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Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Summary of organisation wide issues		
Sponsoring Executive	David Carruthers, Medical Director (Acting Chief Executive)		
Report Author	David Carruthers, Medical Director (Acting Chief Executive)		
Meeting	Trust Board (Public)	**Date**	2nd July 2020

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

As services undergo restoration after the peak of COVID-19 cases in March and April we reflect on our processes to reduce virus transmission, screen staff and patients for previous virus infection and respond to emerging evidence on treatment approaches. The focus maintains on keeping patients safe when attending the Trust for their care.

Preparation is underway for return of students in September and our contribution to wider review of COVID-19 care is reflected here.

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?]*

n/a

4. Recommendation(s)

The Trust Board is asked to:

a.	Note and discuss issues raised in the report

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

Trust Risk Register		n/a					
Board Assurance Framework		n/a					
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 2nd July 2020

Summary of organisation wide issues

1. Patients

1.1 As we move into a time when social distancing is being reduced and shielding of public and staff is going to be eased from the 1st August we need to be weary of both the risk of increased community infections but also increased susceptibility of staff and patients. Staffs whom are able to come out of shielding will go through the risk assessment process we have in place for any members of staff generated after discussion with BAME staff members. It would be important that we continue to build public confidence with the infection control procedures within the organisation. We therefore need to build on the advertising of the reopening of the BTC and BMEC as COVID secure areas and to actively publicise new policies around staff and patients wearing surgical facemasks within clinical buildings in the organisation as well as in the ward environment.

1.2 It is important that we continue to focus on the reduction in risk of nosocomial infection and the above processes will help. We need to maintain a strict approach to all staff following best practice in infection control. The very visible approach of having all staff wearing masks within clinical buildings will help promote the importance of infection control in ward areas as well. The provision of appropriate PPE will be key to this and we will keep a close eye on increased use, encouraging staff not to overuse or remove PPE for personal use outside of the hospital.

1.3 We may need to consider our Visitor policy although relaxation of restrictions does not appear to have taken place in any of the neighbouring organisations. There are still concerns amongst visitors and patients of the effect of having increased footfall into the organisation. We will need to consider any changes very carefully as lifting restrictions may lead to other significant risks both around COVID spread but also unwanted access to the hospital. We need to maintain our access to and use of video links with patients to their relatives and make sure that relatives of those patients receiving end-of-life care, those with learning disabilities or partners of women giving birth can maintain access.

2. Testing

2.1 There has been a fantastic response from phlebotomy and laboratory services to undertake antibody testing of about 6000 staff already. This has been rolled out to include community staff and some care homes but will also be offered to patient's admitted to the organisation on blue and lilac wards where they would not have had infective symptoms for at least 21 days. At the moment we don't fully understand the relevance of the antibody testing. It appears that there are between 15% and 20% of individuals with prior confirmed COVID on swab testing who test negative on serum

antibody testing. This may be an effect of timing of the test or reflect the levels of antibodies. At the moment the result of the antibody test does not influence any infection control procedures or work undertaken by any staff member. We need to continue with our pro-active approach of screening patients with regular swabbing in our blue and lilac wards due to the challenges we know that clinical staff have in identifying those patients who may be asymptomatic carriers and therefore pose a risk to other patients and staff members.

2.2 Our likely involvement in research studies to serially monitor antibody levels and swab positivity in staff members will help address some of the questions about the relevance of antibody testing, whether it is protecting against second infections and whether there is a reduction in antibody levels over time. This will be another research project added to the strong portfolio of the Research and Development team who are to be commended for their contribution to the national research studies which have led to early therapeutic announcements. These have shown that high dose hydroxychloroquine is not useful and potentially harmful to treat acute COVID deterioration, remedesivir, an antiviral can reduce the length of stay in ITU and hospital, but the big change is that the steroid dexamethasone can reduce the risk of death in those patients either requiring oxygen (1 patient saved in 25 treated) or those on ITU (1 patient in 5 has their lives saved) and these products have been included within treatment strategy for COVID patients approved through the clinical advisory group and therapeutics committee. This shows the importance of the Trust maintaining its role and contribution to R&D studies. This is in addition to developing our own research portfolio and agenda with what I hope will become increasingly strong with collaborations with University of Birmingham and Aston over the coming months.

3. Students

3.1 In the same vein it is important that we also contribute to Education and Training of our future workforce. Student nurses have contributed strongly to the Trust during the COVID pandemic. We will be opening our doors again to medical undergraduates from the beginning of September 2020 which will include our new cohort of students from Aston medical school. The education team are actively looking at how our teaching programme can be delivered whilst taking into account the restrictions that will be applied to where the students can be placed in the hospital as well as how the teaching can be delivered. I am sure that the very committed education team will come up with a suitable model, in conjunction with the Medical Schools, for teaching during the autumn semester to all undergraduate years.

3.2 Prior to this we will welcome our new Foundation Year 1 and then all other grade of trainees to the organisation and a new video based induction is being prepared, which will incorporate suitable training in Unity and Fit testing for those individuals that still require this. We have been joined by 30 FiY doctors already, the majority of whom will stay here for their Foundation Year 1 post. This group will provide an excellent period of continuity on the wards and will help on-site support for Unity induction for the new staff when they do start. For both existing and new staff it is important that we continue with our mental health support which has been a real positive feature and is spoken highly of by our current trainee doctors. This would be particularly important

should there be a second surge allowing staff to be able to better deal with the changing working pattern and clinical environments that may be required. In the event of a second surge, new pathways for acute services and future staffing are an important part of our development work.

4. Clinical services

4.1 We are pleased to see that the Acute Paediatric Unit opened at City ED and is now operational 24/7. Excellent work from the estates team allowed the rapid transformation of the space, with staff and patients very positive about the new facility and service. This links to the development of services for movement into MMUH and we heard about the plans for service pathways across all specialities at CLE. These need to be developed with the clinical directorates and specialities over the next 4 months and I think this will regain some of the energy and excitement around MMUH after its renaming ceremony and work recommencement in February 2020.

4.2 As we look to rebuild our services to improve patient attendance it is noted that A&E attendances are creeping back up and despite the challenges of establishing whether a patient with infective symptoms may or may not be experiencing COVID related symptoms, we are seeing an increase in blue (non COVID) verses red (COVID likely) admissions. A more senior clinical review coupled with timely laboratory swab results will continue to help appropriate streaming of patients so that they are cared for in a suitable environment where they are not posing a risk to others or others posing a risk to them.

4.3 There has been good performance in achieving the projections for return of clinical out-patient services in most areas but some have been more challenged than others due to staff redeployment and some sickness. Diagnostics have been performing well, particularly in Radiology but those diagnostic procedures that are associated with possible aerosol generating procedures will be slower to get going. We are all working through the reporting process to make sure all tests solicited and ordered on Unity are available for endorsement and that process is being followed closely. Surgery maintains at the independent sector for cancer work and our plans develop to increase surgical capacity within BTC as we reduce requirement in staffing in ITU. This has to be balanced against the training process in place for staff in case of the need for future redeployment with a second surge.

4.4 We are maintaining close work across the STP and that is particularly reflected with our mortality work looking at not just COVID related mortality in hospitals but also non COVID and community mortality. Mortality in care homes is being looked at with excess mortality not attributable to COVID-19 from death certificates. Primary care are committed to reviewing this data and although the medically examiner process is not imbedded in primary care, they are moving towards a system as required by the learning for deaths agenda by next year. Through our mortality lead we are providing training support for SJR and have suggested a structure for mortality reviews. This will hopefully lead to an improved process with joined up reviews of patient from community through to hospital care.

4.5 We have seen an improved process of end-of-life care discussion with patients which has improved decision making for treatment escalation if the patient deteriorates. It is clear that communication is the key factor here and this becomes a challenge with unwell patients where there is little time to reflect and consider the information given to them. Communication within these difficult situations has been a focus of some of our learning alerts to medial staff and it is important that learning from care of COVID-19 patients is disseminated.

5. Awards

5.1 Recognition of how hard staff have worked in the organisation is shown by the high number of submissions for Star of the Week award. In addition, the Star Awards nomination process is coming to a close and nominations are encouraged in both individual and team categories. There will be a slightly modified shortlisting process this year and planning for how the ceremony will be run will depend on local social distance restrictions but a variety of plans have been considered to be able to deal with most eventualities. However delivered I'm sure the ceremony will reward and strongly reflect the excellent work done across all areas of the organisation over the past 12 months.

6. Recommendations

6.1 The Trust Board is asked to:

a. Note and discuss issues raised in the report

Dr David Carruthers
Medical Director (Acting Chief Executive)

25th June 2020

Annex A – TeamTalk slide deck for June
Annex B – June Clinical Leadership Executive summary
Annex C – Imaging improvement indicators
Annex D – Vacancy dashboard
Annex E – Safe Staffing data including shift compliance summary