Paper ref:	TB (05/20) 002

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	COVID-19: Restoration and recovery		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Toby Lewis, Chief Executive		
Meeting	Trust Board (Public)	**Date**	7th May 2020

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

It is evident in Trust data, as in regional and national data and communications, that the first hospitalisation peak for COVID-19 is past. From outset we have been concerned to think through what our employees and our patients would need in this recovery phase, while the country is seeking still to Exit from the pandemic. This paper discusses that recovery and restoration, in light of our own plans and guidance from NHS England issued on 29th April. **Public anxiety and belief are a key dynamic relevant to successful change and the Board should discuss the role that we have and can play locally in that conversation.**

It is crucial that in implementing plans we do not compromise our own, or anyone else's ability to deliver care. From the outset a key Black Country constraint was laboratory capability, with PHL as the sole supplier for some time, and we will need to maintain visibility of medicines, PPE, blood and reagent capacity. The creation of the 'cell' inside the Trust will take place in coming days. The paper should be read alongside the other Gold papers on risk and psychological wellbeing. These two too will be tracked rigorously as enablers to the Silver implementation of the recovery plan.

Guidance on Exit is awaited. We would expect that a tracing regime alongside testing, altered but ongoing shielding arrangements, and vaccine/best treatment development will all form parts of that plan. Given the vulnerabilities evident in our 'hotspot' we are urgently seeking to ensure that collective governance within our STP is focused on the right issues.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan	X	People Plan & Education Plan	X
Quality Plan	X	Research and Development	X	Estates Plan	X
Financial Plan	X	Digital Plan	X	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Gold command meetings, gold workshop

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** the guidance issued and emerging plans from the Executive
b.	**AGREE** to receive for approval a final Restoration Plan at our June meeting
c.	**RECOGNISE** the need to proceed at risk in advance of confirmed long term finances

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		As per accompanying paper 003					
Board Assurance Framework		Various					
Equality Impact Assessment	Is this required?	Y	x	N		If 'Y' date completed	1st June
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 7th May 2020

COVID-19: Restoration and Recovery

1. Introduction

1.1 Latest data shows the Trust involved in all relevant clinical trials associated with COVID-19. We have promoted opportunities relevant to staff, such as plasma donation. It is important that that scientific commitment is at the forefront of our Restoration Plans. COVID-19 will be a feature of the future and establishing how best to manage its harm, and the fear concurrent to that, is central to our Trust in the coming months and years.

1.2 The Board will wish to discuss re-establishing services in the coming six weeks, as well as to understand the impact on our workforce, our technology, our estate and our finances. This paper aims to cover those aspects, some in more detail than others.

1.3 As indicated in the Chief Executive's report, we have re-phased some of our strategic work on 2025 ambitions, and the associated Leaders' Conference to September. At the same time, work on tackling poverty and driving regeneration is pushing ahead at pace. The community emphasis of the organisation is essential with the new challenges posed by both the pandemic and the recession.

2. Current COVID-19 status

2.1 Our daily bulletin issues key data and here is the set issued on Friday May 1st.

Number of our patients confirmed with COVID-19 *during the pandemic*	Number of positive COVID-19 patients who have been discharged *during the pandemic*	Number of patients who have died in our hospitals who tested positive for COVID-19 *during the pandemic*	Number of patients entered by the Trust into a COVID-19 research trial to date	Number of COVID-19 positive patients who are inpatients with us today	Number of our staff absent due to ill-health or isolation today
1009	607	293	96	109	537

2.2 The surge paper from Liam Kennedy outlines the evolution of the Trust's response since the Board last met. We established 'blue' (COVID unlikely) and 'red' (query COVID) zones and wards across our community and estate sites. Those arrangements became widely and well understood across the Trust, with strong visual management in place. They broadly mirrored our Personal Protective Equipment guidance. That guidance of course nationally evolved, and tactical derogations were agreed with Gold. Typically the Trust offered more PPE than PHE guidance, in particular offering enhanced access in blue areas including community assessment. That design intent is mirrored in our approach to supporting Care Homes from the outset. The Board will be aware that asymptomatic patients in red wards, especially those moved after admission, into red

wards caused some community confusion and disquiet. That was a symptom both of specific circumstance and of the broader discussions about COVID-19 and demography, including high BaME incidence. The Quality and Safety Committee has discussed our data in this field and will return to the subject at the May meeting, alongside the requested report on three key mortality related questions.

2.3 From a peak of over 250 inpatients, the figures above reveal that COVID-19 red beds are lowering towards 100 across our sites. As at 28th April the Trust commenced testing of all admissions whether clinically indicated or not. We would expect to report blue stream positives, as well as the outcome of our community staff asymptomatic test, as soon as possible and I would hope to orally advise the Board when we meet.

2.4 Demand for 'blue' care remains well below prior levels. This is consistent with national and regional data, and is a key care concern. The return of children to school may give rise to rising paediatric attendance, and that is one reason why our recovery plans prioritise opening by the end of May our planned ED/PAU 24/7 service at City Hospital, and maintaining under review our revised children's emergency pathway at Sandwell. We are exploring the creation of altered community childrens' nursing services akin to the model through which we deliver our widely praised iCares adult community service.

2.5 The Trust has delivered a number of off-site services to date in the pandemic, including revised maternity support, hot COVID general practice services, and relocating chemotherapy, haematology inpatients, dermatology services, endoscopy and cancer surgery away from our sites. We would expect to continue to use independent sector sites for some but not all of these services through the end of June.

3. Learning lessons and evaluating options (patient facing)

3.1 The Trust has delivered care in general practice, hospital outpatients, hospital inpatient care and emergency care using video-based technology. Patient acceptability rates for these services have been high. A telephone alternative has been available for some. The skills needed to make such consultation efficient, effective and compassionate are ones that we want to hone through peer learning, education, and simulation. We expect to publish initial reflections on this large scale change over the coming month to inform national thinking and local practice.

3.2 National guidance makes plain that the expectation will be that video enabled technology is the basis for clinical care on an ambulatory basis going forward, where no procedure is involved. Consequentially we will focus work in May on ensuring that issues such as blood taking, weight/height calculations, interpreting capabilities, chaperone practice, and such like are considered, documented and standardised for use. We will work alongside YHP, Modality, Urban, and other partners to aim to offer common approaches where we can such that local residents experience consistency and continuity. Record keeping and IG considerations will be addressed in that process.

3.3 In developing the clinical model for Midland Met, we will give consideration by the end of June to how the hot COVID centres may inform the nature and staffing model for the Sandwell Urgent Care Centre, conscious that the lease of Parsonage Street, means that

that centre, any WIC capability, and our own Lyndon practice need to relocate by March 2021.

3.4 Much lower ED attendance volumes (<90%) are unlikely to apply through June and July. That fall includes both minor ailments not attended and major ill health avoiding care. The Trust launched pilot work with West Midlands Ambulance Service on April 29th to seek to address that latter issue, albeit it will clearly take a broader societal heuristic change before those with latent ill health again look to travel for care. Bearing this in mind, we do need to explore what distal home options could be offered, as well as ensuring we publicise with great clarity in relevant local languages both the safety of acute stream services and the impact of delay or non-attendance. The communications work-stream will make a final proposal of such for launch after 12th May. Notwithstanding these features there is no plan by the Trust to operate a single A&E service and we expect to retain both units through to the opening of the University Hospital.

3.5 Emergency surgical services have largely operated from our Sandwell site with the relocation of urology and ENT operating. BMEC and gynaecology remain City-based. Paediatric surgery has relocated onto the Sandwell site. Each of these changes needs adaptation, mindful of public view, but also the MMUH end-state. That sees paediatric surgery separated from adult practice and based at Midland Met. Considerations in respect of urology and ENT for adult differ in that our end-state offers local access in both the STC and BTC. Acute surgery and trauma are already single site services. We will need to consider how we take forward our Tertiary specialist gynae-cancer service, which moves to Midland Met, is presently city based, but is operating from the Priory site in Edgbaston.

3.6 The Trust's wider oncology plan saw a separation planned between our chemotherapy unit and haematology. That separation has now happened, and the sole consideration involved will be the best location for such patients given the risks posed to them by COVID-19. The urgency to re-scale cancer care is apparent and is a priority for the Trust. Key diagnostics such as endoscopy are at the forefront of our re-start plans in the Birmingham Treatment Centre, likewise we now do have arrangements in place for our PET scanner adjacent to the BTC to commence operation from June.

3.7 Respiratory services were relocated largely to City Hospital in autumn 2019. Their role has expanded during the pandemic and we will review the pace and nature of their restoration. Notwithstanding that consideration there is a need during May to define our seven day acute care model for medicine, with staffing having been put in place over the last two months on that basis. In developing that approach we need to consider issues not limited to but including:

- The ward medical model for surgical patients, especially older surgical patients
- The hospital at night model, especially after midnight given the pattern of work
- Ensuring End of Life care choices for patients, and transfer to our new EOLC hub at Leasowes, is facilitated
- Medical cover models now and in the future for our community based beds, with options via technology to enhance oversight and shift the risk profile seen there

3.8 Critical Care services might expect to need to operate COVID and Non-COVID services for the foreseeable future. A summer plan has been developed in outline and we would expect to make final decisions about that plan by 19th May. In all likelihood we will operate three units and accordingly for either COVID or non-COVID patients there may be a need for inter-site transfer. The medical model for this scaled up distributed service needs further work, as anaesthetic cover will need to largely return to surgical provision. We will seek to discuss with commissioning bodies the long term bed base trajectory to Midland Met given previously circulated data showing under provision of ICU beds at Sandwell and West Birmingham compared to peers.

3.9 We need to do work in month on visitors views of care models. Since 14th March we have not permitted most visiting to hospital sites. During May that position will need to evolve as we develop a narrative that moves communities beyond the fear of hospital attendance. We have provided video options into ward areas and the communications, governance, IT, and corporate nursing teams will work together over the coming month to develop a clear offer to visitors, patients and staff that actively promotes engagement between those who are inpatients with us and their loved ones. This will include capturing data on how many times a day in each ward we proactively or reactively talk with loved ones. We are exploring options to bring forward our Patient Portal development with Cerner into Q2.

4. Learning lessons and evaluating options (workforce facing)

4.1 Both for clinical and non-clinical staff the pandemic to date has seen huge changes. We have around 400 colleagues working from home. On 14th May we run a WebEx study of how that has felt, linked to an anonymised survey we will do beforehand, and work undertaken through People and OD to provide wellbeing support. Martin Sadler has been asked to define a technology offer for Home Working which could become a future basis, and we are re-examining through Rachel Barlow's work how some of the staff currently based in Hallam may be relocated into Trinity House if certain corporate departments on site scale is reduced either for Q2 (when office spaces need social distancing) or for the longer term.

4.2 By July staff will undoubtedly wish to understand from the Trust our longer term intent on a range of matters and our short term intent on issues such as annual leave allocation. During COVID-19 we have implemented a whole series of 'emergency' policies and we need to be clear when they end and on what basis they are retained beyond 1st July. These changes include but are not limited to:

- Redeployment to new work areas
- Redeployment through brigading to new roles
- Creation of blended roles with ancillary work
- Revocation of permission to work for other employers
- Introduction of revised rotas in clinical and corporate areas

4.3 Our current communications emphasis that COVID-19 workplace arrangements remain in situ until the end of May, and that is consistent with restoration in June, and policy re-alignment from July. Timetabling is bound to be kept under review as both lockdown

and patient demand arrangements evolve. However, it is probably timely over coming days to establish expectations on that twin basis. As is noted elsewhere in our papers we are proceeding with both recruitment at scale and PDR evaluations of 2019-20 individual performance. We would expect most facets of corporate leadership to be operating as 'normal' from July, with a transition to that during June.

4.4 Communication under COVID-19 internally has typically been praised. We will consider through the Clinical Leadership Executive and elsewhere what has worked well, what has not worked well, and how we go forward with our pledge that everyone working in the Trust should be able to talk with their line manager and experience meaningful conversations about their work. Likewise this is a dependency for the mental health emphasis in the psychological wellbeing paper before the Board.

5. Risk management (including finance)

5.1 The risk paper outlines considerations relevant to Surge, but in key respects also sets out matters covered above in terms of the Cell for key enablers, and the workforce issues that restoration will create. Dual running of COVID and non COVID services at scale is clearly a different matter than the displacement of the Surge phase. We know that the precision of the changes we made for individual employees, especially nurses and HCAs, was not ideal at times, and we need to consider what we will be changing about business as usual to obtain a more agile centrally controlled model over both deployment and sickness management.

5.2 The financial arrangements for COVID-19 are best understood in three phases. There has been a *hot phase* in March where external funds were sourced for the urgent scaling up of services. The Trust's 2019-20 accounts reflect those costs and that income and there has been no material change to our position, with control total being achieved. Cash balances above plan reflect lower and deferred spend on non-COVID matters. The *Q1+1 phase* (to end of July) pays the Trust on a block income basis with additional costs met centrally. Scrutiny of that latter fund is rightly intense. The Board agreed oversight of matters via the CEO, chair of FIC and CFO on a weekly basis, and that is operational. We will advise the Board orally of (i) the income delta between block and necessary for months 1-4 and (ii) the early estimate I&E risks for *months 5-12. This third phase* was always showing a gap on plan of around £10m and discussions with the CCG about ensuring that local funds for SWB were spent in SWB were, and are, ongoing. Implementation of our 2020-21 CIP is operational and renewed controls over agency spend are referenced in other papers. When the Restoration Plan returns to the Board in June we will set out the costed nature of the plan, including any increased charges associated with revised use of the BTC by the Trust or wider system partners.

5.3 The Trust has moved forward with our IT, with implementation of Unity. That work continues and we will present Optimisation information to the Digital MPA at the end of May. Meanwhile, we are taking forward plans to ensure external expertise is available to give more manpower bandwidth to the IT function. This work, as well as work with Engie on phase 2/3 is ongoing and is essential. Because our Midland Met move is a firm

deadline for the Trust, it is important that we do not shift back 2021-22 plans. It is evident from the paper as a whole that expectations of both IT and estate functionality are larger than before and we need to ensure that we have the scale and pace of expertise to allow the Trust to deliver our immediate and 2025 ambitions.

5.4 The Trust continues to engage with our regulators over COVID-19 plans, including the Care Quality Commission. The balance between regional and local arrangements for scrutiny of restoration plans is currently unclear, but virtual engagement between the Trust team and the local CQC team continues. Ruth Spencer joins the team with a lead responsibility to Kam Dhami on CQC matters in mid-May. Relevant transfers of responsibility under the YHP transaction have been completed and all Trust GP practices are presently rated as Good. The weighting for that within the overall Trust rating is not yet clear-cut.

6. Exclusions

6.1 We used the recent Gold Command workshop to consider three other issues that are not repeated in this paper. They will be considered in detail in our June Restoration Plan. It is possible that other strategic considerations will also be incorporated there informed by our upcoming ICP meetings with partners in May and June, and by the emerging 'system' plan being developed with the STP. Those three issues were:

- Case-finding and preventative health on a vertical basis
- Poverty and regeneration work at Trust and clinical consultation level
- The psychological contract, informed by wider work on labour supply

6.2 As explored in the cover note, this paper does not address the wider Exit plan from COVID-19. The Trust has taken extensive steps to try and ensure that Testing is available to not only our own staff but other key workers. We await the results of the asymptomatic trial and will then consider across the STP how best to approach these matters, given supply issues nationally. Part of the case-finding reference above includes consideration of vulnerable patients, both those shielding and others, and how they are best supported in the balance of this calendar year.

7. Recommendations

The Trust Board is asked to:

a. **NOTE** the guidance issued[1] and emerging plans from the Executive
b. **AGREE** to receive for approval a final Restoration Plan at our June meeting
c. **RECOGNISE** the need to proceed at risk in advance of confirmed long term finances

Toby Lewis
Chief Executive

1st May 2020

[1] NHS England guidance on next phase will be circulated separately to Board members and is publicly available on national websites