UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 OCTOBER 2021

Title:	**QUALITY & PERFORMANCE REPORT, COVID BACKLOG RECOVERY UPDATE & Q2 2021/22 STRATEGY IMPLEMENTATION PLAN UPDATE**
Responsible Directors:	Jonathan Brotherton, Chief Operating Officer Mark Garrick, Director of Strategy & Quality Development
Contact:	Amelia Godson, Managing Director for Operations 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:	• Update provided on staff investigations. • There are notable improvements in key areas whilst performance remains exceptionally challenging overall due to lasting effects of the pandemic and pressure experienced in all Emergency Departments, assessment areas and wards. • A second 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 2 progress against the 2021/22 Strategy Implementation Plan.

Signed: Mark Garrick	**Date:** 20 OCTOBER 2021

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BOARD OF DIRECTORS

THURSDAY 28 OCTOBER 2021

QUALITY & PERFORMANCE REPORT, COVID BACKLOG RECOVERY UPDATE & Q2 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.

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 lasting effects of the pandemic, 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 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 2 update of progress against the 2021/22 Strategy Implementation Plan is also included.

2. Investigations into Staff Performance

There are currently 9 staff investigations underway in relation to a patient wellbeing component.

Staff group	Total currently underway*	Percentage of total staff numbers**	New during September 2021	Closed during September 2021
Consultants	4	0.38%	0	1
Junior Doctors	2	0.15%	0	0
Nurses and Midwives	0	-	3	7
Nursing Auxiliaries / HCAs	2	0.07%	4	1
Allied Health Professional	0	-	1	0
Scientific & Technical	0	-	0	0
Additional Clinical Services	0	-	0	1
Admin & Clerical / Estates & Ancillary	1	0.02%	2	3
Total	**9**	**0.04%**	**10**	**13**

** As of 30/09/21.*
*** Percentages calculated using staff groupings on ESR (Electronic Staff Record).*

3. COVID-19

Despite the success of the Birmingham and Solihull vaccination programme, the prevalence of COVID-19 in the community remained high throughout September, although the number of inpatients has fallen somewhat. As of 30 September there were 165 COVID-19 positive inpatients (of which 107 were "active" COVID) with 24 being managed on the Trust's ITUs.

Workforce absences continue to be significant, including COVID-19 related absences such as staff being required to isolate due to test and trace, positive COVID-19 results and symptomatic illness. The number of staff absent either due to COVID or self-isolation as of 27 September remained static at a fifth of all staff absences. The total number of staff being absent increased to 5.4% in comparison to the previous week by 0.2%, but remains in the lower quartile when compared against the Midlands region as a whole at 6.7%. As at 30 September, the Trust received 282 exemption applications for staff self-isolating, of which 268 were approved and 14 declined. We continue to recognise and appreciate the outstanding efforts of our workforce in what continue to be very difficult circumstances. The Employee Relations team continue to undertake weekly analysis of sickness absence to identify hot spot areas and trends. Following this and discussions which have taken place with Divisional Management teams, a number of preventative measures have been identified and are being implemented.

The Birmingham and Solihull Reservist Coordination Centre has continued to support safe staffing levels across all hospital sites, and the Trust has been working with its partners across the ICS to prioritise activity appropriately across the system.

In line with national guidance, the Trust has continued the existing restrictions for staff, patients and visitors e.g. face masks must be worn in all areas, by both staff and patients; staff must continue to adhere to PPE requirements specific to the area/s they work in; visiting restrictions will remain in place; the two-metre social distance rule will continue to apply in all areas of our hospitals, except for clinical areas (one metre) with appropriate PPE; security

will remain on all sites to enforce restrictions; and COVID marshals will continue on sites to enforce compliance amongst colleagues. Supporting communication has been issued trust-wide to confirm these arrangements.

4. Operational Performance Exception Reports

4.1 Acute Pathways

Delivering effective acute pathways is essential to increase elective access in order to deliver the required reductions in the numbers of patients waiting for an elective procedure. Work continues to further improve acute care delivery across the sites including the establishment of a dedicated programme team to focus on improvement in this area.

Attendances at the Trust's Emergency Departments (EDs) remain high following the easing of national lockdown measures and also the return to schools and work following the summer period. Daily attendances across all sites in September remained higher than pre-COVID levels with an average of 1136.1 attending the ED departments in comparison to 1050.7 in August; an increase of 8.1%.

In September the Trust's internal performance improved by 1.7pp to 55.5%. Both Good Hope (GHH) and Heartlands Hospitals' (BHH) four-hour performance improved by 3.0pp and 2.8pp respectively. Performance at the Queen Elizabeth Hospital Birmingham (QEHB) declined by 1.1pp.

Pressure at the 'front door' of the hospitals from people presenting with COVID-19 steadily declined through September. On a seven day rolling average ending 27 September, 18.4 patients were admitted each day with COVID-19 compared to 28.7 at 31 August.

Attendances in September remained above pre-COVID numbers. All sites experienced higher number of attendances in comparison to August. Very high inpatient occupancy levels on each hospital site accounted for the increased time in emergency assessments and the time from decision to admit to a patient physically leaving the department. The average time spent in ED across all sites remained fairly static with a reduction by 1 minute compared to August. Admitted patients accumulated an average time spent in ED of 488 minutes and non-admitted patients 250 minutes. The number of patients with extended trolley waits in the Trust's EDs increased sharply, with 47 patients spending longer than 12 hours from a decision to admit being made to actually being admitted to a bed. These breaches are related to delays with transferring patients to wards or another health care facility.

By the end of September, pressure across the E Ds, assessment areas and subsequently wards eased off somewhat; allowing the Trust to de-escalate from the highest possible status of level 4 to a level 3. In order to reduce strain on the acute care service, a number of plans have been worked through to alleviate pressure seen across all three ED sites. A dedicated programme team has been recruited to work with the

clinical site team, clinical and operational teams in order to combat the long delays with ambulance handovers as well as identifying key issues causing delays to be addressed and worked on accordingly.

4.1.1 Ambulance Handovers

The number of 60 minute ambulance handover breaches across the month of September remained high but reduced compared to previous month by 15.9%. There were a total of 1,493 breaches in September compared to 1,776 in August. All sites saw a decrease in the number of 60 minute breaches; there was a 20.0% decrease at Queen's Elizabeth Hospital; an 18.3% drop at Heartlands and a 3.6% drop at Good Hope Hospital. A new area to facilitate ambulance offloads when there is insufficient space within the ED has been opened at Good Hope. High inpatient occupancy levels continue to be the primary contributor to poor flow.

4.1.2 Ask A&E

Ask A&E activity contributed 0.4pp of the overall performance over the month. The attendances for each site are displayed in the table below:

Site	Daily atts September 2020	Daily atts August 2021	Daily atts September 2021	Change September 20 to September 21	Change August 21 to September 21
QEHB	324.2	349.4	367.4	+13.3%	+5.2%
Heartlands	414.6	439.5	481.2	+16.1%	+9.5%
Good Hope	235.6	261.9	287.5-	+22.0%	+9.8%
UHB	974.4	1050.7	1136.1	+16.6%	+8.1%

Ask A&E was used by 269 people during September; the daily average of 9 users was an increase from 7 in August. Of the total September users, 161 (59.9%) were advised to use alternative providers rather than attend hospital.

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

Outcome	No.	% of Total
Advised to attend Ophthalmology Accident and Emergency	3	1%
Advised to contact general practitioner; As soon as possible	64	24%
Advised to contact general practitioner; Within 48 hours	5	2%
Advised to contact general practitioner	16	6%
Advised to attend accident and emergency department	77	29%
Advised to contact emergency ambulance service ASAP	28	10%
Patient not given advice	31	12%
Advised to self-care	31	12%
Advised to attend minor injuries unit	10	4%
Other	4	2%
Total	**269**	

4.1.3 Capacity Expansion

The three medical wards at Solihull remain open to provide surge capacity. The Fractured Neck of Femur service was successfully transferred to BHH from QEHB on 27 September in order to help support the restoration of tertiary surgical services at QEHB. Work on longer term plans has commenced with work being carried out on the east block of QEHB to create 3 additional wards and an oncology unit; due for completion by January 2022. The two additional modular wards at each site (BHH and GHH), will create additional surgical capacity by late Spring 2022. The business case and associated workforce plan for these are in progress.

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.

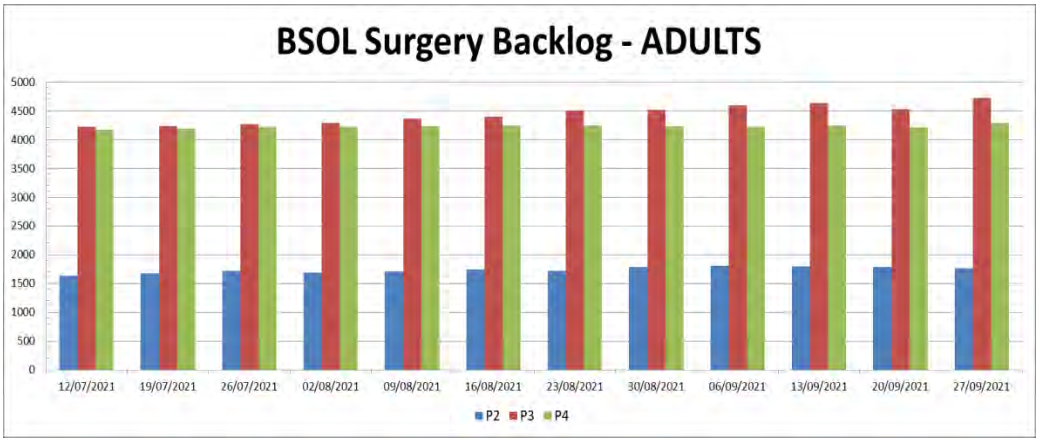
5.1 Birmingham and Solihull Elective Recovery Programme

The BSOL Operational Delivery Group (ODG) and sub groups are now well established, with regular reporting in place. System engagement continues to be good with collaborative working in multiple areas.

The system is committed to delivering a reduction to the backlog position. A revised forecast is currently being worked through in line with expected initiatives and performance improvements throughout Q3&4.

The mitigating factors in performance against plan are scrutinised and several streams of work are in progress to address issues. Some of these issues are outlined below.

The current surgical backlog position is shown in the graph below:



5.2 RTT Performance

The Trust's RTT position for August shows that 43.1% of all patients on a RTT pathway have waited less than 18 weeks which is a deterioration of 1.3% since previous month. The total waiting list size increased by 4.8% and is now 99.0% larger than it was in August 2020.

With an increasing waiting list size nationally, there is an increased focus on patients waiting over 2 years (104 weeks). In August, the Trust reported 666 patients waiting longer than 2 years; an increase of 46.4% since previous month. The highest increase proportionately was seen in Gastroenterology. All treatment functions saw an increase in the number of long waits apart from Cardiology.

Forecasted projections have shown that this position will significantly increase if the Trust continues at its current run rate. To improve on this forecast in line with assumed Targeted Investment Fund (TIF) and collaboration with the ICS, the BSol system has identified ways to accelerate system recovery. This has included the allocation of funding to support additional validation support (particularly targeted to patients waiting 78+ weeks), utilisation of additional capacity within the system as well as optimising internal booking and utilisation efficiency for existing resources. Additional inpatient and outpatient independent sector activity is being purchased at a specialty specific level.

The number of 52 week breaches increased by 12.3% since July. Proportionately, the largest increase in 52 week breaches was seen in Rheumatology.The largest reduction was seen in Geriatric Medicine, which fell by 29.2%.

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 an 11% increase in patients who should have surgery within one month (Priority 2), 1% increase in patients who should have surgery within three months (Priority 3) and a 1% decrease in patients who can wait longer (Priority 4).

5.3 Waiting List Data Quality

Work continues on the improvement of waiting list data quality, overseen by the Executive-led oversight group.

There has been a further reduction in the number of long-waiting patients (defined as waiting longer than 52 weeks since initial referral) identified as having a data quality error with their pathway. The total number of 52 week records flagged as a potential data quality error has fallen from c. 4,000 to 1,429 in the last eight weeks, representing a 60% improvement.

Training continues to be rolled out across operational areas and is being directed by newly-established reports that identify system users

with the highest error rates. Other reports are being finalised which will identify system users that continue to experience errors and contribute to poor data quality after having undergone training, with persistent issues being escalated via existing divisional assurance channels.

The informatics sub group has focused on implementing a range of auto-stop and auto-close reports to support and supplement the work of the validation team. It has also been refining local data quality indicators to ensure that they align with the recently published national metrics as well as undertaking testing of the national data quality dashboard which is now available.

The implementation of the revised RTT descriptors within Oceano went live during the first week of October. It is expected this will reduce the likelihood of incorrect outcomes/RTT statuses by better reflecting the local operational activities. This will be further supported by revised training material and the continued roll out of focused support.

A revised outcomes form has now been designed which will remove the need for an end user to select the patient's RTT status. Instead, the clock status will be derived from the outcome based on the activity undertaken in clinic and this will significantly reduce the potential for user error in this area. The proposed new form is being presented to CEAG and subject to agreement, will be ready for deployment during the next available PAS software update from Servelec.

Validation of the Trust's waiting lists continues to focus on long-waiting patients and those pathways that trigger a suspected data quality alert. A case for expanding the validation team in order to better respond to the growing size of the PTL and validation demands has been approved at CEAG. This additional resource will be focused on delivering full validation for all patients waiting 40+ weeks from the point of referral. Recruitment to these posts is underway with 3 additional successful candidates already appointed. Further recruitment drives are planned for the coming weeks along with the purchase of additional validation resource to bridge the gap during the recruitment and training phase.

5.4 Cancer Performance

The impact of the pandemic and the loss of activity during the primary waves of COVID-19 are reflected in the challenges faced in delivery of cancer performance.

There continue to be notable improvements in 2 week waits with an increase of 3.5pp to 90.9% in August; the highest monthly performance since November 2018. Endoscopy activity remains below demand and the numbers are significant enough to prevent overall Trust achievement of the 93% target.

Breast symptomatic performance dropped by 4.4% to 81.5% but remains 61.8pp higher than the performance in August 2020.

Cancer performance for 62 day GP referrals deteriorated by 3.8pp to 41.3%, whereas screening performance saw a sharp rise by 19.5pp to 64.2%. 31 day performance in August for first treatments has begun to stabilise following a sharp decline in the previous month.

At the end of August, the number of patients who had waited over 104 days for treatment was at 396 of which 61 patients had confirmed cancer. Extended pressure on wider acute and urgent care pathways (both COVID and non-COVID related) continue to impact on the restoration of elective diagnostic and treatment services including cancer. Major contributing specialties to the 104 day position are Skin and Lower GI. As of early October, Skin are converting routine capacity to generate sufficient slots to clear the diagnostic backlog by mid-November. Enhanced PTL meetings have also begun in early October with Lower GI to ensure timely escalations and actions. Cancer Services is offering increased and intensive support to these specialties to assist with recovery planning and monitoring. This includes detailed demand and capacity modelling with forward view, and intensive PTL meetings with senior representation to introduce more challenge to delays and consideration given to alternative pathways and escalation.

Activity levels for both first and subsequent treatments fell by 7.0% since previous month to a total of 1,111 treatments being delivered in comparison to 1,194 in July.

Performance continues to be affected by significant backlogs in many specialties. Due to the shortfall in capacity performance is expected to be adversely impacted for the coming months. Specialty level plans are in place to support wider system recovery.

5.5 Theatres

Cancellations resulting from the impact of COVID-19 continue to significantly affect performance. The number of cancellations on the day of surgery rose from 244 in July to 283 in August; an increase of 16.0%. The number of breaches of the 28 day guarantee increased by 18.1%; 183 cancellations in comparison to 155 in July. These cancellations were as a result of access to ITU, ward bed availability issues and/or staffing issues. The Trust acknowledges the distress that cancelling surgery causes patients.

Theatre utilisation remains below target in a number of areas, with ITU and inpatient bed availability still the leading contributing factors. Improvement work continues, particularly in relation to the Solihull site.

The theatre plan for Q3 has been agreed and will be used to support theatre capacity and demand forecasts for the remainder of the year.

Recruitment is on-going for specific staff groups to support theatres and perioperative care and the first international recruits are now in the Trust. Across the system, staffing remains the most challenging aspect of delivering the recovery programme. Individual specialty leads have

been asked to identify staff that are willing to volunteer to provide support in ITU in order to continue running elective lists as much as possible.

5.6 Capacity and Demand

The Capacity and Demand model continues to inform the planning for the system. Paediatric modelling by sub specialty is now also in use across BSol.

A separate piece of work has commenced to scope the longer term requirements in relation to demand and capacity and simulation modelling for the wider ICS and to support delivery of the emerging system recovery plan.

5.7 Surgical Prioritisation and Health Status Check

The agreed BSol surgical prioritisation framework is now embedded and in use across all providers, with modifications made in line with Federation of Surgical Speciality Associations (FSSA) updates on an on-going basis. Paediatric waiting lists are also subject to review by the additional holistic assessment process (HAPPS).

The Health Status Check process is now nearing completion of the inpatient waiting list with around 11,000 patients issued a health status survey.

Plans are being finalised to apply the process to outpatients as part of the Trust's wider outpatient recovery programme.

Regular feedback and learning from the roll-out is also reported to ODG on a weekly basis. The subsequent harm review process has now been defined and reporting of harm review / status check progress will also be made to CQMG on a monthly basis.

5.8 Perioperative Care

The QEHB Enhanced Perioperative Care Unit (EPOC) is now well established in a new footprint with a larger floor space and specific dedicated staffing model. This innovative model of care has already proven extremely successful in easing ITU pressures for a number of surgical specialties including Cardiac, Neuro and Liver. Plans are being developed to expand the service capacity further over time at QEHB and Solihull.

5.9 Diagnostic Waiting Times

Six week diagnostic performance dropped by 6.1pp to 63.8% in August. The number of 6 week breaches rose by 1,759 to 9,351 with the number of breaches over 13 weeks also increasing to 4,431.

The total number of patients on the waiting list grew by 2.5% since July. The largest increase proportionately was seen in Echocardiology by 38.4%. The largest reduction was seen in MRI by 17.6%.

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.

6. Long-Term Condition Management, Outpatients and Diagnostics

The BSol outpatients and diagnostic steering group has recently completed an updated summary of progress against agreed action plan. This plan works in tandem with the agreed system plan and includes now a focus on helping the system achieve 104 week backlog clearance. There is wide stakeholder involvement in all workstreams and close working with GP Partnership Board and GP Local Medical Committee. The progress of this work is summarised below:

6.1 Models of Outpatient Care

An ICS group containing all relevant stakeholders has been established and current work programmes are as below linking into individual provider work streams. This includes data collection as specified by now released NHSEI requirements. This includes paediatric care and covers the following work areas:

a) Advice models including advice and guidance: learning from current practice to refine with focus groups with consultants and primary care held with thematic analysis. A stocktake of current advice models provided across BSol to allow discussion around an individualised system target is expected in H2. This is included within the GP Universal Offer to aid uptake. We are developing a consensus ‘BSol way’ for advice models. System level data returns are being completed although the exact requirements for the advice models included are currently a little unclear in national guidance. BSol should meet target of 12 referrals via advice route per 100 new patient appointments
b) Patient Initiated Follow Up (PIFU) project established with pilot specialities identified across all providers and commenced end of Q3. Provider level returns have commenced. The H2 planning requirement is for 5 specialities undertaking PIFU by March 2022 and the transfer of 2% of all follow-up appointments to PIFU pathways. This will be a stretching target for BSol.
c) Establishment of agnostic phlebotomy workstream to explore rationalisation of provision across ICS.
d) Dermatology backlog pilot with enhanced primary care support – the specification and contract have been completed and awarded and work has begun.
e) Further work to support 104 week backlog reduction in particularly challenged specialities such as Urology and ENT using similar

methodology of commissioning enhanced support from primary care underway. The project will be scoped, costed and the service specification designed.

f) Unified technology bid – support for customer hub which will tie into patient experience, prioritisation, harm review and escalation, as well as support to facilitate 104 week reduction and learning review of remote clinics to identify next steps.

6.2 Remote Outpatient Appointments

Total outpatient activity across all modes of delivery (face-to-face, telephone and video) increased by 10.1% in September compared to August. All modes of delivery saw greater activity than the previous month with telephone appointments seeing the highest increase of 10.2%.

There were 5.8% more video appointments in September than August and 10.1% more face-to-face appointments. Total remote activity increased by 13.9% but remains 24.1% lower than September 2020. Numbers have recovered somewhat as fewer staff were on annual leave from September.

A series of outpatient video call webinars are being run by the Digital Transformation team throughout October to support the roll out of additional functionality. This is anticipated to support further recovery of remote outpatient activity.

6.3 Prioritisation and Harm Review

This group is focussing on introducing ICS owned methodologies to reduce risk of harm to those awaiting an outpatient review, building on learning from inpatient waiting list health status checking.

6.4 Critical / Cancer Pathways

Work in this area is led by the established Cancer teams and commissioning structures. A ‘vague symptom’ pathway pilot has commenced in two East locality PCNs where it is known that inequalities impinge on access and diagnosis. Further work on updating and rolling out the new 2ww referrals forms for primary care continues. A pilot of an Iron Deficiency Anaemia pathway is underway – other areas who have implemented this pathway have seen between 10 and 17% reductions in requests for endoscopy. BSol has been successful in a bid to pilot Targeted Lung Health Checks – the pathway of this will be linked into Community Diagnostic Hub development.

6.5 Service Improvement and Transformation

The aim of this group is to:

a) Ensure that strategic transformation of pathways is based on national requirements and local need, taking into consideration system priorities and national improvement reviews such as Getting It Right First Time (GIRFT).

b) Ensure that transformation is joined up across system level pathways and dovetails with UHB NHSX-supported digital transformation programme where appropriate.
c) Work on principle of access to all; if pilot studies are to be introduced they must have defined evaluation criteria and clear methodology for review and expansion or termination.

Multi-stakeholder meetings are being held in areas defined as needing 'restart' focus.

Dermatology: successful submission of a business case to ICS investment committee to fund backlog screening of long waiting patients. A specification has been written and group of 1500 patients identified as suitable for this model. Contracting mechanisms are being worked through. Similar models are being explored for other long waiting specialties.

Diabetes: meeting was held with system wide representation to agree areas of re-focus after the pause of ICS wide diabetes plans by COVID. Several task and finish groups have been established to refine previous plans based on current funding models and COVID-based learning of new ways of working.

Oversight and integration of regional transformation programmes such as Midland Elective Delivery Programme are being translated into local action. Work is also ongoing to ensure that digital solutions are implemented system wide where appropriate and that there is shared learning between providers.

6.6 Diagnostics

Access and provision of appropriate diagnostics will be picked up in previously described areas; this workstream will provide additional focus where required. This will include facilitating review of primary care access to imaging and the work required around provision of Community Diagnostic Hubs (CDHs). Estates and planning work for the pilot site at Washwood Heath is underway. A mobile MRI unit has been specified and the contract is about to be awarded. Work will continue on a system-wide strategy for CDHs with an options appraisal paper to be presented to the ICS by December. Draft costings for future CDHs have been submitted nationally to inform the autumn spending review.

Providers continue to work to prioritise diagnostic procedures and submit waiting list data including this prioritisation information to the national waiting list minimum data set. This is however complicated by PAS requirements, which is not unique to BSol. Work continues on a paper outlining which data can and cannot be submitted at this point.

7. Communications and Engagement

The system communications and engagement plan continues to be in place and is working effectively, supporting an on-going 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.

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. H2 2021/22 Planning Guidance – Operational Performance Standards

The H2 planning guidance covering the second half of 2021/22 includes a number of objectives or targets applicable to both planned and urgent and emergency care. There is also a requirement to ensure health inequalities are considered within elective recovery plans and progress is tracked through board level performance reports. Future reports will be amended to reflect these changes in the national performance framework.

The full list of specific measures is as follows:

8.1 Urgent & Emergency care

a) Reduce the number and duration of ambulance to hospital handover delays.
b) Eliminate 12-hour waits in EDs.
c) Ensure safe and timely discharge of those patients without clinical criteria to reside in an acute hospital, especially individuals on Pathway 0.

8.2 RTT

a) Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer.
b) Hold or where possible reduce the number of patients waiting over 52 weeks.
c) Stabilise waiting lists around the level seen at the end of September 2021.

8.3 Outpatients

a) A minimum of 12 advice and guidance requests should be delivered per 100 outpatient first attendances by March 2022.
b) 1.5% of all outpatient attendances to be discharged to PIFU pathways by December 2021, and 2% by March 2022.
c) Grow remote outpatient attendances where clinically appropriate with an overall share of at least 25%.

8.4 Cancer

a) Return the number of people waiting for longer than 62 days to the level we saw in February 2020.
b) Meet the Faster Diagnosis Standard (FDS) from Q3.

Many of these targets are likely to prove challenging to deliver, however it should be noted that the Trust is already achieving those relating to remote outpatient appointments and Advice and Guidance.

9. Q2 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 is now in the committee stage in the House of Commons. As a brief reminder the main provisions of the Bill include:

a) The abolition of Clinical Commissioning Groups (CCGs);
b) The formation of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) for each ICS;
c) The formal merger of NHSE / NHSI; and
d) A focus on collaboration instead of competition.

It is thought that an amendment of the proposed power of the Secretary of State to "call in" and block local reconfiguration plans at any stage may be possible. Of course other significant changes may occur as it passes through the Houses of Commons and Lords.

Extensive guidance has been published to support implementation of the Bill, most notably: *Working Together at Scale - Guidance on Provider Collaboratives* which sets out three proposed models for provider collaboratives – provider leadership board, lead provider and shared leadership and *Thriving Places - Guidance on Place Based Partnerships* which emphasises that places will be the foundations of ICSs and place-based partnerships will co-ordinate the planning and delivery of services. In addition an Integrated Care Partnership engagement document sets out expectations for the role of ICPs within ICSs.

Changes to align ICSs to local authority boundaries mean that Sandwell and West Birmingham CCG will split with Sandwell joining the Black Country ICS and West Birmingham becoming part of the BSol ICS.

9.1.2 Health and Social Care Funding

The Government has announced the implementation of a new, UK-wide 1.25% Health and Social Care Levy (the Levy), ring-fenced for health and social care. The Government will also increase dividend tax rates by 1.25 per cent, revenue from which will help to fund this package. This additional funding is intended to help address the elective backlog, put the NHS back on a sustainable footing, increase the focus on prevention and provide a long term solution for social care

funding. Approximately £15.8bn of this funding is expected to go into the main NHS England budget of which around £8bn is expected to be used to tackle the elective backlog. NHS Providers and the NHS Confederation have calculated that the NHS needs £10bn additional funding in 2022/23 whereas this additional funding equates to £6.6bn that year so there remains a significant shortfall. Initially there will be a £250m Elective Recovery Technology Fund to enable cutting edge technologies and £250m to increase operating theatre capacity and improve productivity.

From October 2023, there will be an £86,000 lifetime cap in England on personal care spending. The means test for accessing local authority funding will also be made more generous at the same time. The Government will publish a white paper on adult social care later in 2021, focusing on wider system reform. They will also invest at least £500 million in measures over three years to provide support in professionalising and developing the social care workforce; fund mental health wellbeing resources; and improve recruitment and support.

9.1.3 H2 2021/22 Planning Guidance

The planning guidance for the second half of the 2021/22 financial year maintains the six priorities outlined in the guidance published in March:

a) Supporting the workforce;
b) Delivering vaccinations and ongoing COVID-19 support;
c) Transformation to accelerate recovery of electives and address rising demand for mental health services;
d) Expanding primary care capacity to address health inequalities (see section 9.1.5 below);
e) Transforming community and urgent and emergency care to reduce pressure on emergency departments; and
f) System collaboration.

There is a targeted investment fund of £700 million to spend by the end of March 2022 with proposals to be submitted by 14 October. The operational performance objectives included in the guidance are listed at Section 8, above.

9.1.4 Future New Hospitals (Formerly Health Infrastructure Plan)

The Government has announced that a final 8 hospitals are to be funded as part of this scheme. Expressions of Interest had to be submitted by 9 September with a final decision due by spring 2022.

9.1.5 GP Plan

NHS England has published its plan outlining its proposals to support primary care in the following areas:

a) Increasing and optimising capacity - including a new £250m Winter Access Fund running from November to March to help patients with

urgent care needs be seen on the same day in an out of hospital setting and continuing to recruit 6,000 additional GPs and 26,000 other primary care professionals/

b) Addressing variation and encouraging good practice – including undertaking a practice-level review of levels of face-to-face care. NHSE will also commission a QOF improvement module, focused on optimal models of access including triage and appointment type. NHS Digital is also working to publish activity and waiting time data at individual practice level as soon as possible. ICSs will be expected to take immediate action to improve access at the practices with lower activity than prior to the pandemic or the lowest number of face-to-face appointments as well as those practices with high numbers of in-hours 111 calls or high rates of ED attendances.
c) Zero tolerance of abuse and a communication programme in relation to this.

9.1.6 NHS England Leadership

Amanda Pritchard is the new Chief Executive of NHS England (she was formerly the COO and prior to that Chief Executive of Guy's and St Thomas' NHS Foundation Trust). Mark Cubbon, previously the Director for Long Term Plan Delivery and Deputy Chief Operating Officer and before that Chief Executive of Portsmouth Hospitals University NHS Trust has been appointed Interim COO in her place.

9.1.7 Ministerial Reshuffle

Following the appointment of Sajid Javid as Secretary of State for Health and Social Care, a number of new ministerial appointments were made in September's reshuffle. Gillian Keegan is the new Minister of State for Care and Mental Health, replacing Helen Whately. Maggie Throup will now be leading on COVID vaccine deployment and public health more generally. Maria Caulfield now has responsibility for patient safety and primary care, whilst Lord Kamall is the new Minister for Technology, Innovation and Life Sciences, replacing Lord Bethell.

9.1.8 Regional Changes

Richard Beeken has been appointed substantively as Chief Executive for Sandwell and West Birmingham Hospitals replacing Toby Lewis. This means he has now officially moved on from Walsall where both the Chair (Steve Field) and Interim CEO (David Loughton) are now shared with Wolverhampton.

9.2 <u>Key Updates against the 2021/22 Plan</u>

Key areas of progress in delivery of the 2021/22 Strategy Implementation Plan 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. There are a number of objectives where delivery is delayed by external factors but where delivery of the overall objective is not at risk including:

a) The final completion of the rollout of Windows 10 has been slowed by availability of replacement PCs due to shortages of semiconductors in the global supply change. Likewise the delivery of Winscribe due to remedial action required by an external company.
b) The negotiation of SLAs for the Harborne Hospital have continued longer than planned but these will still be completed by the end of 2021, well in advance of the Hospital opening in late 2022.
c) Increased non-medical recruitment activity during Q2 has resulted in a delay in implementing the roll-out of the assessment centre model and the Oleeo recruitment platform which will now take place during Q3.

Overall the Trust continues to make significant progress in delivery of the plan despite the operational challenges it faces.

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 2 progress against the 2021/22 Strategy Implementation Plan.

Jonathan Brotherton
Chief Operating Officer

Mark Garrick
Director of Strategy & Quality Development

18 October 2021