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