None

AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 29 JULY 2021

Title:	**QUALITY & PERFORMANCE REPORT, COVID BACKLOG RECOVERY UPDATE & Q1 2021/22 STRATEGY IMPLEMENTATION PLAN UPDATE**
Responsible Directors:	Jonathan Brotherton, Chief Operating Officer Mark Garrick, Director of Strategy & Quality Development
Contact:	Imogen Acton, Head of Quality Development Andy Walker, Head of Strategy & Planning Poonam Jagatia, Performance Assurance Manager Georgina Charles, Quality Development Support Manager

Purpose:	To present an update to the BOARD OF DIRECTORS
Confidentiality Level & Reason:	None
Board Assurance Framework Ref: / Strategy Implementation Plan Ref:	BAF - SR3/18 - Prolonged and/or substantial failure to meet operational performance targets BAF - SR6/18 - Material breach of clinical and other legal standards leading to regulatory action SIP - #3 Provide the highest quality of care to patients through a comprehensive quality improvement programme SIP - #4 Meet regulatory requirements and operational performance standards, in line with agreed trajectories
Key Issues Summary:	• During what continues to be an exceptionally challenging time for the Trust, this paper provides oversight and assurance on operational performance against national targets, including those in the NHS Oversight Framework. • Whilst performance remains well below the requisite standard for the majority of national indicators due to rising rates of COVID-19 within the community, there are notable improvements in key areas. • A first quarter update is provided against the 2021/22 Strategy Implementation Plan.
Recommendations:	The BOARD OF DIRECTORS is asked to: Accept the report on operational and quality performance, associated mitigating actions and progress with COVID backlog recovery. Accept the update on quarter one progress against the 2021/22 Strategy Implementation Plan.

Signed: Mark Garrick	**Date:** 21 JULY 2021

None

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BOARD OF DIRECTORS

THURSDAY 29 JULY 2021

QUALITY & PERFORMANCE REPORT, COVID BACKLOG RECOVERY UPDATE & Q1 2021/22 STRATEGY IMPLEMENTATION PLAN UPDATE

PRESENTED BY THE CHIEF OPERATING OFFICER AND DIRECTOR OF STRATEGY & QUALITY DEVELOPMENT

1. Introduction

This paper provides assurance on quality and operational performance to the Board of Directors and details the actions being taken to improve performance. Other information on quality previously included in this report is now included in the new Integrated Quality Report.

During what continues to be an exceptionally challenging time for the Trust, this paper provides oversight and assurance on operational performance against national targets, including those in the NHS Oversight Framework.

Whilst performance remains well below the requisite standard for the majority of national indicators' due to rising rates of COVID-19 within the community, there are notable improvements in key areas, such as: cancer two week wait; the successful establishment of Enhanced Perioperative Care Units (EPOCs); six week diagnostics; 52 week breaches in a number of areas; the initial roll-out of the health status check; and theatre capacity. The effect of strong partnership working within the Integrated Care System (ICS) is also providing significant and tangible benefits to the Trust and patients, and will help to ensure that health inequalities are not further affected.

Material risks are detailed in this paper and Appendix 1, along with the main targets and indicators. Further detail is provided on elective recovery of clinical services in line with NHSE/I requirements. The Quarter 1 update of progress against the 2021/22 Strategy Implementation Plan is also included.

None

2. Investigations into Staff Performance

There are currently 18 staff investigations underway in relation to a patient wellbeing component.

Staff group	Total currently underway*	Percentage of total staff numbers**	New during June 2021	Closed during June 2021
Consultants	3	0.28%	0	0
Junior Doctors	0	-	0	0
Nurses and Midwives	4	0.07%	1	7
Nursing Auxiliaries / HCAs	3	0.11%	1	2
Allied Health Professional	0	-	0	0
Scientific & Technical	0	-	0	0
Additional Clinical Services	3	0.32%	0	1
Admin & Clerical / Estates & Ancillary	5	0.08%	0	3
Total	**18**	**0.07%**	**2**	**13**

** As of 14/07/21.*
*** Percentages calculated using staff groupings on ESR (Electronic Staff Record).*

3. COVID-19

Despite the significant and commendable number of vaccinations administered by the Birmingham and Solihull Vaccination Programme to date, the prevalence of COVID-19 in the community is rising, as is the number of COVID-19 positive inpatients. By 15 July, 10 to 15 patients were being admitted each day, with 166 inpatients in total and 27 being managed within the ITU.

Workforce absences have increased and are being monitored and reported daily. COVID-19 related absences, such as staff being required to isolate due to test and trace and positive COVID-19 results are increasing. In addition, increases in non-COVID-19 related absences are also occurring. The Trust fully recognises and appreciates the momentous and tireless efforts of our workforce, at what continues to be a very challenging time.

The Birmingham and Solihull reservist coordination centre is in the process of being re-established, in response to the increasing prevalence of COVID-19 in the community and within the hospitals, to support safe staffing levels across all hospital sites, and protect cancer and urgent elective activity, as much as possible. The Workforce Group is also progressing with overseas recruitment for ITU, theatres and other key areas.

In preparation for the easing of restriction on 19 July, and inline with national guidance, the Trust has confirmed that there will be no relaxation of restrictions for staff, patients and visitors e.g. face masks must be worn in all areas, by both staff and patients; staff must continue adhering to PPE requirements specific to the area/s they work in; visiting restrictions will remain in place; the two meter distance rule will continue to apply in all areas

of our hospitals, except for clinical areas (one meter); security will remain on all sites to enforce restrictions; and COVID marshalls will continue on sites to enforce compliance amongst colleagues. Supporting communication has been issued to confirm these arrangements.

4. Operational Performance Exception Reports

4.1 Acute Pathways

Attendances at the Trust's Emergency Departments (EDs) are above pre-COVID numbers a day and have increased significantly over recent months, due to a number of external factors. Daily attendances across all sites increased in June, with an average of 1175.9, compared to 1091.2 in May (an increase of 7.8%). This is the highest average daily attendance since July 2019.

In June, the Trust's internal performance deteriorated by 5.0pp to 60.5%. All sites saw a decline in the four hour performance, with Heartlands and Good Hope hospitals' performance dropping 5.1pp and 7.0pp respectively, and QEHB by 3.6pp.

Pressure at the 'front door' of the hospitals from people presenting with COVID-19 rose steeply in June. On a seven day rolling average ending 28 June, 7.7 patients were admitted with COVID-19, compared to 1.7 on 7 day average ending 17 May.

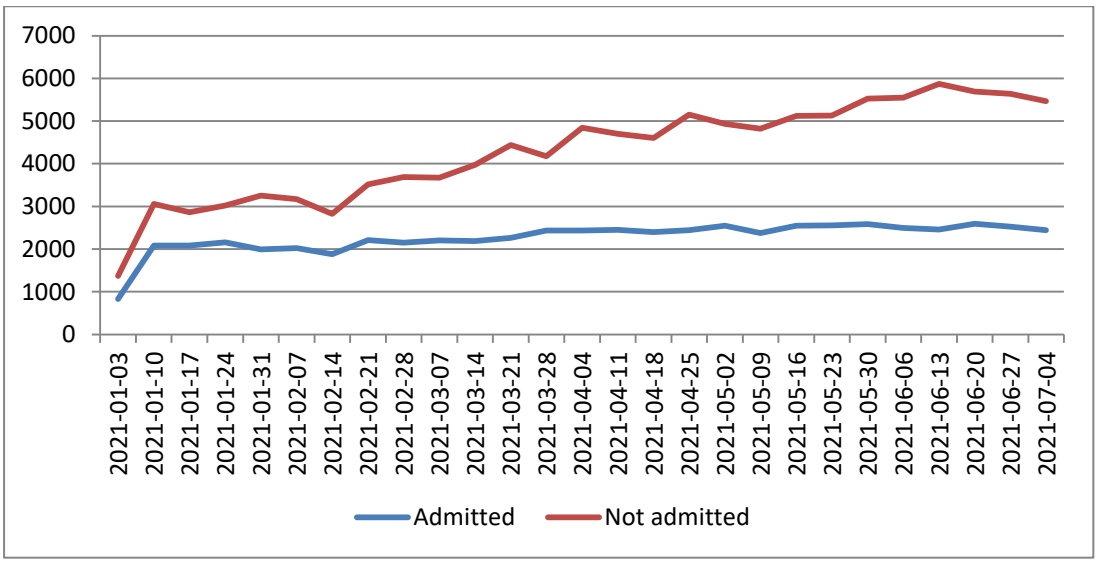
A particular increase has been seen in the number of patients arriving by ambulance. Along with the decline in four hour performance, the average time spent in the ED increased by 22 minutes. The average time for admitted patients increased by 28 minutes and for non-admitted patients, 23 minutes.

There were two 12 hour breaches over the month; one at QEHB and one Good Hope Hospital, both were due to delays with transferring patients to mental health beds.

4.1.1 Emergency Flow

Since the start of 2021, ED attendances have increased significantly and it is apparent that the number of patients who could be managed outside of the hospital has disproportionately increased over this period. The graph below illustrates the destination of patients (admitted or not-admitted) who attended the Trust's EDs since the start of 2021:

None



To address this, the Trust has worked in partnership with NHS Birmingham and Solihull Clinical Commissioning Group (CCG) to create a large volume (250 appointments per day) of new, face-to-face, GP appointments. These are being used to redirect patients from the ED, when their healthcare requirement would be more appropriately managed in primary care. Although the scheme has been reasonably successful to date, a focussed pilot to increase the numbers of patients redirected from Heartlands' ED to primary care will start in July.

4.1.2 Ambulance Handovers

There was a significant increase in 60 minute ambulance handover breaches in June; 1427 in comparison to 709 in May. This is as a result of increased pressure, due to the factors described above. All sites saw an increase in breaches, with the highest growth seen at Heartlands Hospital; 672 breaches, compared to 279 in May. Improvement work continues across all UHB EDs, with the aim of achieving the national 15 minute standard.

West Midlands Ambulance Service (WMAS) has implemented a new process which is designed to prevent ambulance staff being on duty for excessive periods, as a result of delays to enact clinical handover on arrival at hospital. Discussions with WMAS regarding how concerns about this process can be mitigated are planned.

4.1.3 Ask A&E

Ask A&E activity contributed 0.7pp of the overall performance over the month. The attendances for each site are displayed in the table below:

Site	Daily atts June 2020	Daily atts May 2021	Daily atts June 2021	Change June 20 to June 21	Change May 21 to June 21
QEHB	285.3	359.5	381.8	+33.8%	+6.2%
Heartlands	332.1	460.7	511.4	+54.0%	+11.0%
Good Hope	195.1	271.0	282.7	+44.9%	+4.3%
UHB	812.5	1091.2	1175.9	+44.7%	+7.8%

None

Ask A&E was used by 385 people during June; the daily average of 13 users was a decline from 16 in May. Of the total June users, 233 (60.5%) were advised to use alternative providers rather than attend the hospital.

Ask A&E navigators were introduced at Heartlands Hospital on 6 July, to help redirect patients to the most appropriate service. This should lead to greater use of the 250 GP slots reducing the number of admissions on site and in turn improving A&E performance.

The table below has summary of the outcome options and activity during the month.

Outcome	Number	% of Total
Advised to attend Ophthalmology Accident and Emergency	5	1%
Advised to contact general practitioner; As soon as possible	116	30%
Advised to contact general practitioner; Within 48 hours	8	2%
Advised to contact general practitioner	18	5%
Advised to attend accident and emergency department	109	28%
Advised to contact emergency ambulance service as soon as possible	38	10%
Patient not given advice	47	12%
Advised to self-care	31	8%
Advised to attend minor injuries unit	5	1%
Other	7	2%
Total	**385**	

4.1.4 Expansion

In response to the increasing pressure across the three EDs, the Trust has already opened up additional capacity across all sites.

A total of seven additional wards across the QEHB, Heartlands Hospital and Good Hope Hospital sites have been agreed. This will directly support the emergency, COVID and elective patient flows and provide flexible capacity for essential estates works. It will be complimented by ongoing service improvement work, to further optimise bed and theatre utilisation.

4.1.5 Medical rotas

The substantial increase in demand for emergency care has placed significant strain upon the medical clerking team and processes. To accommodate the increased levels of demand, rotas have been strengthened at peak demand periods.

5. Planned Care

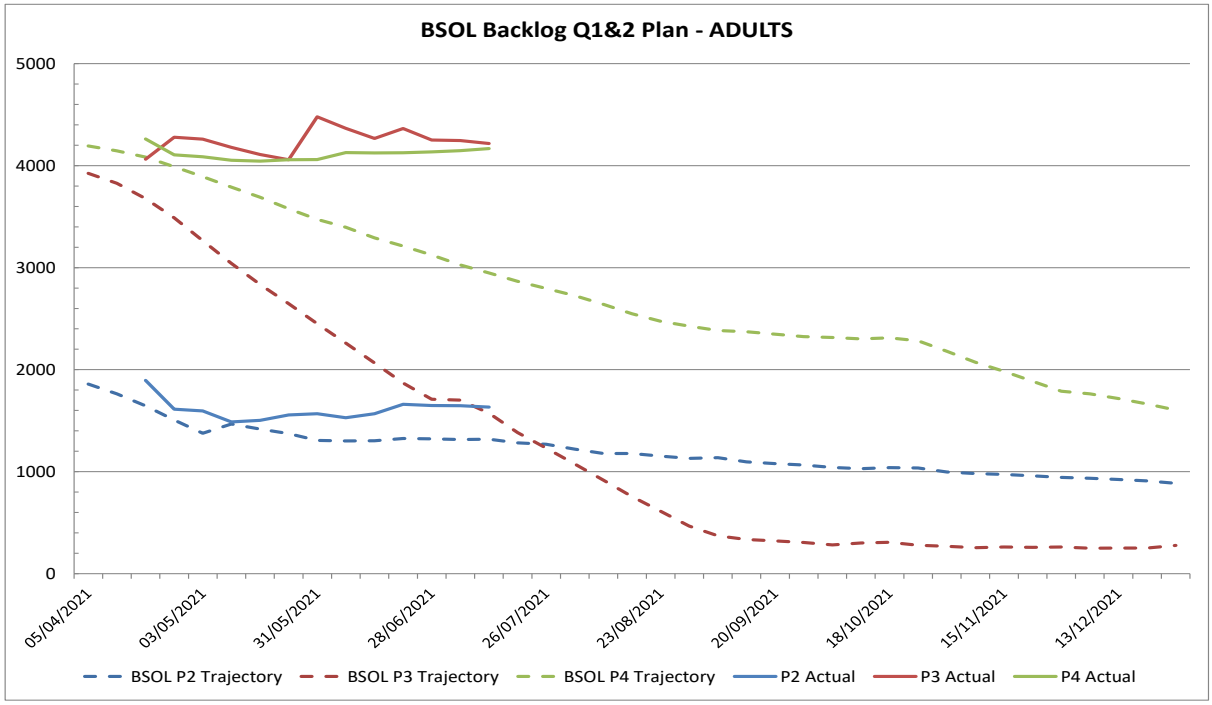
Due to the cancellation of elective inpatient admissions and outpatient appointments during the pandemic, there has been rapid growth in the Trust's waiting lists and a deterioration in waiting time performance with significant numbers of patients now waiting longer than 52 weeks from referral to

treatment. However, there are a number of positive interventions underway to tackle this, lead by the Operational Delivery Group (ODG).

5.1 Birmingham and Solihull Elective Recovery Programme

The Operational Delivery Group (ODG), and associated sub-groups, continues to drive the local system's response to elective recovery and backlog reduction.

The current surgical backlog position is shown below:



Key areas of variance against the plan are theatre utilisation, which remains some way short of the 85% ambition and case-mix, with some specialities undertaking a far higher proportion of P3 and P4 cases than was initially planned. Increases in lower priority activity should be considered in the context of recent surges in urgent care demand and challenges in accessing elective ITU capacity, as well as recent concerted efforts to improve overall utilisation and increase activity volumes.

5.2 RTT Performance

For those patients waiting on an RTT pathway, 50.0% had waited less than 18 weeks in May, a fall of 0.9%. Over the month the overall RTT waiting list increased by 5.3%. The rate of elective recovery increased by 9.8pp across Birmingham and Solihull ,from 41.6% of previous year's activity, to 51.4% in four weeks ending 30 May; this remains lower compared to the Midlands as a whole. During June, activity across Birmingham and Solihull rose dramatically with elective activity in the four weeks ending 13 June being 97.2%, compared to the baseline.

The number of 52 week breaches rose slightly by 0.5pp in May to 20,269, due to increases in ENT, Urology and General Surgery. Whilst

Ophthalmology, Neurosurgery, Oral Surgery and Gastroenterology saw reductions in the number of 52 week breaches.

All patients currently on an inpatient waiting list have been clinically reviewed by a consultant and assigned a clinical prioritisation, based on guidance from the Federation of Surgical Specialty Associations. The inpatient waiting list has been re-prioritised in line with this guidance. The impact of this, plus new additions to the waiting list, has been 2% increase in patients who should have surgery within one month (Priority 2), 3% increase in patients who should have surgery within three months (Priority 3) and a 1% decrease in patients who can wait longer (Priority 4). A programme of work in relation to data quality and coding issues is underway.

5.3 Cancer Performance

The pandemic has had a very significant effect on cancer performance, particularly where surgery was the chosen form of treatment. However, the Trust continues to prioritise emergency and cancer treatments, as we work to recover all services, as well as offering appropriate ddasdasd and treatments. Specialty level recovery trajectories and action plans are in place to support the wider system recovery plan. UHB delivered a total of 1066 treatments (first and subsequent) in May, compared to 1105 in April, a reduction of 3.5%.
31 day first treatment performance improved by 2.4pp to 86.8% and performance for subsequent surgery improved significantly by 11.4pp to 74.4%. Activity levels have reduced since the previous month; first treatments reduced by 6.0% and subsequent surgeries by 9.4%. Performance for the 31 day subsequent chemotherapy and radiotherapy remained above target at 99.1% and 96.0% respectively.

Performance for the two week wait target for suspected cancer improved by 8.8pp to 76.1%. This is the best performance seen since May 2020. Performance for patients with breast symptoms improved by 14.9pp to 62.3%, the highest since June 2020. The majority of breaches for suspected cancer were in breast, colorectal, upper GI, and head and neck. Upper GI cancer saw an activity increase of 31.6% compared to April.

Performance continues to be affected by significant backlogs due to the shortfall in capacity, as these are cleared, performance is expected to be adversely impacted for the coming months particularly for breast and gynaecology. Specialty level plans are in place to support wider system recovery, including implementation of revised pathway management, supported with reinstated and expanded capacity.

5.4 Theatres

Cancellations resulting from the impact of COVID-19 continue to significantly affect performance. There were 214 cancellations of surgery on the day in May, compared to 154 in April. The number of breaches of the 28 day guarantee increased to 78, compared to 71 in April. These cancellations were as a result of ward bed availability

issues and/or staffing issues. The Trust acknowledges the distress that cancelling surgery causes patients.

The quarter one plan is delivering capacity as expected, but utilisation remains below target in a number of areas. A task and finish group has been established to identify and deliver the necessary actions to improve theatre utilisation at Solihull, with some of the early benefits already coming to fruition.

The theatre plan for quarter two has also now been agreed across the system, but may need to be modified. Overall there will be a significant uplift in available theatre hours for elective care.

The re-establishment of paediatric surgical services at Heartlands Hospital, as well as the plan to restart some elective orthopaedic theatre lists at Solihull Hospital, will both bring wider benefits to the system and patients

Recruitment is on-going for specific staff groups to support theatres and perioperative care; the first offers for international recruits have started. Insourcing options have been detailed and now approved to commence. These staff will support the wider opening of capacity, including weekend capacity at Solihull Hospital.

5.5 Capacity and Demand

The capacity and demand model continues to inform the planning for the system. Quarter three theatres plans have now been incorporated into the modelling, as well as several other updates to average procedure time, utilisation and case-mix following analysis of quarter one data.

5.6 Surgical Prioritisation and Health Status Check

The agreed surgical prioritisation framework is now embedded and in use across all providers, with modifications made in line with Federation of Surgical Speciality Associations updates, on an on-going basis.

The health status check process is now firmly established with a phased roll-out plan agreed that will cover all specialties. This is on track to be completed by the end of September 2021.

To date, the programme has seen a 64% response rate, with around a third of responses requiring some form of specialty review.

Following the successful pilot with maxillofacial and paediatric patients, around 1,500 letters have now been sent to orthopaedic patients, with urology and ENT planned over the coming weeks.

Learning is being shared with other providers across the system and work is underway to apply a similar approach for outpatients and diagnostics, with a selected group of specialties initially.

None

5.7 Perioperative care

The Enhanced Perioperative Care Units (EPOCs) are now established and continue to work well at the QEHB and Solihull hospitals. A booking system and on-going audit is in place.

In June, the QEHB EPOC transitioned into the QEHB ITU, with a larger floor space and specific dedicated staffing model. There is still work needed to support the workforce with junior staffing from surgical teams, to ensure the appropriate skill mix and deliver the training opportunity which EPOC presents.

Recruitment for the EPOC facilities has been successful, in line with expected developments of this area.

5.8 Diagnostic waiting times

The Trust's six week diagnostics performance improved in May by 3.5pp to 73.5%. There were 5,995 patients who had waited longer than six weeks at the end of May; a fall of 633 which is three times greater than the fall in April.

The number of patients who waited longer than 13 weeks also reduced by 569, to 3,717. The total number of patients waiting for one of the included diagnostic tests increased by 2.5% over the month. The largest increases were seen in DEXA scans, with an increase of 19.8% and echocardiology at 16.9%. The largest reductions were seen in gastroscopy at -14.6% and urodynamics at -7.4%.

Diagnostic performance continues to be significantly affected by the reduced capacity, resulting from adherence to social distancing and infection control measures. The majority of diagnostic testing taking place continue to be for clinically urgent and cancer patients, with work continuing to increase the number of diagnostic tests being provided overall. Longer term plans, such as the implementation of diagnostic hubs and the opening of the Ambulatory Care and Diagnostics Centre (ACAD), will help to alleviate pressure in regards to capacity and accelerate the rate of recovery.

Following the success of the national clinical prioritisation and validation programme on surgical waiting lists, NHS England and Improvement is introducing validation of diagnostic waiting lists. In support of the wider elective recovery programme, this new programme of work calls on clinical reviews to be carried out on patients waiting for a diagnostic procedure (either on a diagnostic waiting list or surveillance waiting list), to assess clinical urgency and categorise patients accordingly. There is an expectation that Trusts will have clinically reviewed all patients on the diagnostic waiting lists by 30 July.

None

6. Long-Term Condition Management, Outpatients and Diagnostics

The scope of work and initial work plans have been produced, which is now being prioritised and implemented by the CCG, along with stakeholder engagement. The progress of this work is summarised below:

6.1 Models of Outpatient Care

An ICS group has been established, with current work programmes linking into individual provider work streams. This includes paediatric care and covers the following work areas: advice models, including advice and guidance; patient initiated follow-up (PIFU); and the establishment of agnostic phlebotomy work stream.

6.2 Remote Outpatient Appointments

Total outpatient activity across all modes of delivery (face-to-face, telephone and video) increased by 12.6% in June, compared to May. Face-to-face appointments saw the greatest increase of 15.9% and telephone appointments increased by 6.5%. The number of video appointments was fairly static for the second consecutive month.

6.3 Prioritisation and Harm Review

ICS owned methodologies have been introduced to reduce risk of harm to patients who are awaiting an outpatient review; building on learning from the inpatient waiting list health status check.

6.4 Critical and cancer pathways

Two week wait cancer pathways have been brought together to ensure raid coproduction and introduction of changes, where required. A ‘vague symptom’ pathway pilot has started in two primary care networks (PCNs) in the East Birmingham, where it is recognised that inequalities impact on access and diagnosis.

6.5 Service improvement and transformation

A stocktake of the CCG’s service improvement projects has been completed. To ensure focus on current recovery needs, stakeholder ‘restart’ meetings are being held to establish priority actions where ICS working will be beneficial. The current focus is on dermatology and diabetes.

6.6 Diagnostics

A review of primary care access to imaging and the work required around provision of Community Diagnostic Hubs (CDHs) is planned. The initial bid for a CDH in Washwood Heath has been successful and a full business case is being developed.

6.7 Assessment of Inequalities

Work continues to assess the impact of inequalities on patient access and experience. Learning will be shared within wider ICS programmes

to help address inequalities, to improve access, inclusion, experience and mitigate against digital exclusion.

7. Communications and Engagement

The system communications and engagement plan continues to be in place and is working effectively, supporting an on-going cycles 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 primary care colleagues are well attended and continue to receive positive evaluation; the latest being on imaging, with the next planned for advice and guidance. The latest staff briefing was very well attended and focussed on current pressures, clinical strategy development, capacity expansion and the health status check.

A specific communications plan is being prepared to ensure that appropriate channels are being utilised to promote the staff events to relevant audiences within UHB, and also at the Birmingham Women's and Children's Hospitals, Royal Orthopaedic Hospital and the CCG.

Oversight of the communications and engagement elements of the programme is provided at the ODG and weekly ICS communications forums, which key partners attend.

8. NHSE/I System Oversight Framework 2021/22

The new NHSE/I System Oversight Framework was published 24 June 2021 and describes how the NHS will continue to manage the impact of COVID-19 and deliver all non-COVID services. The framework reinforces system-led delivery of integrated care and provides Trusts with more autonomy to engage and establish greater collaborative working, in order to meet the priorities set out in the 2021/22 Operational Planning Guidance.

In response to the consultation during April and May, NHSE/I has provided organisations the flexibility to design their own ways of working in delivering services which best fit individual systems and system partners. Alongside flexibility, there are now a clear set of metrics to assess performance at ICS, Trust and CCG level across five domains:

1. **Quality, access and outcomes** – metrics for trusts include operational measures, such as overall waiting list size, 52 week wait levels, ambulance response times and quality indicators like CQC ratings and mortality. At the ICS level, additional metrics include cancer outcomes, neonatal outcomes and antimicrobial resistance.

2. **Preventing ill health and reducing health inequalities** – indicators in this domain are primarily measured at ICS and CCG level, including vaccination coverage and screening programme uptake. Trusts are assessed on some measures related to reducing health inequalities, including ethnicity and deprivation across service restoration and NHS Long Term Plan metrics.

None

3. **Leadership and capability** – Trusts, ICSs and CCGs will all be assessed on quality of leadership, and on an aggregate score for NHS staff survey questions that measure perception of leadership culture.

4. **People** – Trusts, ICSs and CCGs will all be assessed against the people promise index, health and wellbeing index, staff experience measures including bullying and harassment, satisfaction with flexible working patterns, staff retention and diversity of leadership.

5. **Finance and use of resources** – assessment of performance against financial plan, underlying financial position, run rate expenditure, and overall trend in reported financial position will be made at CCG, trust and ICS level.

9. Q1 Progress Update on the 2021/22 Strategy Implementation Plan

9.1 Changes in the Policy Landscape over the Last Quarter

Since the approval of the plan, there have been a number of developments that are pertinent to the Trust's future strategy and plan. Key areas are outlined below.

9.1.1 Health and Care Bill

The proposed Health and Care Bill would put into law a number of the proposals for legislative change originally suggested by NHSE/I and the Department of Health and Social Care's (DHSC's) Integration and Innovation White Paper, published in February.

The majority of the Bill is focused on developing system working, with ICSs being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include: putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities.

The Bill introduces a two-part statutory ICS model:

a) An integrated care board (ICB), bringing together the organisations that plan and deliver NHS services in the area covered by the ICS.
b) An integrated care partnership (ICP), bringing together a wider alliance of organisations related to improving health and care.

ICBs will replace Clinical Commissioning Groups (CCGs) and the CCG(s) within each system footprint must consult with relevant parties and propose the first ICB constitution, taking into account any guidance published by NHSE/I. The ICB will be required to improve the quality of services, reducing inequalities and promote integration. They must ensure patients and communities are involved in the planning and commissioning of services.

ICBs will consist of at least a chair, chief executive and at least three other members. One member will be nominated by NHS trusts and foundation trusts, one by general practice and one by local authorities.

ICB and its 'partner' trusts and foundation trusts must prepare a five-year plan setting out how they propose to exercise their functions. They must also create a joint capital plan for a period specified by secretary of state. ICBs must exercise their functions with a view to breaking even and each ICB and its partner providers must seek to achieve financial objectives set by NHSE/I.

ICP membership, on the other hand, will include one member appointed by the ICB, one member appointed by each of the relevant local authorities, and any other members appointed by the ICP.

The Bill includes provision to allow the Secretary of State (SoS) to intervene in local service reconfigurations. NHSE/I, ICBs and providers will be required to notify the secretary of state when there is a proposal to reconfigure services. The SoS will have the power call in any proposal and can then take on the decision-making role of the NHS commissioning body concerned or re-take a decision already made.

The Bill introduces a new duty, which applies to ICBs, NHSE/I, foundation trusts and trusts to have regard to all likely effects of their decisions on: the health and wellbeing of the people of England; the quality of services provided or arranged by relevant bodies; and the efficiency and sustainability of resources used by the relevant bodies.

Other provisions in the Bill change the freedoms of foundation trusts somewhat, with NHSE/I gaining the power to set a capital expenditure limit for an FT, FTs being allowed to carry out functions jointly with other organisation (e.g. forming a joint committee with an ICB or another provider). Other provisions streamline the licensing and transaction processes for FTs.

9.1.2 New Secretary of State

The appointment of the new Secretary of State for Health and Social Care, Rt. Hon Sajid Javid MP, who is also MP for Bromsgrove, is likely to result in some changes of emphasis to national policy. In addition, the appointment of the new Chief Executive of the NHS is expected before the end of July. Notwithstanding this, the Health and Care Bill was laid before Parliament in July. It is however clear that there is a renewed emphasis on both the NHS and the nation as a whole 'living with COVID'.

9.1.3 West Birmingham locality move to Birmingham and Solihull Integrated System (ICS)

The Department of Health and Social Care has announced that future Integrated Care Systems across the country will be aligned to Local Authority boundaries. Locally this means that the place of West Birmingham, currently in the Black Country and West Birmingham

None

System, will move to the Birmingham and Solihull Integrated Care System (ICS) from April 2022 (subject to legislative changes going through Parliament).

9.1.4 COVID-19 winter vaccination programme

The Joint Committee on Vaccination and Immunisation (JCVI) has proposed that a COVID-19 vaccine booster should be given to over 70s, the extremely clinically vulnerable and frontline health and social care staff, alongside the flu vaccine. Over 50s and others who would ordinarily receive the flu vaccine will receive the vaccines in a second stage. The Government has also launched a consultation on vaccination being mandatory for all NHS staff.

9.2 Key Updates against the 2021/22 Plan

In addition to the areas highlighted above, key areas of progress are outlined in Appendix 2. This is not intended to be an exhaustive overview of progress against the plan but instead provide a snapshot of some key activities against the strategic objectives over the past three months.

At this stage there are no significant exceptions reported beyond the challenges to operational performance covered earlier in this paper. This is because there has been limited time since the plan was approved and the majority of deadlines are back-loaded towards the end of the financial year.

10. Recommendations

The BOARD OF DIRECTORS is requested to:

Accept the report on operational and quality performance, associated mitigating actions and progress with COVID backlog recovery.

Accept the update on Quarter 1 progress against the 2021/22 Strategy Implementation Plan.

Jonathan Brotherton
Chief Operating Officer

Mark Garrick
Director of Strategy & Quality Development

21 July 2021

None