post-COVID Syndrome?

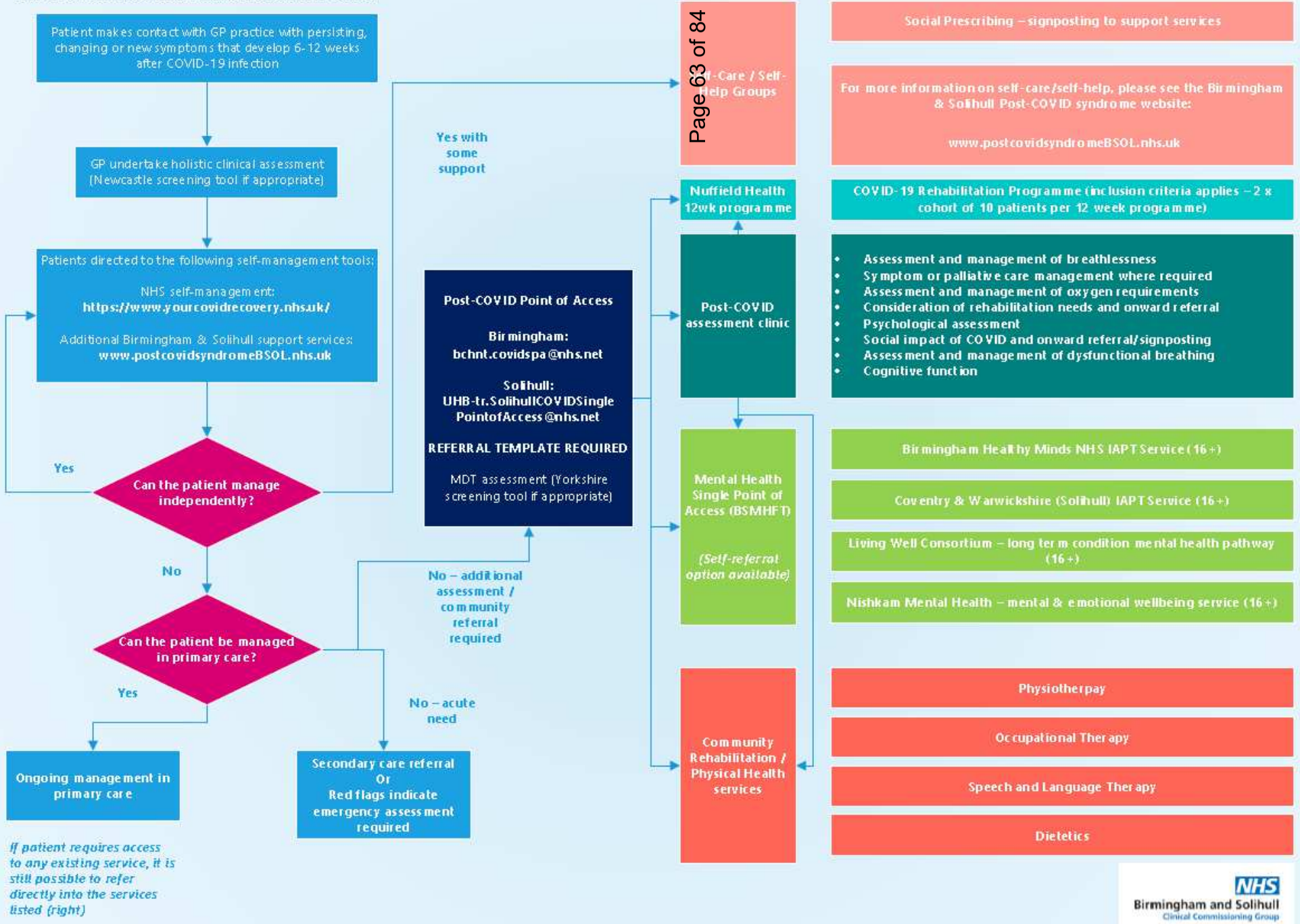
- Post-COVID Syndrome (*as defined by NICE, SIGN and RCGP)*
  - Signs and symptoms that develop during or following an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis.
  - The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body.
  - Many people with post-COVID syndrome can also experience generalised pain, fatigue, persisting high temperature and psychiatric problems.
  - Post-COVID syndrome may be considered before 12 weeks while the possibility of an alternative underlying disease is also being assessed.
- Includes:
  - Patients who remained at home or in a care setting
  - Patients who were hospitalised

Post-COVID Syndrome Programme: A partnership approach

- Programme governance established with representation from all partners within the Birmingham and Solihull Integrated Care System
- Jo Williams, CEO at The Royal Orthopaedic Hospital NHS Foundation Trust was appointed ICS CEO lead for this programme, reporting into a new Programme Board chaired by Paul Jennings
- The new pathway was built around existing services, with a new MDT assessment as part of two ‘Single Point of Access Hubs’ (Birmingham/Solihull) and new Post-COVID assessment clinics led by UHB
- The successful implementation of an integrated pathway across community, primary, secondary & tertiary care was testament to excellent clinical leadership, and the engagement of all partners

Birmingham & Solihull Post COVID Syndrome Rehabilitation Pathway

Post COVID Rehabilitation: Primary Care Referral Pathway



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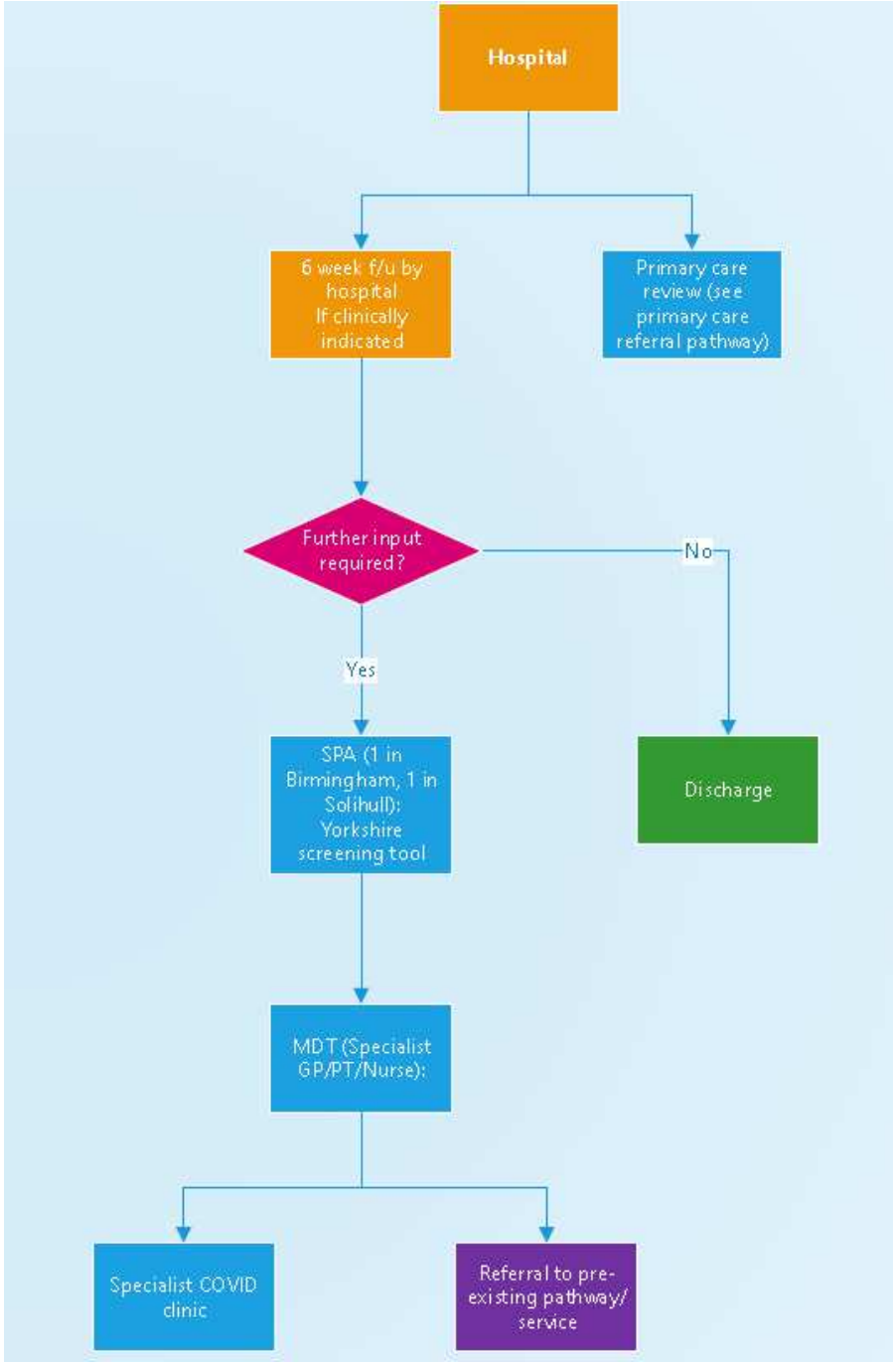
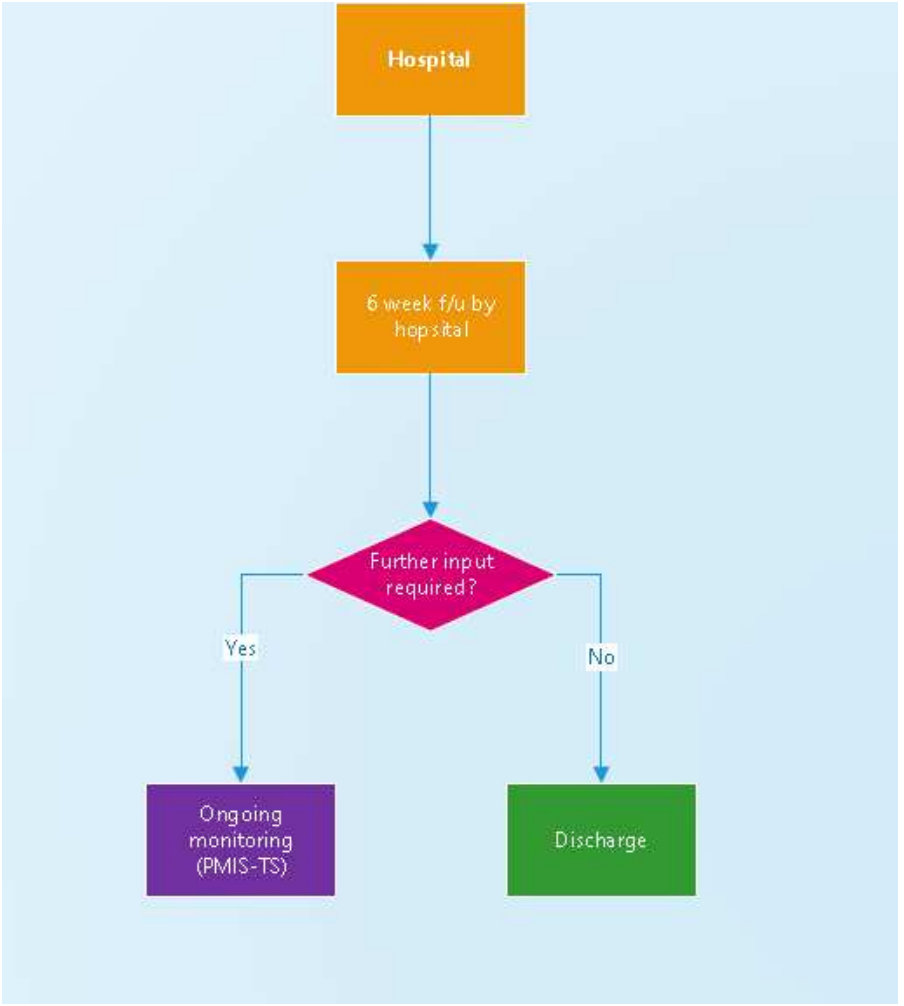
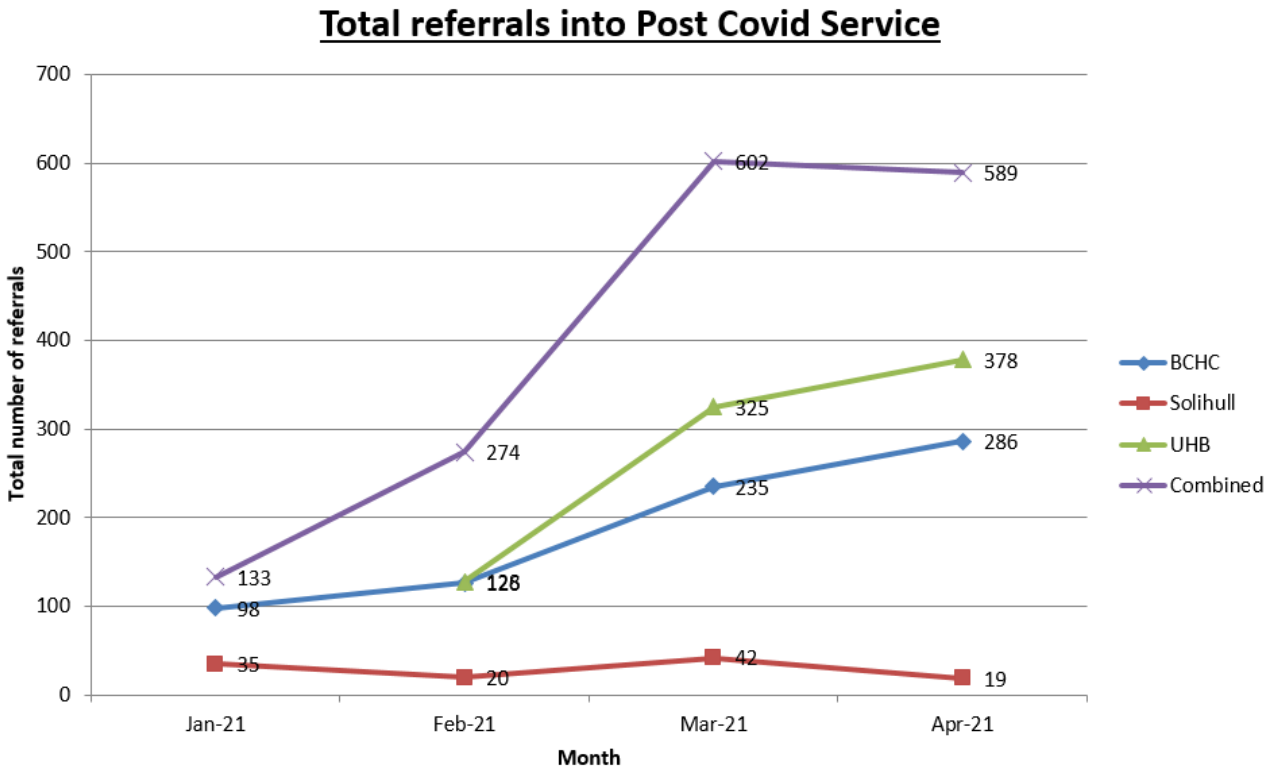
Adults

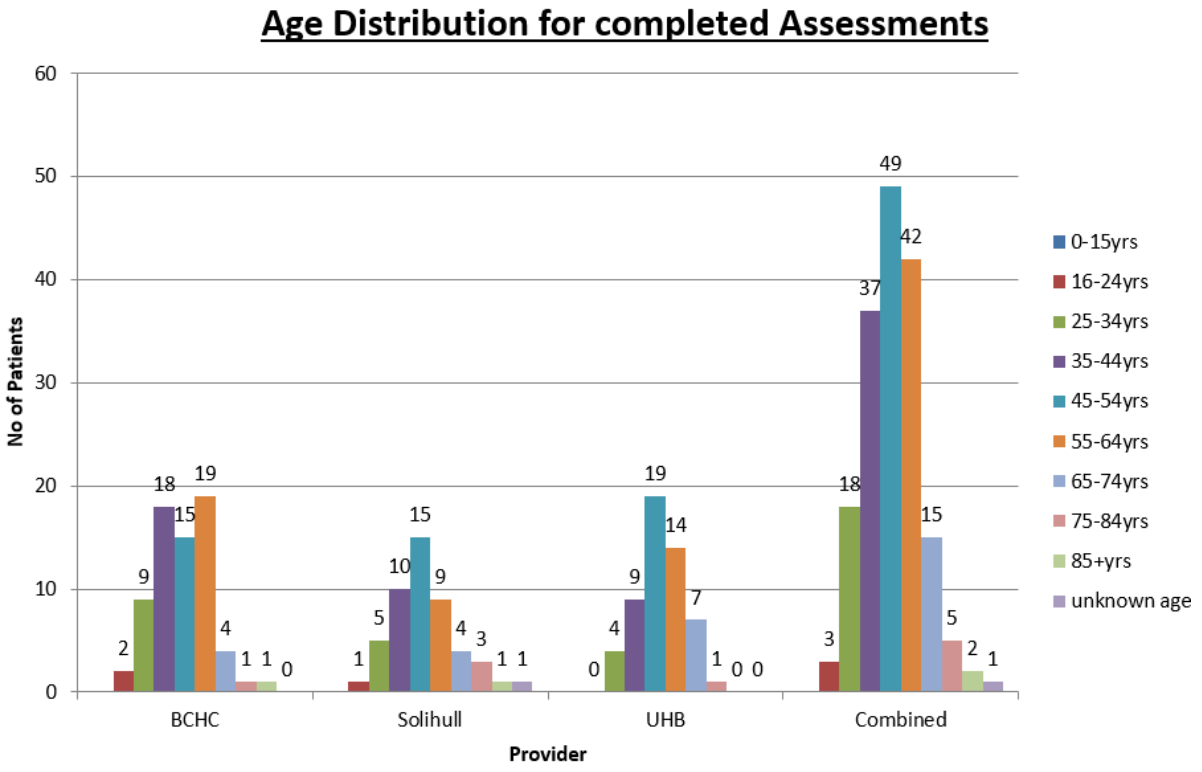


Paediatrics

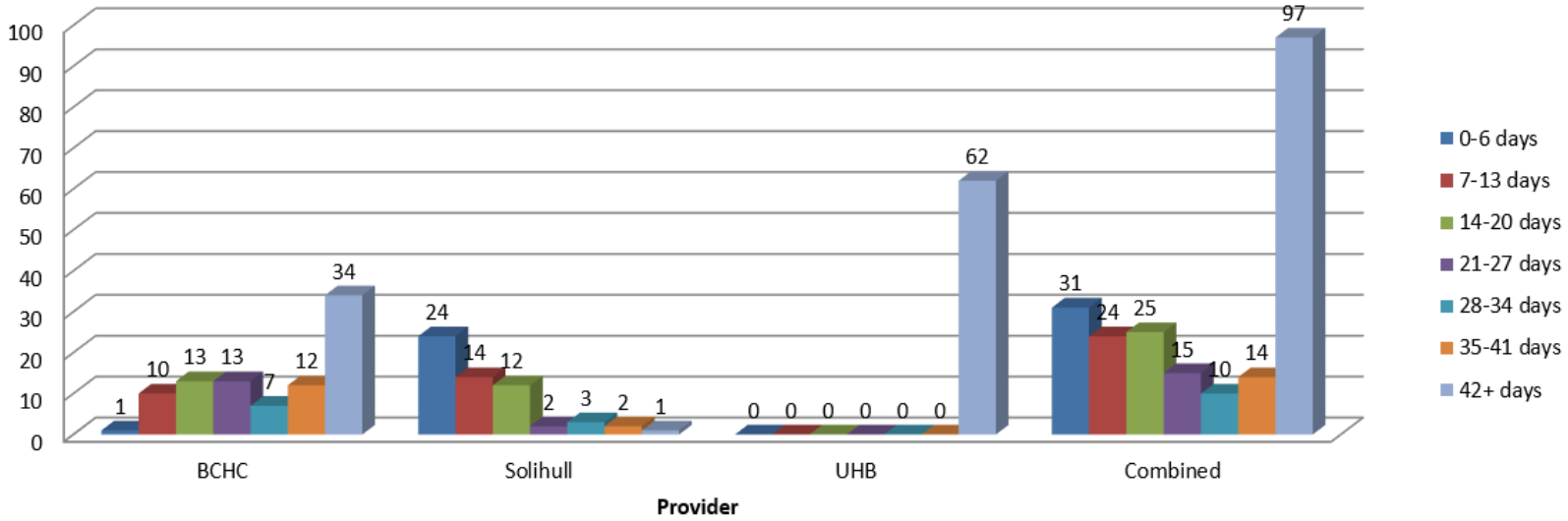


Data Collection

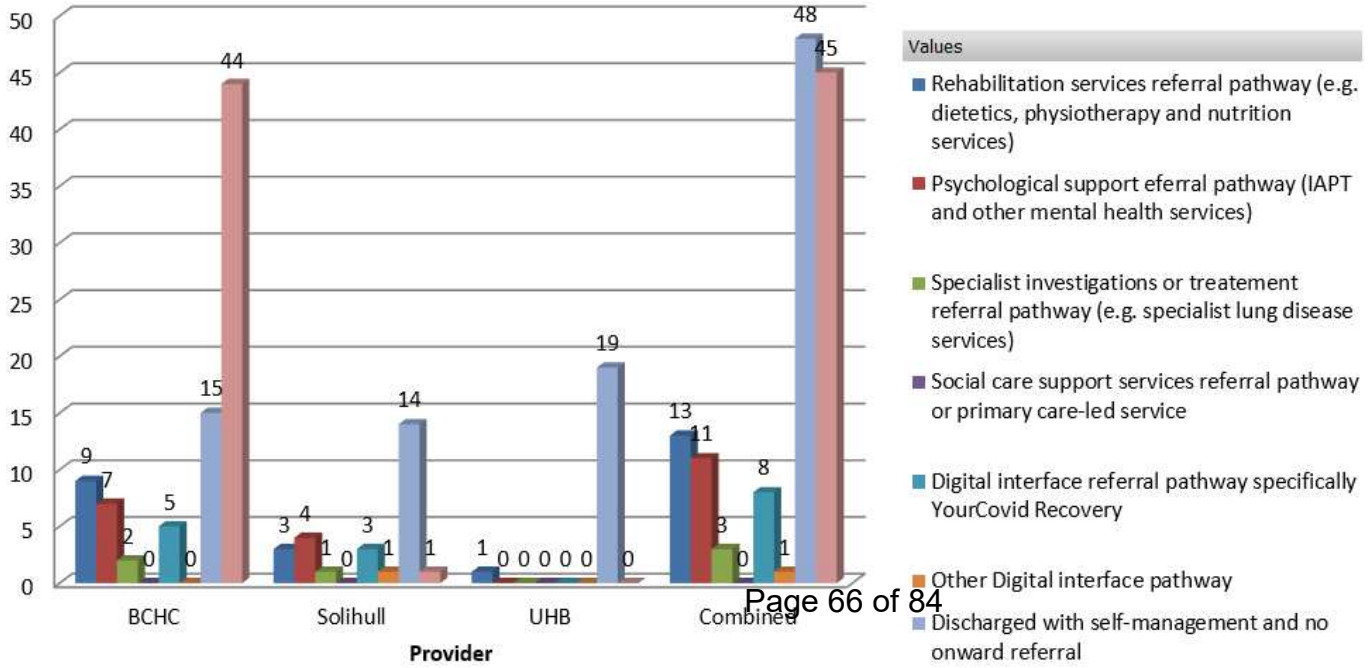




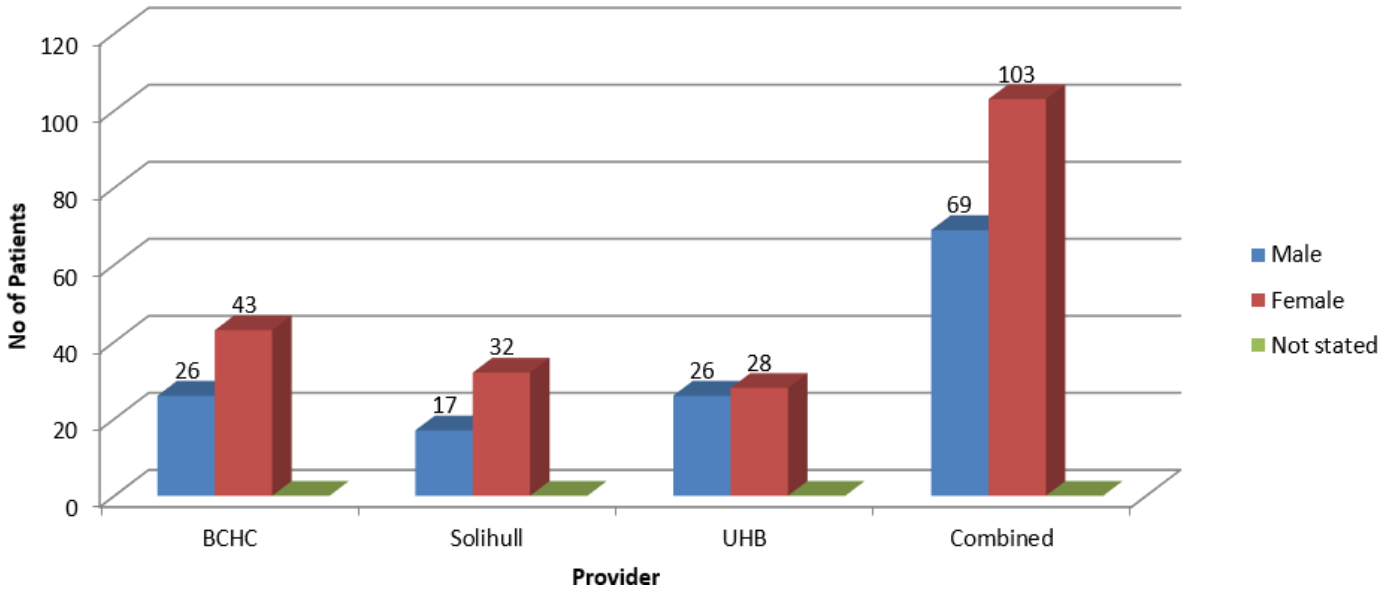
Waiting times from Referral to Assessment



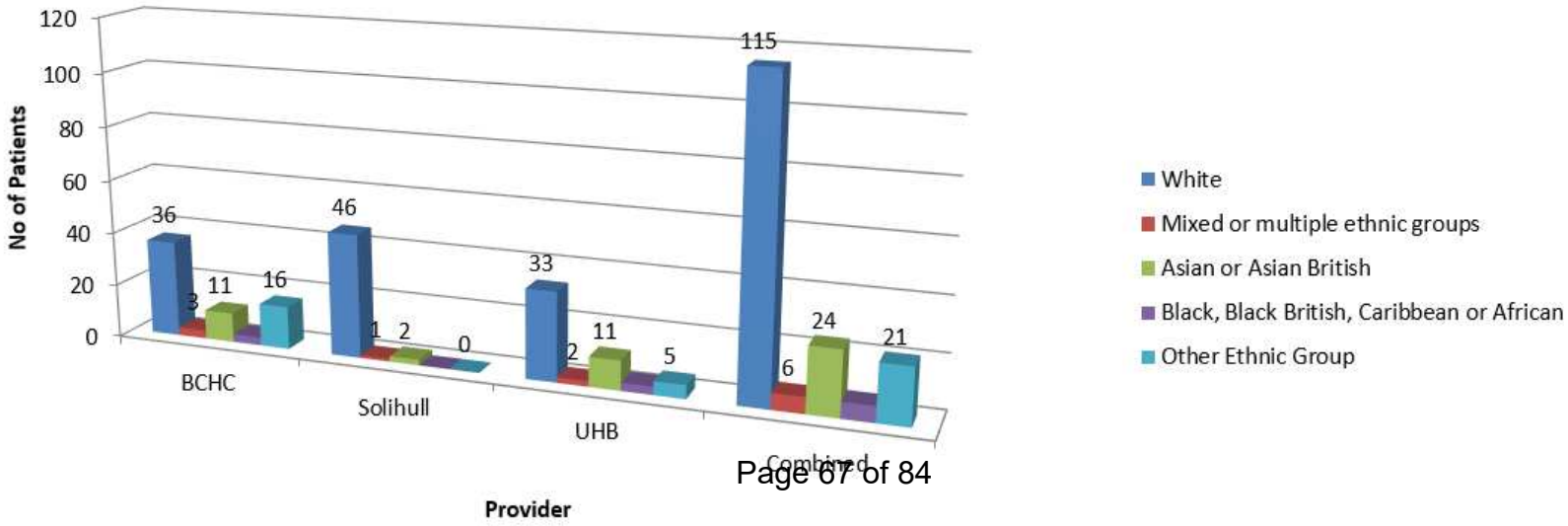
Outcomes for Completed Patients



Gender Group for completed Assessments



Ethnicity of completed Assessments



Patient feedback | BSol Long Covid Pathway

John, 60 year old male (Covid in Oct ’20)

Good experience with the screener taking her time to explain everything to me. I felt included in any decisions and the information guidance and assurance was well received and has certainly aided my recovery. Next steps in my recovery were explained clearly .

Areas for Improvement

A suggestion would be to tweak the assessment form to enable all appropriate answers to be ticked. I found it difficult to tick one box only, as I am experiencing many different symptoms

Patricia, 53 year old female (Covid in Dec ’20)

Simone has been compassionate, informative and engaging throughout the whole process. This was really important as the waiting time from referral to first assessment was too long and caused anxiety. Assessment questions were appropriate and explored multiple symptoms. The reassurance from Simone about variable symptoms very much helped to ease my anxiety. Having contact details and being signposted to self help resources and informative websites was very good also. Advice and check in following medic discussions and MDT - Assessment letter very thorough.

1. Improve the waiting time to assessment.
2. Follow up session with a consultant/medic would be of benefit.
3. No actual physical health investigations to determine what is actually going wrong within the body. e.g. X-ray, CT scan etc.
4. Onward referrals as my symptoms could now be looked at in isolation potentially by clinicians that do but understand long Covid and definitely not as well as a Specialised clinic would.
5. More development required

NHS England Taskforce on Long Covid| BSol CCG patient feedback (Feb 2021)

I've been referred to 'post covid rehabilitation' which is over the phone. I don't know whether it's associated with a post covid clinic. She completely believed what I said and she had a coherent explanation for why the symptoms that I have might be happening even though she said she can't know for sure. She was so reassuring. She said that it's clear I'm getting better even if it's slow and that indicates that at some point I might get back to how things were before I got ill. She told me things to do and not do till the next appointment. It was amazing and I can genuinely feel improvement. Even if it was only over the phone it was like I wasn't doing this alone any more - and after 10 months I finally have a bit of an explanation that makes sense to me. I hope that for others it won't be so long...

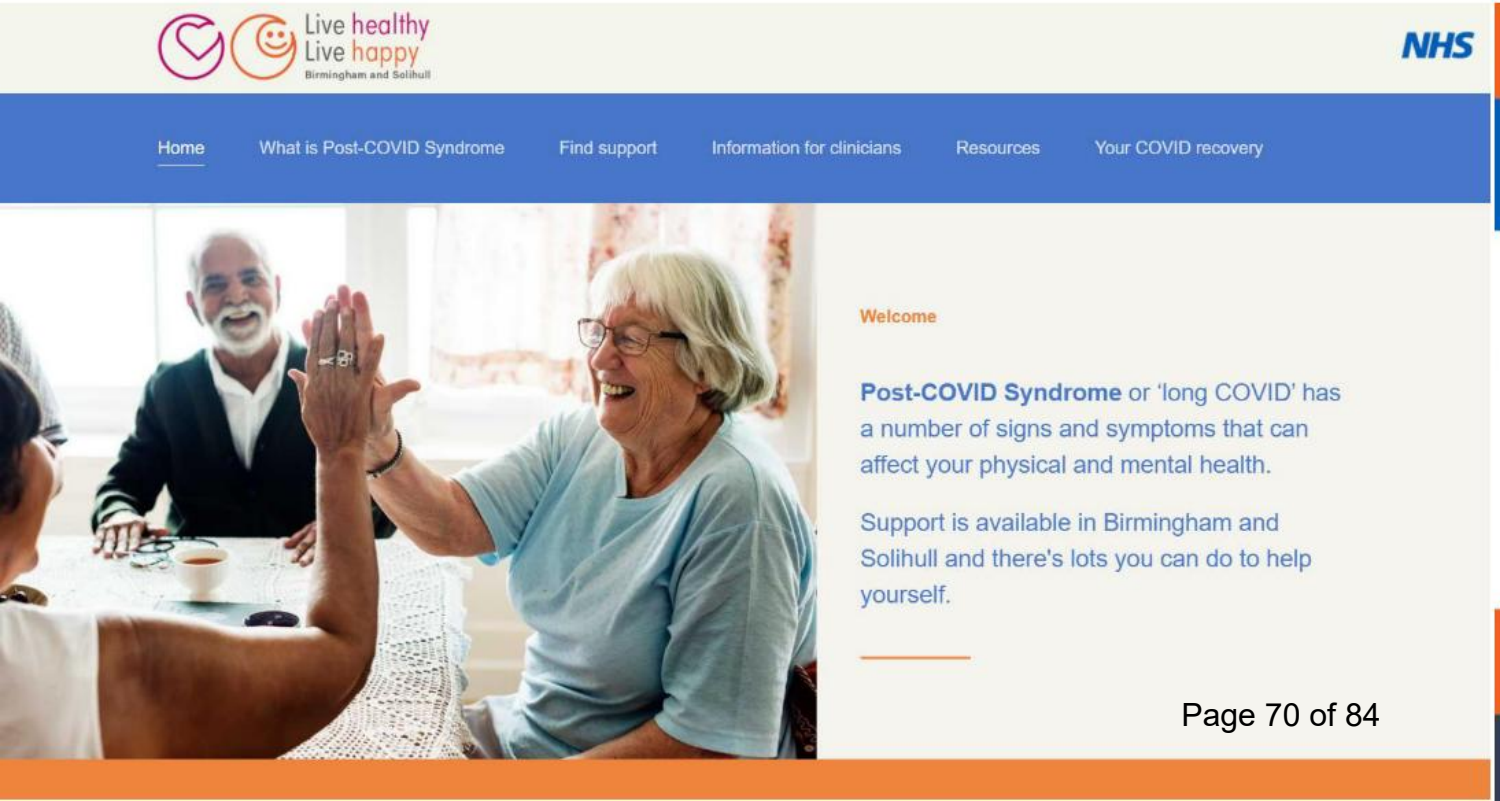
Despite multiple requests, continuing issues, still off work and confirmation of covid, still heard nothing back. More info needed at doctors on how to make the referral and on long covid

My doctor never mentioned about a clinic

Yes but heard nothing back 6 weeks later

GP and Patient Engagement

- Improved communication with primary care
- Patient information
  - multiple languages
  - online and paper versions
- Virtual patient engagement events
- Dedicated website
- Local media



Successes of Phase 1:

Focus: To work together as a system at pace, to implement a supportive (not over-medicalised) pathway for patients affected by Post COVID Syndrome

- Two single point of access hubs with MDT assessment & triage accepting referrals from December 2021
- Assessment clinics established and fully operational by January 2021
- Strong clinical leadership & programme governance with weekly meeting & reporting
- Commitment to creating a patient-centred pathway, with opportunities to use existing services & referral routes
- Communications a priority from the beginning – dedicated website and training portal in place by December 2020
- Support from teams across all NHS providers, as well as independent, voluntary & charitable sector
- New opportunities for partnership established with Jaguar Land Rover & Nuffield Health

Priorities for Phase 2:

Focus: To consider the wider impact of COVID on our citizens

- Developing and implementing a plan to address health inequalities
- Improve breadth and quality of data collected for patients accessing service
- Agree the capture and analysis of clinical outcomes to inform further improvement
- Patient education / health prevention, including patient engagement events and symptom-specific patient information
- Lead on co-production programme with patients, building links with existing and newly established PCS patient networks
- Ongoing education events for primary care colleagues to improve quality of referrals and understanding of services available
- Reduction in waiting times from referral to assessment, and assessment to rehabilitation
- Embedding a dedicated Paediatric pathway, working within a regional model (BWC – lead provider for 'Midlands' region)
- Developing a business case for future service delivery, considering the following challenges:
  - Unknown demand and the potential impact on existing services without any additional funding to support
  - Ongoing challenge of resources for the longer-term – increased demand from second wave, staff returning to substantive roles, additional space for clinics required

Thank you & questions

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Goodrest Croft Surgery

Joint Health Overview and Scrutiny Committee

Summary and Purpose

- The GP partners at Goodrest Croft Surgery handed back the contract without notice, and as a result all responsibility for their patients in October 2019
- The Clinical Commissioning Group (CCG) as required by NHS England identified a temporary interim provider, at less than weeks notice
- The uncertainty regarding the future intention of the surgery building ongoing availability remained unclear for a year. This influenced the CCG decision to disperse the list in best interest of patients due alternative local provision.

- This overview report details the chronology at summary level of the key events and the activities in relation to public consultation.

Chronology 1

Date	
21 October 2019	GP Partners escalated breakdown in relationship, CCG and LMC attempted to mediate, however GP handed back the contract to CCG CCG commissioned an alternative local provider at less than a weeks notice to provide an immediate temporary caretaking service for the patients of Goodrest Croft Surgery to ensure services continue
14 January 2020	The CCG Primary Care Commissioning Committee granted approval to procure patient services from Goodrest Croft Surgery premises
16 January 2020	Unsuccessful in obtaining assurance or availability of the existing or alternative premises Procurement of a new Alternative Primary Medical Service (APMS) provider was not possible without access to premises.

Chronology 2

Date	
14 February 2020	A further attempt to secure clarity on the GP (landlords) intentions in relation to the future availability of the building was undertaken. The CCG met with two of the owners to allow primary care to be delivered from the site for at least 10 years. The owners requested more time to discuss and consider their options. Caretaking arrangements continue with temporary clinical staff continuing to be funded by the CCG,
11 August 2020	The CCG agreed to a rent uplift of £9,328 per annum at the request of the landlords. We understood the rent review was key element in informing the landlords decision regarding the ongoing use of the premises.
23 September 2020	A request for backdated in part payment to 2009 was received while the uplift approval was pending- this was considered at an Extraordinary Primary Care Commissioning Committee and was

Chronology 3

Date	
29 September 2020	Premises meeting with the landlords requesting a final decision around the ongoing availability of the premises by 9 October 2020.
9 October 2020	E-mail received from the landlords confirming the premises availability. The landlords declined to provide a legal undertaking to that effect.
13 October 2020	The CCG considered all options and made the decision to disperse the patient list.

Chronology 4

Date	
4 December	Stakeholder briefing provided to Birmingham and Solihull HOSC members
15 December 2020	Patient Participation Group (PPG) members were contacted individually by the CCG Primary Care Contracting Team. Patient communication, including a dedicated support telephone line for patients.

Consultation requirement summary

As set out in the NHS publication *Legal duties for service change: a guide*:

NHS Birmingham and Solihull CCG decided to change (close) the primary care service at Goodrest Croft without allowing time for full public consultation with patients due to consideration of imminent risk to the welfare of patients (and staff) based on the uncertainty of the premises and unfeasible scope of procurement of a new provider.

Exceptions also cover the requirement to consult with the local council, however the CCG did consult with the health overview and scrutiny committee and have worked closely with a number of councillors to inform and advise them of the reasons for the change and keep them abreast of the how the change will impact patients and the support being offered to patients to register elsewhere.

Where services need to be closed or suspended at short notice, NHS bodies and their partners should act in accordance with the Joint Working Protocol, which the CCG has followed.

The CCG has acted in accordance with their legal duties, including:

• keeping good records of the factors we considered in making these decisions;

• communicating the changes to affected people; and

• informing the local authorities in the areas affected about changes and reasons for not consulting under the regulations

In terms of the National Health Service Act 2006, section 14Z2, which states that as the commissioning body we “must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways” – we have informed and supported patients through providing letters to all registered patients, holding patient meetings and providing a dedicated helpline for support in registering elsewhere.

Learning

- Engagement with patients
  - Introduce more virtual patient sessions
- Communication with members of the Joint HOSC
  - Make a call clear to action regarding email briefings
- Inform some stakeholders earlier in the process
  - Engage with community services to ensure smooth transition of patients when living on borders of different areas
- Transparency regarding the main driver of the issues
  - A key driver was the uncertainty of the availability of the premises and this could have been communicated more openly


Thank you for
listening.
Any questions?