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.

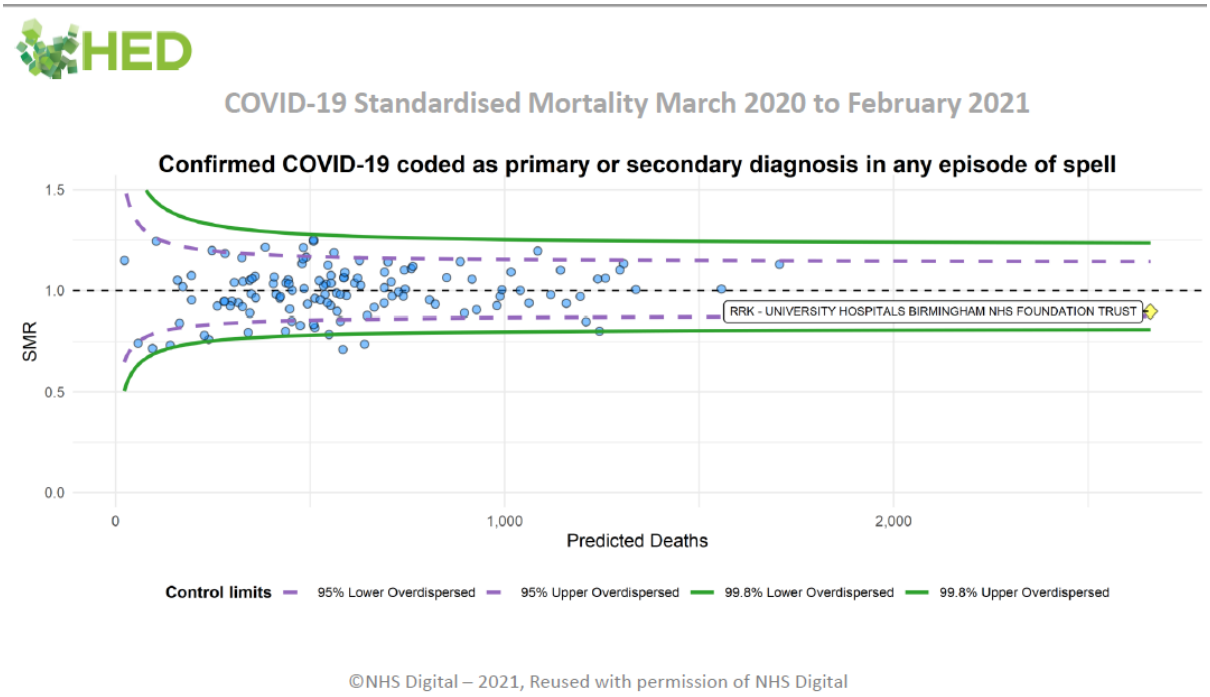
3. The context - UHB activity

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



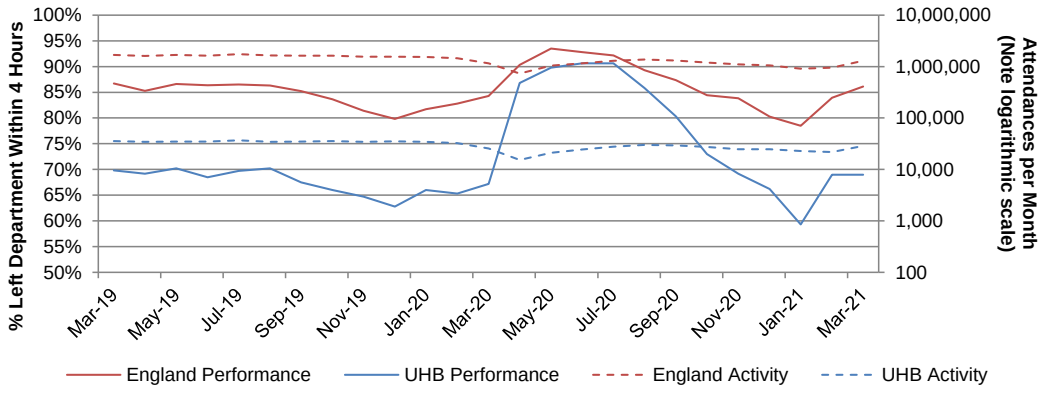
3.1 Emergency Departments

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

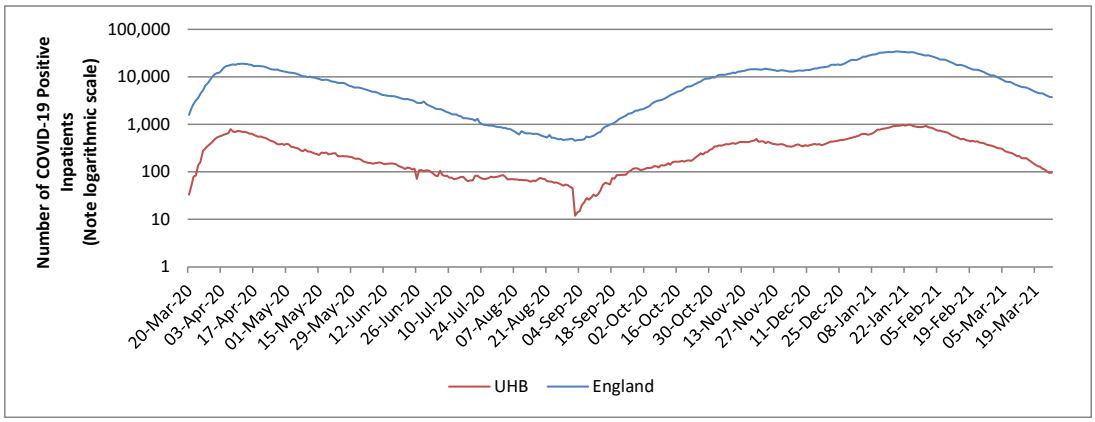


3.2 Inpatients

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.

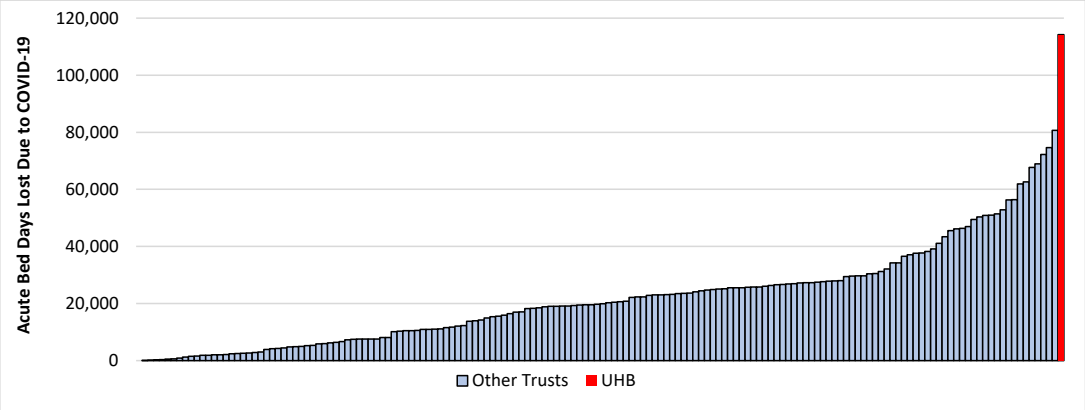
It should also be noted that in the year from 20 March 2020, UHB had the highest number of COVID-19 positive patients on 209 days. Over that period the NHS as a whole had nearly 3.7 million bed days occupied, with UHB contributing nearly 129,000, or 3.5% of this.

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



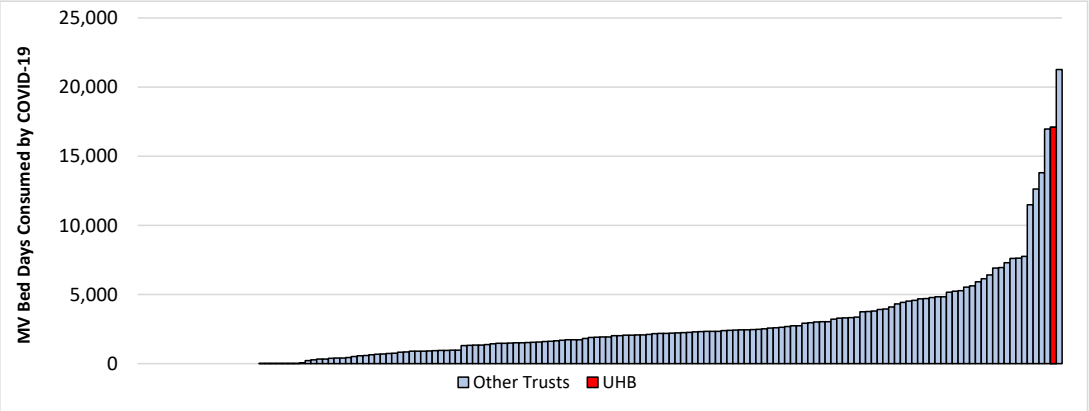
3.3 Critical care

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

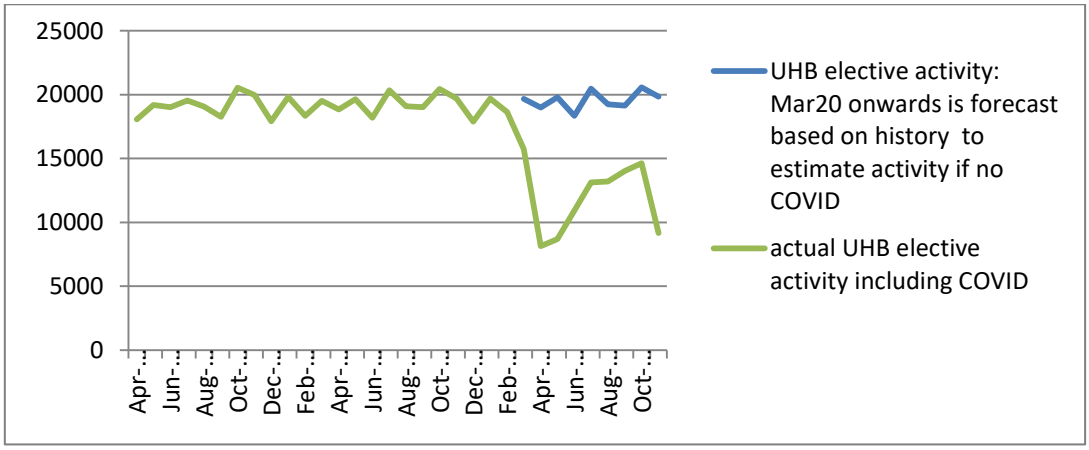
workforce by 250%, to enable us to care for our sickest patients. Meeting this requirement eliminated almost all elective treatment, for patients requiring access to operating theatres.

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.

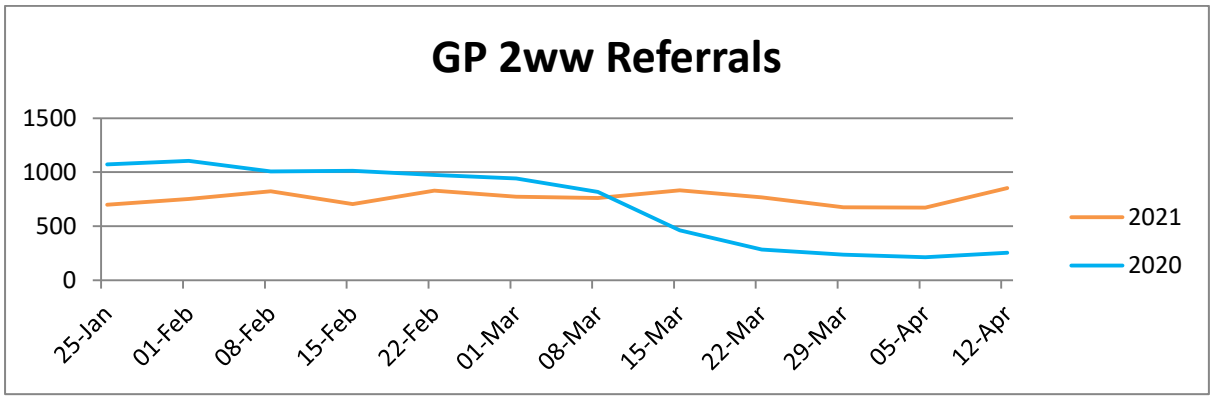
The Trust and CCG have maintained ongoing dialogue with statutory committees e.g. Joint Health Overview and Scrutiny Committee, to ensure they are informed and sighted on the current situation, whilst the NHS and Trust is operating under emergency legislation.

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

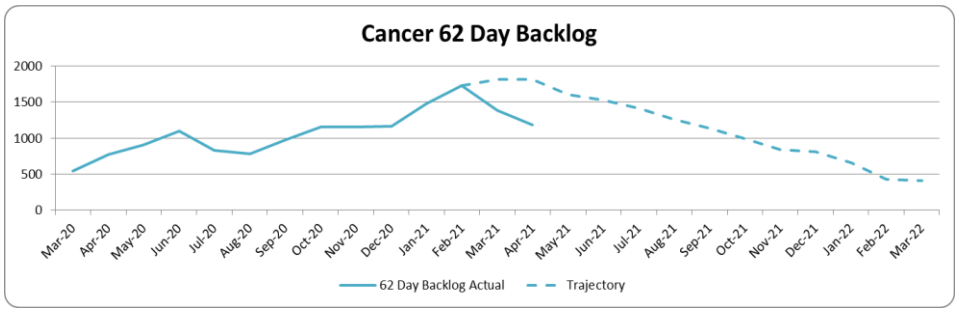
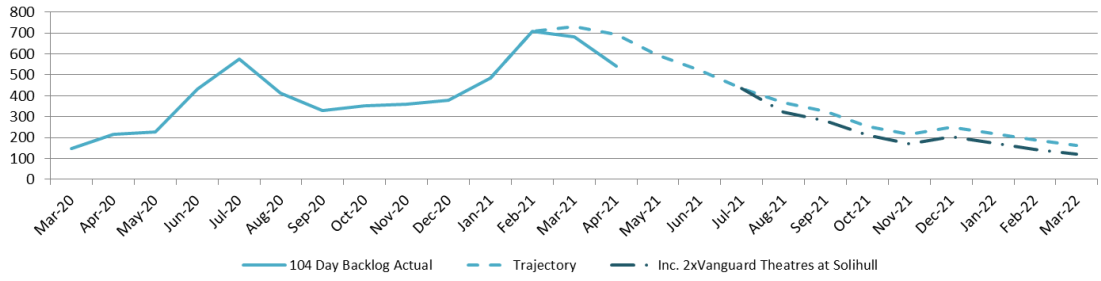


Figure 9: Number of cancer patients waiting >104 days from referral to treatment and trajectory for reduction



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)

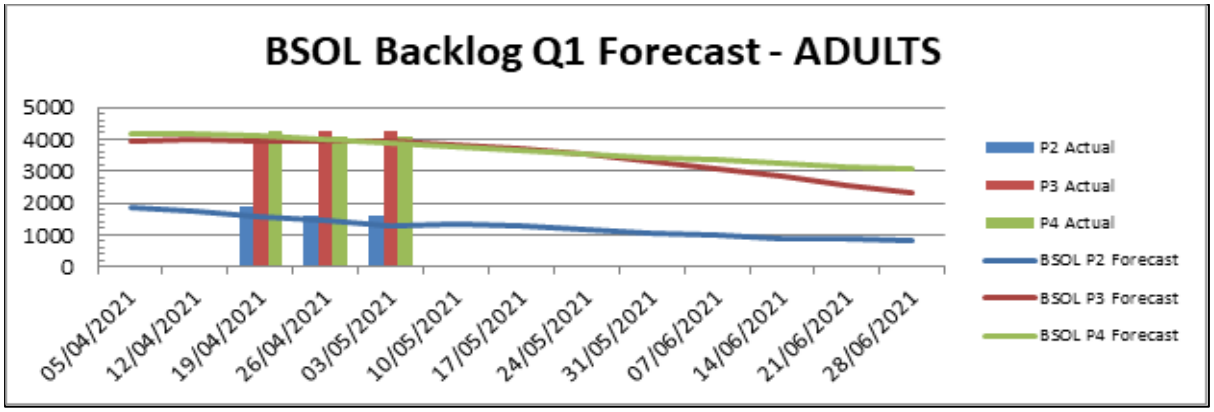
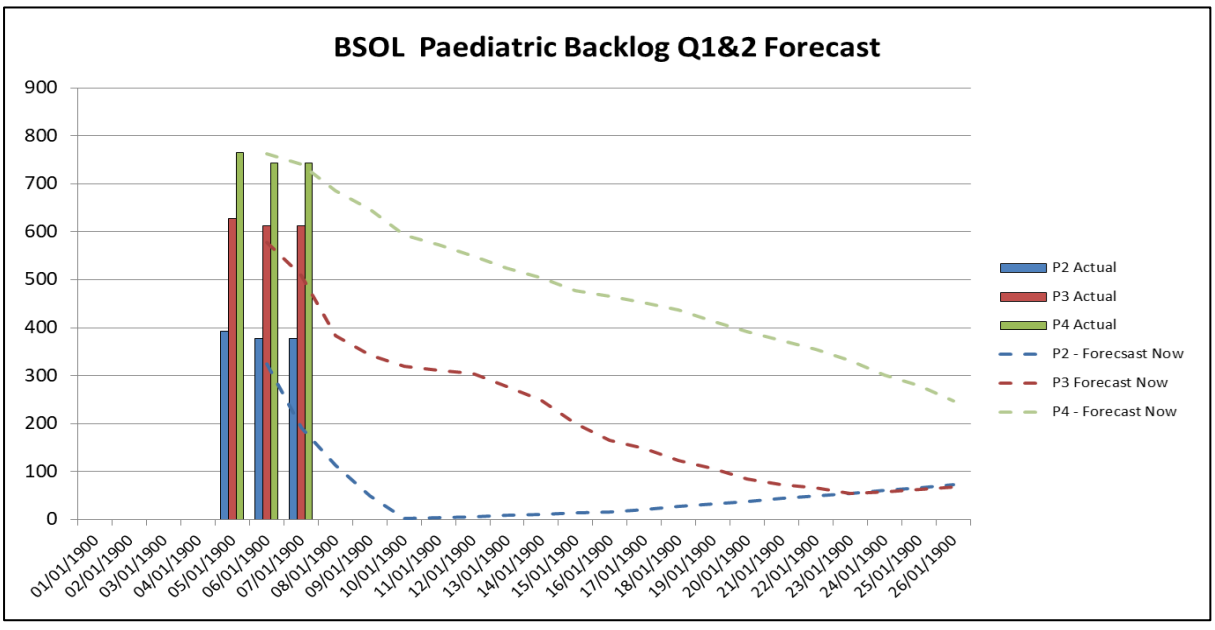


Figure 11: Actuals and forecast for quarter 1 (paediatrics)



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.

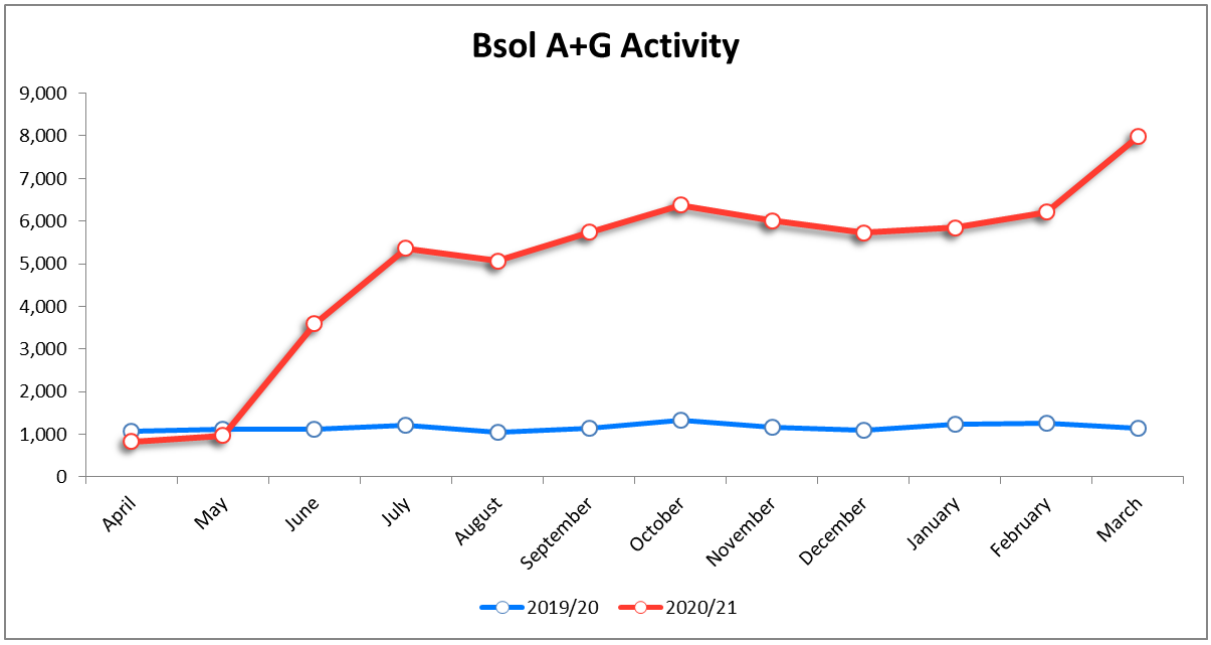
A key component of ensuring patient safety within this wait is the ability to assess for any deterioration in health status during this wait that may need re-prioritisation. Equally, the condition for which a referral has been made may have resolved, such that review is no longer required.

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.