BIRMINGHAM CITY COUNCIL

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (BIRMINGHAM & SOLIHULL) 16 DECEMBER 2020

MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM AND SOLIHULL) HELD ON WEDNESDAY 16 DECEMBER 2020 - ONLINE MEETING

PRESENT: - Councillor Robert Pocock in the Chair;

Birmingham: Councillors Mick Brown, Diane Donaldson, Peter Fowler and Paul Tilsley

Solihull: Councillors Katy Blunt, Diana Holl-Allen, Diane Howell, Laura McCarthy, Rosemary Sexton

Attendees:	Harvir Lawrence	Director of Planning and Performance, (Birmingham and Solihull Clinical Commissioning Group), BSol CCG
	Ian Sharp	Clinical Lead, Elective Care, (University Hospital Birmingham), UHB
	William Taylor	Clinical Lead GP, BSol CCG
	David Melbourne	Deputy Chief Executive, Birmingham Women's and Children's NHS Foundation Trust
	Paul Athey	Chief Finance Officer, BSol CCG
	Helen Kelly	Associate Director of Integration (Urgent Care/Community), BSol CCG

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1. **CHAIRMAN'S WELCOME**

Councillor Pocock welcomed all to the meeting.

NOTICE OF RECORDING/WEBCAST

2. The Chair advised that the meeting would be webcast for live and subsequent broadcast via the Council's internet site (www.civico.net/birmingham) and that members of the press/public may record and take photographs except where there were confidential or exempt items.

APOLOGIES

3. There were no apologies submitted.

DECLARATIONS OF INTEREST

4. There were no declarations of interests made.

The business of the meeting and all discussions in relation to individual reports are available for public inspection via the web-stream.

MINUTES

5. That the Minutes of the Joint Health Overview and Scrutiny Committee meeting held on 13 October 2020 were approved as an accurate record of the meeting.

MINUTES – MATTERS ARISING

6. There were no matters arising from the minutes of the 13 October 2020.

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7. **BRIEFING ON BIRMINGHAM AND SOLIHULL STP WAVE 2 UPDATE**

The Chair noted this agenda item would be presented in two sections. These were; 1) Birmingham & Solihull STP Wave 2 update 2) Primary Care – General Practice Winter Operating Model.

Harvir Lawrence, The Director of Planning and Performance (BSol CCG), referred to the paper submitted for this

(See document No. 1, page 9 of the document pack)

Part 1 - Birmingham & Solihull STP Wave 2 update

The Director of Planning and Performance (BSol CCG), informed Members the report provided an update on the latest developments in managing COVID-19 service changes in BSol's response to wave 2 and the approach and ongoing engagement with key stakeholders.

At the point of submitting this report, it was noted the rate of infection was decreasing however, the case rates had since increased both in Birmingham and Solihull which had manifested in hospital admissions and ITU cases.

She highlighted from the 16 Dec 2020; the case rate of Birmingham was 207 per 100,000. On the published data, Solihull had 147 per 100,000, however further intelligence had been received via the Director of Public Health for Solihull. This indicated the rate for Solihull may be higher than the published

information. The over 60's was continually affected by Covid-19 and there was a sharper increase in hospital admissions amongst this age group.

A summary was given on the geographical prevalence maps for both Birmingham and Solihull. It was noted these comparative maps indicated cases by Ward over three various periods. These were; i) 1st March to November ii) last 30 days iii) last 7 days. Members were informed information contained in both sets of maps were recorded up to the 27th November 2020. A similar pattern for both areas had been identified during this period.

An overview on the Covid-19 related admissions within UHB was given to Members. She informed from the 14 December, there were 430 admissions to UHB of which 36 were in ITU. The number of cases had reduced slightly however the overall admissions was still high. This is causing some strain on managing the cases and capacity issues. At present, the Royal Orthopaedic Hospital (ROH) and Solihull Hospital site were Covid free sites delivering urgent elective care. Further decisions will be required to see how the capacity is utilised in accordance to the pressure on the system.

There were concerns for a potential third wave around January 2021 as a direct impact of the festive period. It was crucial for the public in Birmingham and Solihull to adhere to the tier 3 restrictions. Daily conversations were taking place to monitor the case rates and to make decisions around service delivery.

The impact of the second wave had been significant, therefore, a number of local decisions had been made on the way services were delivered. A number of services had been reconfigured. It was emphasised the number of admissions since the first lockdown had tripled and the non-Covid emergency activity was almost at the level of pre-Covid 2019. This was an additional pressure on the system.

It was highlighted Covid-19 had accelerated the implementation of the Digital First Programme. During the summer, the CCG conducted an engagement exercise to evaluate the impact of Covid-19 with the assistance of the voluntary and community sectors. It was found that majority who accessed services found it easy to do so. The report was being shared with partners across Birmingham and Solihull to address the findings and develop future work within this area.

An important area of focus was around clinical prioritisation and harm review. Ian Sharp, the Clinical Lead, Elective Care (UHB) informed Birmingham and Solihull, Chief Medical Officers in the CCG and Trusts had worked together to develop an agreed process and more specific guidance to support patients as well as respond to specific pressures within this area. This was launched in June 2020 in order to bring consistency for decision making and allocation of care across the area.

An outline of the six prioritisation categories was shared with the Committee. A process was in place to deliver a fair, manageable approach to patients care across all the providers,
Each acute trust had adopted the Clinical Prioritisation Policy and were delivering this in line with their internal governance.

Member's response

The Chair and Councillor Brown raised a number of queries around the priorities and categorisation. The queries related to the number of patients distributed across each priority categorisations; what percentage of patients were opting to go into priority 5 (Patients wishing to postpone surgery because of Covid related concerns) and how the figures around priority 5 had fluctuated over the last 9 months and support provided to patients.

Councillor Holl-Allen had concerns around backlog on waiting lists and workforce resilience to support this. Councillor Tilsley also had concerns around staffing. He noted UHB is the predominate provider in Birmingham and Solihull and queried the staff shortages on the current establishment.

In addition, Councillor Sexton made several queries around digital consultations. The queries related to how well the digital consultations were working; if there was a criteria for digital consultations to take place; feedback and future analysis on these; what was meant by post-operative care and releasing acute beds. Councillor Fowler queried if the work around digital consultations would be expanded upon in the future.

Questions were raised around what conditions the Nightingale Hospital would be used, and Councillor Brown questioned the logistics to open Nightingale Hospital and turnaround to open this.

In response to Member's queries, the Clinical Lead, Elective Care responded and the following points were captured: -

- **Priorities 1-6** - In response to the Chair's queries, it was noted the figures relating to the prioritisation were routinely reported to the national team. Examples were given around the priorities and figures associated with these. It was noted as the priority numbers increased so did the number of patients in each category. The number of patients waiting longer 52 weeks for treatments was being reported upon routinely. A key target as part of internal plans was to see how quickly the backlog could be closed.

  In response to Councillor Brown's queries around priority 5, it was noted this part of the criteria was launched at the end of September/ October 2020, therefore was recently introduced. Only a small percentage of patients had made a choice to move to a higher priority group. There was a challenge to work through this in a systematic way especially in relation to priority 4 (Patients who can wait longer than 3 months and can be delayed by a further 3 months). At present, less than 5% of patients postponed their surgery. Solihull Hospital had an Elective Care Centre which provided continued support to patients. The non-Covid pathway at the Queen Elizabeth Hospital had been very successful, and clinicians had provided reassurances to patients to go ahead with their procedures. In addition, patients who wished to defer their surgery would be provided with an alternative method of therapy.

- **Workforce & backlog of waiting lists** – In response to Councillor Holl-Allen's queries, it was noted the larger backlogs were mainly around the speciality's areas e.g. Neurology. There were concerns around specialities priority 4 patients who did not have good elective capacity levels. However, there had been success to deliver some volume of elective capacity for most speciality areas.

  The main concerns were around orthopaedics, plastic surgery and category 4 patients who had been waiting for a long time. Capacity was being explored for both with the independent sector with ROH and internally.

  Staffing was one of the key limitations across the NHS. There was a shortage and as well as accessing agency staff to deliver care. The STP had successfully bid to NHS England/Improvement to put in place mental health and wellbeing wrap around support which was starting to take shape working with the Birmingham and Solihull Mental HealthTrust. This would support the current workforce.

  In response to Councillor Tilsley's concerns on staffing, it was noted some areas were more affected than others i.e. theatres. The sickness levels were monitored routinely, and it was noted 1 in 40 staff were off from work due to Covid-19 related absence. The vaccination work had started which would support staff at work. Further details on staffing across the organisation would be provided to the Members.

- **Digital Consultations** - In response to Councillor Sexton's concerns on digital consultations, it was highlighted that video consultations resolved a number of accessibility and transport issues for patients with disabilities. The digital resources allowed more people to be a part of the care of a patient i.e. linguists, family members to be involved in one call. Video calls seemed to work well with deaf patients as the interpreter was able to join calls.

  It was noted, for UHB patients, a dialogue would take place prior to virtual appointments. There was no expectation that all appointments would be covered digitally, and clinicians assess accordingly. Overall, the feedback from clinicians had been positive.

  David Melbourne, the Deputy Chief Executive at Birmingham Women's and Children's Hospital indicated across mental health services the switch to digital consultations had been incredibly successful and noted this across the whole of the NHS.

  The analysis of virtual consultations would be built into future delivery as it was important to improve and learn continually.

  In response to Councillor Fowler's query around expanding on digital consultation in future, it was noted there would be further developments on digital consultations by using a blended approach for care pathways. At present, the digital consultations were working well in response to Covid-19 and had accelerated some areas of the long-term plan.

A summary of the statistics related to analysis of virtual consultations should be shared with the Committee Members.

- **Post-acute fractured neck of femur rehabilitation pathway to release acute beds** - Members were informed post-acute fractured neck of femur rehabilitation pathway to release acute beds had more than one pathway which required different levels of rehabilitation and processes. Due to Covid-19 there was now one pathway and therefore the length of stay in hospital had been reduced to 10 days. This released beds for acute care.

- **Nightingale Hospital** - It was noted the Nightingale Hospital would open if acute care was 'swamped' by hospitals in the region. The Clinical Lead, Elective Care expressed concerns on opening this hospital as staff would have to be reassigned from existing hospitals. The Members were informed the Nightingale Hospital would be opened within 72 hours if needed.

- Councillor Fowler noted the efficiencies plans looked very encouraging.

Further discussions took place on this item, where additional questions were asked by Members.

Councillor Holl-Allen referred to the changes in the Emergency Treatment Centres and what patients were currently doing as a result of the Covid-19 pandemic changes.

Councillor McCarthy and Councillor Brown requested further detail around long-covid under the priorities section.

- **Emergency Treatment Centres**
  In response to Councillor Holl-Allen queries, Helen Kelly, the Associate Director of Integration (Urgent Care/Community), BSol CCG informed Members people were using NHS 111 First service. If required, referrals were made to the Urgent Treatment Centres. 2 out of 3 patients were dealt with via a telephone consultation and 1 out of 3 via face- to-face appointments at the Urgent Treatment Centres.

- **Further detail around long-covid under the priorities section** – In response to Councillor McCarthy and Councillor Brown queries the Clinical Lead GP (Birmingham and Solihull CCG) explained a rehabilitation clinic would be set up for patients with Post-Covid syndrome. There were different areas of Covid to deal with i) following ITU admission – patients whom experience physical consequences of Post-Covid syndrome ii) Primary care route – patients with long term fatigue, muscular pains etc. Specialist Clinics had been set up i.e. therapy led, cardiac respiratory to cover patient's needs.

- Councillor Fowler referred to priority 4 (Patients who can wait longer than 3 months and can be delayed by a further 3 months) and questioned if this was agreed with the patient. He had concerns around the possible

rise in cases in January 2021 and if the workforce would be able to cope with the pressure.

In response to Councillor Fowler's query, it was noted, prioritisation was based on the needs of the patients. If patients were required to wait for procedures, direct communications would be made. Several communications channels were available to get key messages across to the public. Patients whom are on waiting lists were not forgotten and would remain placed on the waiting lists.

Patients were encouraged to inform the hospitals if their situations had changed in order to reprioritise and escalate their care accordingly. Members were informed patients would be made aware of their pathology. Following this, they would have to consent to operation to proceed. It was the pathology and likely treatment which would determine the priority coding. Priority 4 was a large category therefore a graduated approach was taken to split this into various areas. Several workforce plans had been formulated and these were constantly reviewed in order to deliver a large number of elective care procedures. Plans would be revised if required.

The Director of Planning and Performance (BSol CCG) added section 3.3 of the report gave specific details on changes made to protect the emergency capacity and the ability to deliver priority elected care. She welcomed Members to email her with any additional queries around this paper.

Part 2 - General Practice Winter Operating Model

William Taylor, the Clinical Lead GP (Birmingham and Solihull CCG) informed Members a huge amount of work had been undertaken in Primary Care to ensure the system continued to support ambulance conveyances and to ensure the were less patients going into A&E. It was crucial to manage the infection rate for both the patients and staff in primary care.

An extensive overview of the General Practice Winter Operating Model was given to the Committee.

It was essential for General Practice to stay open, however, there would be additional workload with the Covid-19 vaccination programme that may require GPs to prioritise clinical activity. CCGs would be taking sensible decisions around the repurposing of funded capacity delivering locally enhanced services which could also be paused.

The Universal Enhanced Service Patient Offer had been reviewed and stood down non-essential elements of the offer to support practices to prioritise urgent patient care. This had a focus on core provision until the pressure reduced. Ambulance conveyancing, additional appointments and review of staff support had been introduced. He gave details around the GP Covid Expansion Fund which had been made available to GPs and focussed on 7 key priorities. There was work happening to manage expectations during this pressurised period, in terms of managing and booking appointments.

Appointments per month were back to pre Covid levels with more appointments undertaken via telephone but more than 50% are face-to-face.

The Director of Planning and Performance (BSol CCG), added regular communication updates were taking place with stakeholders, including the Joint Health and Social Care Overview and Scrutiny Committee, Solihull Health and Wellbeing Board and Birmingham Health and Wellbeing Board.

Member's response

Councillor McCarthy received several queries from residents about long-Covid and requested for more detail on this and the referral process to clinics.

Councillor Sexton was pleased to hear patient preference was being considered. She queried if this applied to all Primary Care Networks and had concerns around patients who had difficulties to articulate their symptoms on the phone. It was questioned if this would be looked out for. There was also concern around the additional demand on GP's and primary care and questioned if there was any extra resource to support this area.

Councillor Blunt noted GP's were delivering their work for primary care however she raised that pharmacies should be made available to access any necessary medication. She had concerns there were no 24/7 pharmacies available in Birmingham and Solihull for patients to access certain medicines. As a result, she highlighted these concerns with the CCG and was advised NHS England made these decisions. A response from NHS England was yet to be received. It was noted services should be linked with non-hospitalised areas to allow continuity of service.

Councillor Tilsley referred to the post-Covid comments made during discussions which were described as Chronic Fatigue Syndrome (CSF). He noted there was a lack of training at GP level in recognising the symptoms and limited amount of remedies. CSF was delivered by the Birmingham and Solihull Mental Health Trust and queried support to post-Covid CSF.

Councillor Howell referred to the challenges of clinicians and performing virtual consultations. It was noted that virtual consultations required a skill i.e. to be an active listener and probe deeper to understand the patient. She questioned the training GP's and clinicians had been provided and whether resources were available to develop communication skills.

In response to Member's queries, the following points by the Clinical Lead GP (Birmingham and Solihull CCG) was captured: -

- **Long-Covid** – This would be actioned via various routes; i) as people come out of hospital and directed into clinics ii) People who presented directly themselves directly through GPs, they would go through a prioritisation tool by reviewing their symptoms. Rehabilitation would be integrated into the clinics as well.
- **Advice** - Standard advice was given across all primary care. There were 32 Primary Care Networks incorporating approximately 100 Practices including GP's and physicians. Feedback from patients was being

monitored through the CCG and support was given to practices whom were experiencing problems. Work was being undertaken on educating people on how the telephone triage should be utilised. This was a new system to adopt across general practice.

- **Patients who had difficulties in articulating symptoms** – A skill was required to note where patients were having difficulties to share this via phone calls. Currently, this was not perfect however this would develop and improve over time. It was highlighted as a learning curve.
- **Additional demand on GP's and Primary Care & resources** – CCGs had reduced the demand on Universal Offer Scheme which released some of the resources for GP's to focus on Covid related areas. However, GP's were trying to maintain the standard of national service to their patients though there had been some cutbacks on the chronic disease reviews. Focussed work had taken place around prioritisation to assist this.
  A new structured system around medication reviews to care homes was being undertaken. Discussions were taking place around repurposing pharmacies to support the covid vaccinations programme.
- **Non-hospitalised areas to allow continuity of service** – e.g. 24/7 pharmacies – Pharmacies were commissioned via NHS England and not CCG's however, there was a constant dialogue with them. The Clinical Lead GP (Birmingham and Solihull CCG) was happy to support suggestions made by Councillor Blunt and suggested if a response was not received, she should liaise with him to escalate.
- **Post Covid Syndrome** – There was not enough known in this area to comment upon continuity to Chronic Fatigue Syndrome. The symptoms were very similar however detailed research would have to be undertaken to see if there were any similarities between post-covid and CFS.
- **Training GP's and Clinicians for Virtual Consultations** – The Royal College of General Practice (RCGP) had been very pro-active and produced several resources to support Clinicians and GP's in telephone triage. Several other organisations had set up video and telephone training courses as there was a huge demand for area of training. The GP training had been modified to reflect the new ways of working on consultations and examinations were reflecting this.

8. **RESOLVED:-**

That the Committee;

i) Noted the work undertaken and next steps on managing COVID-19;

ii) Noted the ongoing engagement with key stakeholders on the response to wave 2 and service recovery and restoration;

iii) Members noted four key concerns during discussions and requested further information in the next update report;

- Scale and increasing numbers of people for delayed treatment;
- Degree of influence patients had on priorities they were allocated;
- Staffing concerns – to receive further details on this area;
- Availability of accessible pharmacies in BSol area.

BIRMINGHAM AND SOLIHULL STP FINANCE UPDATE 2020/21

Paul Athey, the Chief Finance Officer, BSol CCG, referred to the presentation submitted for this item: -

(See document No. 2, page 23 of the document pack)

The Chief Finance Officer, BSol CCG gave an overview to the financial regime which had been applied. This was a temporary regime for CCGs and NHS providers for the first 6 months of the financial year. The key features of the regime were outlined.

A comprehensive breakdown was given around the Financial Performance – April to September 2020 and STP Covid Expenditure – April to September 2020. It was noted in the first 6 months of the year, the STP incurred £170.2m of additional costs as a result of responding to the Covid pandemic. A material element of the cost was related to the set up of the Nightingale Hospital.

He noted, Government had introduced a support package to encourage hospital beds were only used for those patients who needed these and enhance discharge i.e. to provide more community beds, community support and to enable patients to be discharge appropriately from a hospital setting.

A range of primary care services were enhanced during wave 1 of Covid-19 which included the Covid Referral Centre at the NEC as well as a number of home visiting and other services that were stood up during the first wave.

From Month 7 (October 2020), a modified financial regime had been introduced and a breakdown was given to the Committee.

For months 7-12, the NHS systems had been given allocations to cover the specific areas of expenditure. These were; business as usual services; additional Covid costs; growth monies to support restoration and recovery of services. This was beneficial from a finance perspective as funding and monitoring was taking place over a whole system rather than individual organisations.

There was a continuation of block payments to NHS providers to support “business as usual”. The value of the blocks had been increased from month 7 to reflect agreed shares of system top-up, growth and Covid funding. The systems were expected to comply with existing investment targets and ring-fenced funding for services such as Mental Health and Primary Care.

David Melbourne, the Deputy Chief Executive, Birmingham Women’s and Children’s NHS Foundation Trust notified Members the current plan shows a shortfall of funding of £45m, £10.4m of which was expected to be resolved by the national team. The funding had been allocated in two parts one of the key assumptions in the funding for the second half of the year was around the recovery of income from non-NHS. It was acknowledged that non-NHS income would be adversely affected by a number of factors linked to the pandemic. Work had been undertaken with NHS England and NHS Improvement to get the deficit down to a reasonable level.

The financial figures for month 8 indicated the deficit of under £20 million. The NHS were careful not to impact on Mental Health Investment Standard and investment into primary care.

An overview of the efficiencies and savings plans were shared with the Committee.

Looking ahead into 2021/22 and beyond this is challenging at this point of time, given the uncertainty of both the service need and the financial framework within which these services will be funded.

In response to Member's queries, the Chief Finance Officer, BSol CCG and the Deputy Chief Executive, Birmingham Women's and Children's NHS Foundation Trust following made the following points:

- Cash related efficiency savings (CRES) was explained to Members by giving an example around primary care. The allocation would come through the CCG, and the 1% CRES saving would be made against primary care budgets.
- Several schemes had not commenced due to the focus on operational response to Covid. A number of schemes had continued e.g. prescribing budget (material spend £200 million pounds a year) allowing work with clinical pharmacists to ensure spend was efficient.
- Systems savings would come through transformation of pathways.
- Capacity - The cost for capacity used this year would be much clearer in 2021/22. There were elements of the independent sector costs that were already utilised, and it was likely the use of the independent sector capacity would be required in the future in order to get the waiting lists back to pre-Covid numbers. There was a long-term liability of waiting lists around 18-24months.

9. **RESOLVED:-**

That the Committee noted the presentation and requested an update to the next meeting on the long-term financial liability of tackling waiting lists and funding from central government.

URGENT CARE UPDATE AND NHS 111 FIRST

Helen Kelly, Associate Director of Integration (Urgent Care/Community), BSol CCG, referred to the presentation submitted for this item:-

(See document No. 3, page 31 of the document pack)

The Associate Director of Integration (Urgent Care/Community), BSol CCG gave an overview of the current context of urgent care in Birmingham and Solihull an update of NHS 111 First and Urgent Treatment Centres.

It was noted by the 1st December, NHS 111 First will be implemented nationally with the aim to guide the public in making the right healthcare

choices to ensure their safety, as well as making sure they get the right treatment in the most appropriate place.

Around 70% of Emergency Departments attendances were made up of walk-in patients and patient numbers had already begun to increase. Patients had to be kept safe in reduced spaces within waiting rooms. The provision for emergency care safely for the most vulnerable and shielded patients had to be in place. The NHS 111 First provided an opportunity to take patients on a different journey, where it would get them the right treatment in the right place. An Equality Quality Impact Assessment had been completed to ensure people were not adversely affected.

William Taylor, Clinical Lead GP (Birmingham and Solihull CCG) added that a consistent approach was required for the Urgent Treatment Centres (Walk-in centres).

Urgent Treatment Centres (UTC) across Birmingham and Solihull are no longer 'walk-in' services; patients now need to contact NHS 111 First for advice before attending these services which would be less confusing for the people to access.

Member's response

The Chair referred to a digital system called 'Ask A&E' which was previously introduced by UHB and queried if the NHS 111 First has replaced this. He questioned if this system was coherent as having two systems would cause confusion to the public.

Councillor Tilsley queried where the South Birmingham Urgent Treatment Centre was located.

Councillor Sexton raised a number of queries around concerns raised by doctors in British Medical Journal about the NHS 111 First. She queried if a trial for NHS 111 First had taken place before it was rolled out nationally. She questioned what the trial data indicated; what the learning outcomes were on the trial; average call waiting time and number of dropped calls; how many calls were managed by call handlers versus the number past clinicians; number of people accessing NHS 111 First online versus via phone; details on patients that would have attended A&E and where they were redirected to and pressure on Primary Care network, if additional resources were available.

In addition, she questioned if fewer patients were attending A&E as the algorithm was 'risk averse' when calls were handled by call handlers rather than clinicians i.e. more patients sent to receive face-to-face care or sent to A&E.

Councillor Sexton questioned what provision was available for people with disabilities especially if they had to access urgent care. If they were unable to express themselves clearly on the telephone. People had raised concerns that they were unable to get in touch with their GP and caused anxiety.

Furthermore, she queried if there had been any significant events as a result of NHS 111 First i.e. inappropriate signposting, delay in treatment and where would the accountability lie.

Councillor Howell questioned if the Communication Plan for NHS 111 First was a national or local plan. She added if there was awareness around accessing urgent emergency care and who was monitoring the effectiveness of the plan.
In addition, she questioned the geography for the Urgent Care Treatment centres, referring to the current closure of the Solihull Hospital Minor Injuries Unit and temporary relocation to Chelmsley Wood.

In response to Member's queries, the Associate Director of Integration (Urgent Care/Community), BSol CCG and the Clinical Lead GP (Birmingham and Solihull CCG) made the following points:

- The NHS 111 First worked in conjunction with the Ask A&E digital system. The NHS 111 First was a national offer however, if people attended any of the emergency sites without a booking an appointment, the 'Ask A&E' process would be used. The NHS 111 First Service was a booked appointment system into the emergency department where patients were expected to attend. However, people who showed up on sites having not gone through the NHS 111 First would be noted as unheralded activity.
- UHB were trailing the NHS 111 First to see what works best and to see where the Ask A&E fits in.
- The South Birmingham UTC was based at Katie Road.
- Trial on NHS 111 First – The feedback on the trail for NHS 111 First had not been formally shared by NHS England. To date the trial data had not been made public before rolling the programme out Nationally.
- West Midlands Ambulance Service is a good NHS 111 First provider.
- Members were informed the following data was available to share;
  - The data around the average number of calls waiting time and number of dropped calls information.
  - Details on calls managed by call handlers versus the number past clinicians.
  - number of people accessing NHS 111 First online versus via phone.
- Patients that would have attended A&E and would be redirected to primary care and Urgent Treatments Centres were within the primary care offer. All the outcomes were undertaken through the NHS pathway software in order to track where patients were signposted. This had placed some additional demand on primary care however it was not a large number (approximately 1 or 2 patients for most practices). The pressure on GP's was being monitored.
- Fewer patients were attending A&E (linked to algothrim) – This was a management system of the profiles and was being monitored.
- One of the advantages of the NHS 111 First was that it was backed up by a 1:1 clinical assessment service therefore people are not triaged by the electronic system. The combined approach was key to this.
- People who had difficulties expressing themselves on the phone, a provision was available as a standard service to call back and to see

what can be done to facilitate disabilities or language barriers. Those people would most likely be booked to their GP as that would be the most effective place. If people were still struggling, they could contact their GP.

- If patients self-present at UHB they would be supported by facilitators to navigate through the Ask A&E system.
- An update from NHS 111 First would be provided to Members on concerns around people who were unable to get in touch with their GP's.
- Details of the Equality Impact Needs Assessment would be forwarded to Members.
- No significant events had occurred via NHS 111 First however, this was being monitored. There were policies and procedures in place for the operational delivery.
- The accountability would lie in the area where the pathway was at and it was a shared system approach which was mapped out carefully.
- Algorithm for Triage (call handling) verification and testing - Extensive testing was taking place through NHS 111 First pathways. It had been in place for 6/7+ years which was nationally held and validated.
- The Ask A&E approach was in place for those people who had previously presented at sites in order to redirect them to the right settings. Further details around this area could be made available at a later date.
- Communication Plan for NHS 111 First – A national campaign started on the 1st December. Local campaign was also taking place via social media, buses etc. Local communication stakeholder briefs were also taking place for relevant parties, communities in order to ensure equality access was in place. Links for the national adverts to be shared with members.
- The geographical uptake in Urgent Care Treatment Centres was being monitored. In particular, that of the Solihull UTC which has been temporary located in Chelmsley Wood is being monitored via feedback from residents' and impact on local areas which will be fed into longer term strategies.

10. **RESOLVED:-**

That the Committee;

i) Noted the presentation.
ii) Members noted various concerns around during discussions and requested for an update to be provided at the next Committee.
iii) Members requested a comparative analysis of the NHS 111 and Ask A&E systems to be included in the next update report.

OTHER URGENT BUSINESS

11. There was no other urgent business.

DATE OF NEXT MEETING

12. The next meeting will be held Tuesday 9th March 2021 at 1800 hours, Civic Suite, Solihull.

SEASONS GREETINGS

13. The Chair thanked Members for their contributions during 2020 and wished everyone the best possible Christmas and New Year.

The meeting concluded at 19:30 pm.