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Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Restoration Plan Summary		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Liam Kennedy, COO and Mel Roberts, DCOO		
Meeting	Trust Board (Public)	**Date**	4th June 2020

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

We continue to look after 80 people with COVID-19 and are working in parallel to restore Trust services in primary, community and acute settings. This paper summarises progress with recovering services from mid-June to the end of August. As indicated in other reports before the Board there is work to do to align this restoration work with Winter 2020 planning and with the NHS 'Reset' imagined for 2021/22.

Broadly the Trust is able to re-open services aided by separate buildings at City Road and at Rowley Regis. Arrangements are being finalised to split Sandwell which does benefit from two main entrances. This summer the BTC will move to a seven day model. Diagnostic recovery is paramount as we discussed in last month's Board meeting, and there are some COVID safe constraints on certain invasive procedures. Outpatient work, like much of our primary care practice, remains virtual. Funding is outwith the drafting of this paper, but the Board will be aware of the need to ensure that income is available for costs which are as before or higher, even if throughput if lower owing to revised guidance.

We discussed with the Quality and Safety Committee how we might report regular metrics on progress and that remains work in progress, albeit we have detailed trackers in place for activity and are finalising our equipping cell in line with the risk register paper. The Psychological Wellbeing Scorecard is due throughout June as we look to track impact on colleagues.

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?]*

Discussions on restoration and recovery at Quality and Safety Committee

4. Recommendation(s)

The Trust Board is asked to:

a.	CONSIDER issues arising from this report

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

Trust Risk Register		As per accompanying risk paper					
Board Assurance Framework		Na					
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	25/6/20
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	25/6/20

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Public Trust Board

Restoration Plan 2020-2021

Introduction

1.1 The Trust's leaders have developed **a recovery and restoration plan**. As we have emphasised throughout this is distinct from a place or system based Exit Plan. Clearly the ability to implement the plan is dependent on current and reducing incidence of COVID-19 and limited impact by the disease on either staff-off-sick or staff-trace isolating. The latter is to some degree dependent on the scale of antibody positive testing among our employees. Over 1,500 colleagues are booked for testing at present. We will know later in June the + rate.

1.2 National policy requires all services to re-**open by June 15th**. The plans achieve that. The scale of recovery is governed by staff availability, our ability to cohort separately our estate, supply provision through local and national procurement, and the scale of both backlog since March and latent surge demand once primary care is back to prior volume. Assumptions are made on each item and will be tracked over coming weeks.

1.3 The principle risks associated with delivery are addressed in a distinct paper. In addition, the Board has agreed that tracking psychological wellbeing in our staff is the key metric for coming weeks. With that in mind, revised proposals to start that tracking data from next week are presented.

1.4 The paper does no cover either dividing our EDs between red/blue or the pattern of red/blue/lilac wards in the coming weeks. Either can be advised on request. At the time of writing the Trust has just over 80 inpatients who have had a positive test (some many weeks ago) and the trajectory of discharge will be completed before the Board meets identifying the likely scale of red provision needed at the end of June, if no second surge occurs.

2. Primary and community services

2.1 The Trust's GP practices continue to operate. Most work is done remotely. One practice (Parsonage Street) was relocated to the Great Bridge, and remains there. The Parsonage Street location is due to close in April 2021, as its lease runs out, and the new practice we are building at Sandwell opens by then. We are exploring whether we move the GP practice back in coming months or leave matters as they are. The Parsonage Street provision is currently a 'hot site' supporting the walk in centre, which is expected to relocate to Trust premises in 2021.

2.2 The Trust is operating the 'hot site' in west Birmingham from Aston Pride. This provided through our Broadway collaboration out of Heath Street, and we have adjusted our CQC registration to reflect this role (which in the earlier weeks of the pandemic was for the whole of the city). The future location of the hot site is under some discussion and we have a view that locating it near to

a hospital setting or indeed at City, might offer some advantages. That is not yet a confirmed position.

2.3 The majority of our community based children's, maternity, and adult services were significantly changed by the pandemic. Either they relocated to maintain distance from COVID-19 services, or themselves were provided remotely. Crucially some services in Sandwell were reshaped to fit around Care Homes (a transformation that has been widely recognised and praised). We are reviewing each change to consider whether it is acceptable under the commissioned specifications. We are in discussion with commissioners about how best to evaluate such changes, and whether any need to be reversed. All birthing service options offered before the pandemic are operated as before.

2.4 The re-designation of Leasowes, with end of life care beds expanded from two to the whole unit, remains in place. Prior provision at Leasowes for intermediate care was transferred to Rowley Regis (remembering we have services too in Sheldon in west Birmingham). As is indicated in the patient-story paper before the Board in June we are considered now whether and how we retain this provision in the future. No decision has been made. It may be that such provision is helpful to us in supported end of life care services generally and providing an option for patients which is less intense than the oxygen supported general ward, in a situation where side rooms will remain at an absolute premium in the months ahead.

3. Diagnostic provision

3.1 We have completed a detailed analysis of capacity to undertake the full range of diagnostic work, recognising that remote alternatives are very limited. Discussions continue with teams to finalise these plans. Currently, in common with other Trusts, it seems inevitable that scoping provision will be less, and therefore wait times longer, than before because of requirements for cleaning provision between patients. The Trust has a number of endoscopy rooms, and MMUH adds more. In advance of that our options involve weekend and later working. Staffing for that will need to come from prioritising this service over others, which is discussed in respect of GI medicine and GI surgery below.

3.2 Other diagnostic services can reach 100% supply by the end of August, with staff returning from critical care during June. Leave calculations are factored into provision. We are working through with each service views and anxieties about how social distancing will be ensured both in consultation spaces and in wait rooms.

3.3 Where it is possible to do so we are creating 'green' entrances for non-covid services. Of course as COVID-19 numbers decline the vast majority of diagnostic facilities will be given over to routine and urgent work, leaving solitary provision for 'red' patients. The other factor with diagnostic provision will be staffing, with limited opportunity to draw on bank and agency. As such sickness or isolation requirements will have a disproportionate effect on service volume.

3.4 Presently our plans are modelled with an expectation that prior referral volumes return and that the urgency quotient within those referrals does not change. We are working through a sensitivity which reflects a view that in fact urgency rates will be higher for a time to address backlogs of un-presenting patients waiting before attending their GP.

3.5 The Trust is ready to restore all screening services during June, with Public Health England guidance on bowel and breast screening awaited.

4. Video-based outpatient work

4.1 As the Board is aware such outpatient clinics as we have run since March (about half of normal volumes) have operated on a video basis with some telephone options. We are working hard now to scale up that provision to allow us to return to near 100% volume by the end of August. In most specialties we will achieve that sooner and in some disciplines will go beyond 100%. Shielding and isolating should not be a risk to provision as we are able to operate services with employees working from home. A Standard Operating Procedure has been signed off for height/weight/blood calculations and collection.

4.2 Medical specialties with input into general internal medicine (gastroenterology, respiratory, geriatric) will however struggle to put in place as before volumes, because we are choosing to dedicate more time to a seven day inpatient model, and because we need to operate dual-stream red/blue medical cover. We are working through how much nurse-led provision can lessen the gap, and what other options for support, advice and guidance can be put in place.

4.3 The risk register reflects concerns about how video-based work will impinge on research recruitment and on education and training. As this is the direction of travel of the NHS as a whole, we should think of this as a settling in difficulty for which solutions can be found. For new trials the protocols can be reflect new service models. We are of course working with both medical schools, and with HEE, to consider how best to ensure high quality skill based training for trainees when physical examination opportunities are limited.

4.4 If we are successful in developing our Place based plans with the CCG then it may be that sooner rather than later the Trust can take responsibility for the overall pharmaceutical bill/practice in SWB. This would assist in the management of outpatient work as it would give us scope to iron out inconsistencies about what work 'has to be done in secondary care'. This proposal was on the table from February 2020 and has strong GP support. We are exploring whether a mid-year H2 arrangement can be created from October 1.

4.5 Our current model of clinics by video in essence mimics prior practice. Over time we expect that appointment slots may shorten and yet become more regular as the convenience of remote-dialogue allows us to monitor treatments more easily. These developments will operate differently in different specialties.

4.6 There is a concern that digital poverty will impede equitable use. We are committed to studying this, and indeed at STP level we have a shared aim in this area. It may be that we are wiser to provide install technology at home for some residents rather than set up services for those without digital access. We will work this through initially as a prototype for the YHP health system and then consider wider developments.

5. Day treatments and inpatient planned care

5.1 Almost all services are scheduled to return to 100% supply by the end of August. At that point we expect our overall waiting list to be at the level of January 2020. This assumes referrals and

conversion in the next few weeks is between 20-50% of prior volume. If it were to return to prior volume sooner, or see a spike, then the waiting list would reach over 50,000 people.

5.2 Among those listed for surgery, our waiting list is 33% higher than before COVID-19. Our current estimate is that RTT compliance at 92% or better cannot be re-achieved before March 2021. We are working to manage firstly urgent and then very long wait patients, and reduce our maximum wait to 40 weeks or better as soon as possible.

5.3 Supply is driven by competing demands for staffing for other points of care, by issues about separating our estate, and by decontamination impacts on throughput. General surgery is reduced by the need to support endoscopy, T&O and urology by professional guidance on throughput, and services with an inpatient focus at Sandwell by the challenge of creating red/blue theatre complexes. Each of these are issues that we expect to find solutions for over the coming fortnight. Work continues with Ophthalmology to agree a long wait reduction trajectory inside 2020. Their issues pre-dated the pandemic albeit the position is worsened since. The extra theatre capacity we need has to be put in place sooner rather than later.

5.4 Our current arrangements make use of off-site cancer provision until the end of July. From that point we will need to manage through blue beds on both acute sites. There remains a possibility of different arrangements emerging via the Cancer Alliance across the region. To date the Trust has maintained urgent cancer access and we expect to be able to do that in the months ahead.

6. Estate considerations

6.1 We have made use of the Birmingham Treatment Centre as a focus for day-treatments and diagnostics. We will undertake overnight care in the BTC for the first time, and move the site onto a seven day a week basis. This “green” space is clearly distinct from our red wards and ED provision on the main spine. The main spine can of course be accessed from different entrances and we will work to best advertise which entrance is used to access which service.

6.2 Rowley Regis is the first Sandwell base for “green” services. In time we will create separate space within the general hospital to permit services to proceed there. That is unlikely to be in place before July. Conversely after 2022, it is Sandwell, as our [STC] treatment centre, which may offer very distinct cold services not just for immediately local residents, but people wanting care away from either Manor or Russell’s Hall.

6.3 Over a third of our elective practice is the regional eye service offered in the BMEC centre. We have worked now to create very distinct red/blue entrances and are able to bypass the eye casualty service to enter outpatient spaces via the garden. Our eye plans are dependent on the provision of two additional eye theatres through a leased facility and we need to confirm the funding model is in place for that service.

6.4 Our present assumptions retain Leasowes as an end of life care centre. Other papers before the Board set the context for that decision. Notwithstanding good hospice provision in many parts of the STP geography, there remain gaps in Sandwell and we see the unit as a space through which we can develop services better. We will need to set clear success criteria for this project or it risks being a positive but uneconomic proposition.

7. Winter planning 2020

7.1 Performance and insight are finalising **a study of the last 3 years of winter demand** for children's, adult medicine, adult surgery and critical care services. We are expecting to find a pattern of spikes which we will then regard as our base plan. Length of stay will be modelled as in the past, and it is the occupancy baseline that we will need to debate. If that is to be reduced below 98% then it will undoubtedly require us to open additional 'winter beds'. One might expect 30-40 beds are needed to lower occupancy below 92%.

7.2 **Flu vaccination** is a central part of our strategy for the coming winter. In 2019/20 we struggled to achieve prior years' performance hampered by late vaccine availability and some delivery model weaknesses. The executive plan is that a final approach will be readied for early July that is grounded in full-time peer vaccinators operating across departments.

7.3 Vacancy numbers among staff have fallen to their lowest level in some time. This, together with targeted bank expansion, suggests that we are better placed to manage with **core staffing teams through winter**. It will be important before August to determine how any additional beds will be fitted into both medical and nursing teams, such that they are not 'outlier wards'.

7.4 The Trust is working closely with the councils' director of public health to make sure that our approach to the management of **Care Home outbreaks** is joined up. In two of the last three winters, care home closures to new admissions in January was the both the symptom of, and arguably cause for, the 'system' to back up. With the considerable extra challenge posed by COVID-19, it is important that we plan with foresight how each home will cope and how we would respond depending on different outbreak scenarios.

8. Conclusion

8.1 We are well placed to implement the recovery plan and local management teams understand and have collaborated to develop it. **The most likely scenario remains that we achieve most but not all of the deadlines outlined** as the translation from departmental plans to individual circumstances is bound to produce some deviation. It is also too early to predict how many patients will decline to be treated at this stage.

8.2 Our dual emphasis has been on **re-starting diagnostic care at pace and on ensuring that outpatient work is very different** and clinics are not simply recreated on site. I would suggest that the Board focuses attention on how those two transitions are managed. The majority of the clinical risk outlined in the accompanying paper lies in those two domains.

Toby Lewis

Chief Executive

1 June 2020