Trust Board

There will be a meeting of the Trust Board on Thursday 23 April 2020 at 10:00. It will be held virtually. Due to national requirments of social distancing, members of the public will not be invited. Minutes and actions will be circulated and published shortly after the meeting.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence**		
2	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
3	**Declarations of Interest** To note any additional declarations of interest and to note the updated declaration of interests		**Enc A**
4	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **12 March 2020** as a true and accurate record of discussions.*	*For approval*	**Enc B**
5	**Action Log**	*For noting*	**Enc B1**
6	**COVID-19 – the Trust's response**	*For assurance*	**Enc C**
6.1	**Trust Governance During COVID-19 Pandemic** Chief Executive		
6.2	**COVID-19 Incident Response** Chief Executive		
6.3	**Clinical Ethical Framework** Chief Medical Officer		
6.4	**Financial Controls During COVID-19** Chief Finance Officer		
7	**Integrated Performance Report** Chief Executive		**Enc D**
8	**Preparing for the Future** Chief Executive		**Enc E**

Any Other Business *as previously notified*

Date of Next Meeting
The next Trust Board meeting will be held on 14 May 2020, virtually

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Exclusion of the press and public
The Board is asked to resolve that - **pursuant to the Public Bodies (Admission to Meetings) Act 1960 'representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'** (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON
THURSDAY 12 MARCH 2020 AT 10:00 hours
Alexandra Hospital Board Room, Redditch

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Mark Yates	Non-Executive Director
	Stephen Williams	Non-Executive Director
Board members: (non-voting)	Tina Ricketts	Director of People and Culture
	Sarah Smith	Director of Strategy and Planning
	Colin Horwath	Associate Non-Executive Director
	Richard Haynes	Director of Communications & Engagement
	Kimara Sharpe	Company Secretary
	Richard Oosterom	Associate Non-Executive Director
In attendance:	Jackie Edwards	Deputy Chief Nursing Officer (Quality)
	Martin Wood	Deputy Company Secretary (items 172 and 173 only)
	Anna Sterckx	Head of Patient Involvement (until item 180/19/4) (in the public gallery)
Public Gallery:	Press	0
	Public	4
Apologies	Vicky Morris	Chief Nursing Officer
	Vikki Lewis	Chief Digital Officer

172/19 **WELCOME**
Sir David welcomed everyone to the meeting.

173/19 **VOLUNTEER STORY**
Sir David invited the Head of Patient, Carer and Public Engagement and the Company Secretary to present the Volunteer Story.

Mrs Sterckx introduced the story saying that the day of the meeting coincided with World Kidney Day 2020, a campaign aimed at raising awareness, and to mark this day the story would be presented by Mrs Sharpe, a former renal nurse, who had recently become a volunteer on our new renal ward spending a few hours on Monday afternoons. Volunteers come from many backgrounds and join our Trust for a variety of reasons. There are preconceptions that the role is just to make tea, whilst important,

volunteers have considerable experience to bring to the role to effect bigger changes such as supporting improved discharges.

Mrs Sharpe presented her story saying that she had become a volunteer because of her background and wishing to return to a role with patient contact. The attitude of staff to her as a volunteer wearing a tabard is different to her role as Company Secretary in that she is stopped and asked questions by patients and the public. She does make tea and talk to relatives who do not wish to bother nurses and feels the role fills a gap. She has also undertaken a wide range of activities in the short time which she volunteers and feels part of the team. She has supported the Clinical Lead, Dr Oh, in developing a newsletter ensuring patients, carers and visitors are kept informed. It is important that staff have trust in volunteers.

During the course of the discussion, the following were the main points raised:-

- Sir David asked what our offer is to encourage people to volunteer. In response, Mrs Sharpe said that there was little available when she was appointed to the role, but the Volunteer Strategy with pledges is needed to make this clear and, in her view, will make a substantial difference.
- Dr Tunnicliffe, in commending the Volunteer Strategy, asked if there are any themes which volunteers raise which our Trust could easily address. In response, Mrs Sterckx said that the main themes are improved signage, the provision of a reception facility on the Worcester site and an improved level of communication.
- In response to Ms Day and Mr Yates, Mrs Sharpe said that from her perspective there is no limit to use the skills of volunteers which are captured on appointment, the issue being the necessary resources being in place to manage volunteers effectively. Mr Yates added that there is a cost to the effective use of volunteers.
- Sir David said that volunteers provide a vital link between our Trust and the local community and this will be demonstrated in how we respond to the community in the forthcoming weeks.

Sir David thanked Mrs Sharpe and Mrs Sterckx for their informative presentation.

Mr Wood left the meeting

174/19 **ANY OTHER BUSINESS**

There were no items of any other business.

175/19 **DECLARATIONS OF INTERESTS**

Mrs Sharpe declared an interest in the Volunteer Strategy. There were no additional declarations of interest. Sir David noted that the Register was on the website.

176/19 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 13 FEBRUARY 2020**

RESOLVED that:-

- The Minutes of the public meeting held on 13 February 2020 were confirmed as a correct record and signed by the Chairman with the following amendments:

Change *Ms Blakeman confirmed that a System Improvement Board had been established which is chaired by the Regional Director* to *Ms Blakeman confirmed that a System Improvement Board had been established which is chaired by the CCG Accountable Director.* (page 4)

Change *Support was needed from the community and system partners to ensure more*

there were discharges than admissions to *Support was needed from the community and system partners to ensure there were more discharges than admissions from acute hospitals every day of the week*. (page 4)

177/19 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe confirmed that awareness sessions have been set up for Board members in April on Dementia. The ICS actions were deferred to March. All other actions were either completed or not yet due.

178/19 **Chairman's report**

Sir David stated that he was reviewing the way the Board operated in the light of Covid-19. He was advocating teleconferencing and not meeting face to face for the months of April and May. He asked whether the meeting could be streamed to ensure that members of the public were able to participate if they wished.

ACTION: Mrs Sharpe to investigate how members of the public could participate in a virtual board meeting

RESOLVED that:-

The Board

- Noted the report

179/19 **Chief Executive's Report**

Mr Hopkins thanked staff for their work during the recent flooding in the county. He was also pleased with the way staff were responding to the Covid-19 pandemic. Preparations were underway in respect of managing an influx of patients. He also thanked those teams involved in the opening of the new wards in Aconbury, particularly the dedicated renal ward.

He went onto encourage all Board members to complete the staff friends and family test.

He informed the Board that he, together with colleagues in Leicestershire, Warwickshire and Shropshire had met with the National Finance Director as a follow up to the system to board meeting held in January. It was a positive meeting to review how services can be supported financially to meet the requirements of patients.

He congratulated the Health and Care Trust on their recent CQC results.

Finally he pointed out that the law will be changing with respect to organ donation.

RESOLVED that:-

The Board

- Noted the report

180/19 **STRATEGY**

180/19/1 **Annual Plan 2020/21**

Ms Smith presented the Annual Plan. She was satisfied that the Plan linked the Trust Strategy to the outcomes for the year 2020/21. The Plan assumes that a significant financial pressure from capacity expansion in the past two years has been absorbed into the 2020/21 plan.

She was pleased with the Divisional engagement with the development of the Plan thorugh the annual plan process. The divisions had, however, found it challenging due to the downward pressure on financial performance in the Plan required as part of the

system financial improvement trajectory.

She outlined the caveats which were within the cover paper. The national timescale is for the Plan to be submitted at the end of April. There had been an initial system submission last Autumn and an interim operational plan submission in March. More work was needed with respect to the finalisation of contracts, which meant that this version of the Plan needed to remain in draft.

However, despite the caveats, she was pleased that the Plan was available prior to the 1 April, as the basis for 2020/21. There will be an opportunity to finesse the Plan, however the trust could begin to work to it. She pointed out an error which was the number of staff in the trust establishment have increased by 130 wte rather than 43.

Mr Toole stated that Plan was aligned to the system plan. He acknowledged a number of cost pressures and gave examples. However there was a robust Productivity and Efficiency Programme which in his opinion was achievable.

He stated that the key financial statements would be gone through in detail at the Finance and Performance Committee.

He confirmed that there were still areas of disagreement with commissioners. In particular, about services needing properly funding. Further work was needed on the levers of change which would enable cost to be taken out of the system.

In response to Mr Hopkins, Mr Brennan explained the risk sharing agreement had not received universal support, although was common place within the NHS. Essentially, if growth in a service in which investment has taken place does not materialise or make a difference, then the risk of this lies with the organisation providing the service and who has had the investment. The CCG has signed up to this but the Health and Care Trust has requested an alternative split of the risk (from one third each). Ms Smith added that this was essentially double running and it would be too soon to remove growth from the contract. Mr Brennan confirmed that the agreement would be in place by 1 April and be within contracts.

Mr Toole confirmed to Mr Horwath that the final plan would be submitted on 29 April. Mr Hopkins stated that the plan as presented would be worked to from the beginning of April.

Mr Toole raised the issue of no contingency and he stated that this was a risk. There were also a number of infrastructure issues that needed immediate investment. Sir David stated that he would be looking for the Trust to bid for extra money for these investments.

Ms Smith responded to Dr Tunnicliffe and stated that planning for next year's Annual Plan would start in April. She agreed that a three year rolling plan was needed. Mr Hopkins stated that ideally the plan would be presented earlier to allow members adequate time for review. However the priorities and strategic objectives have been agreed previously. Work was now ongoing to translate the Plan and BAF into the Trust's governance processes, work that was being led by Mrs Morris, Ms Blakeman and Mrs Sharpe with Mr Horwath giving the NED oversight. He agreed that the next Finance and Performance Committee would review the financial plan and he was still aiming to reduce the deficit further. However he recognised that it was essential to agree a plan that is deliverable but also one that shows ambition. He was also unclear about the impact of Covid-19.

Mr Williams was keen to understand whether clear actions had been agreed with agreed quality impact analyses. Ms Smith confirmed that the Productivity and Efficiency Programme has a well established process for approval of business plans and associated quality impact analyses. Major programmes have better governance such as Home First Worcestershire and Theatre Productivity. There is a structured approach to outpatient modernisation. There is more resource and resilience within the Workforce and PMO teams.

Mr Oosterom, whilst agreeing that the Trust was in a better position than the previous year, was not assured about the deliverability of the Plan. He was very concerned about the lack of a contingency. He echoed Dr Tunnicliffe in not being able to scrutinise the Plan properly.

Ms Day asked where the transformative work was within the Plan. She also wondered where the single improvement methodology was. She also urged that partnerships with patients be articulated. Ms Ricketts confirmed that the transformation and the single improvement methodology was within 4ward phase 2.

Mr Yates stated that the document was an easy read but queried the value of appendix 2. Ms Ricketts agreed to restructure the appendix to show that within 12 months the Trust will be in line with the agency cap.

ACTION: Ms Ricketts to restructure appendix 2

Sir David, in summarising the discussion, thanked Ms Smith for producing a Plan which showed clearly the links between the strategic objectives and priorities with the risks. He would want to approve the document on 23 April. He urged progress to be made now with its implementation. He also wished key committees to review appropriate sections and articulate 'success'. He also urged the Plan to be rolled out across the Trust with the objectives being reflected in personal objectives for 2020/21.

RESOLVED that:
The Board:

- Noted the progress that has been made to develop the trust's annual operational plan for 2020/21.

180/19/2 **Board Assurance Framework (BAF)**

Mrs Sharpe presented the Board Assurance Frameworks for 2019/20 and 2020/21. The BAF for 2019/20 was presented for approval and closure and the BAF for 2020/21 was presented for approval. She explained that the Committees had reviewed and approved their areas of risk and the Trust Management Executive had approved both documents.

She then outlined the work that was being undertaken with reviewing governance. The Board agenda, from May, would reflect the key risks and priorities. Committee agendas would also be reviewed. The Integrated Performance Report would be restructured. With a greater focus on the key risks, there would be better scrutiny on their delivery.

Mr Oosterom stated that there was a huge dependency on partners to mitigate a number of risks. Mr Hopkins agreed and stated that the System Improvement Board was the vehicle to hold partners to account. Mrs Sharpe stated that there should be a shared risk register for the System Improvement Board which includes risk 1. Mr Hopkins agreed but stated that he Board was not yet mature enough for this way of working. He added that the A&E Delivery Board has shared metrics.

Ms Day state that she was pleased that the Board agenda would reflect the risks and she recognised that this way of working would increase the responsibility for Committee Chairs. Mr Horwath confirmed that work had been taking place with Committee Chairs and he welcomed the focus on making the BAF a living document.

Sir David was pleased with the work undertaken and looked forward to the revised Board agenda.

RESOLVED that:
The Board approved

- The 2019/20 update and closure of the BAF
- The 2020/21 BAF

180/19/3 **#WeAreVolunteering**

Mrs Edwards introduced the Strategy, recognising that this was the first Strategy for the Trust which was specifically about the role of volunteers. The Trust was aiming to be a local and national leader in this work. The Strategy has been developed by Mrs Sterckx in conjunction with the volunteers. She then asked Mrs Sterckx to present the Strategy.

Mrs Sterckx stated that there was a massive untapped potential within the volunteers. She has held a series of events in the Autumn of 2019 to develop the strategy. She was delighted with the end result which was a true co-production. There are four pillars of commitment within the document:

- We will communicate
- We will make it easier to volunteer
- We will value and appreciate our volunteers
- We will do this by

Mrs Sterckx then introduced a short film.

Ms Blakeman asked about corporate volunteering. Mrs Sterckx agreed that further work was needed on this area. Mr Haynes added that work has been undertaken via the Charitable Funds Manager and he described the mailshot to 100 key businesses.

Mr Horwath asked how volunteers could be more diverse, to reflect the local community. Mrs Sterckx agreed that the volunteer base needed to reflect the local community more. Mrs Edwards added that work was on-going with the local University as well as the Youth Forum, Mrs Sterckx confirmed that she had utilised best practice from other trusts.

Mrs Edwards explained to Mr Williams that a business case was being developed for additional support to the Volunteers. Mr Williams urged money to be identified for support.

Mr Oosterom complimented Mrs Sterckx on the document. He wondered whether there needed to be more ambition.

Mr Yates supported the Strategy. Volunteers are part of the workforce and need a sense of belonging and purpose.

Mr Brennan left the meeting

Mr Yates suggested a Volunteer of the Year in the staff awards being held later in the year. He was pleased that it tied into the Trust vision, values and 4ward. He echoed Mr

Williams' plea to identify specific resources. Mrs Sterckx confirmed that she is in contact with the Health and Care Trust volunteer function.

Ms Blakeman left the meeting.

Sir David thanked Mrs Sterckx for her work.

RESOLVED that:
The Board

- Noted and discussed the strategic principles, priorities and aims underpinning the #WeAreVolunteering Strategy
- Approved the strategy.

180/19/4 **Covid-19**

Mr Hopkins stated that there were clear plans for escalation and the Trust was following national guidance. The national picture was changing on a daily basis. Significant plans were in place to upgrade ITU capacity.

Mrs Edwards stated that teams have been working relentlessly, particularly within the Emergency Departments and operational teams. She described the planned role of AEC and MSSU.

Ms Blakeman returned to the meeting

Mr Oosterom asked for clarification in relation to the work of the management team. Mr Hopkins stated that patients were being cohorted away from other areas of activity. Elective activity will be reduced on both main sites. Non-physicians have been supportive in caring for medical patients.

Mrs Edwards expressed concern if schools and child care were closed as this would impact on staff.

Mr Hopkins stated that a risk based approach was being taken by the leadership team. There has been a review of non-essential gatherings of staff (e.g. training, induction). The executive team has been split between the Alexandra Hospital and Worcestershire Royal sites. There will be an increased use of mobile technology and teleconference conference. With the downscaling of outpatients, there was an opportunity to change the way outpatients for example telephone consultations.

Dame Julie asked whether having the virus gives immunity. Mr Hallissey stated that people will have immunity if they have the virus. However, the virus was liable to mutate.

Dr Tunnicliffe asked whether some activities could be bought forward for example the refurbishment of the Alexandra Hospital theatres. Ms Smith agreed to review this and liaise with NHS E/I.

ACTION: Ms Smith to review the timing of the Alexandra Theatre refurbishment and any other suitable major capital projects

Sir David thanked all staff for their work during this challenging time.

RESOLVED that:
The Board

- Received the report

181/19 **INTEGRATED PERFORMANCE REPORT (IPR)**

181/19/1 **Home First Worcestershire**

Mr Brennan reported on Home First Worcestershire which focussed work on patient flow. There had been a sustained improvement on handover delays. However Sundays were the main problem day. There were fewer discharges and there was a focus on this. There was also a focus on red 2 green and the onward care team (OCT).

He reported that readmission rates were broadly stable.

Mr Hopkins was clear that there was more rigour and progress with Home First Worcestershire but it was unclear why the opening of the 33 beds had not had a sustained effect on flow. Surgical length of stay had increased and this was being picked up through professional standards.

Mr Hallissey confirmed that he has had a positive meeting with consultant physicians and they are aware of the internal professional standards that they need to deliver.

Mr Hopkins confirmed that the OCT commenced in mid-February and that the impact of the team has not yet been fully realised. Additional nursing staffing remains within ED following the CQC inspection in December. Fortnightly submissions also continue to the CQC.

Mr Hopkins emphasised that the number of discharges must exceed the number of admissions to address the exit block.

Dr Tunnicliffe complimented the report and asked for more detail on the graphs. It was clear the messages from the data and he wondered whether there should be another metric about the front door processes. Mr Hallissey stated that this was contingent on having an assessment area and he described how this would operate.

Mr Brennan returned to the meeting

Ms Smith confirmed to Mr Horwath that the financial impact was within the Annual Plan. Mr Toole stated that the benefits realisation template would articulate this as well. Mr Oosterom expressed his concern that despite the added capacity there appeared to be little benefit. Mr Hallissey reminded members that the gap analysis of demand vs capacity was undertaken in 2016. He stated that key to the flow was the reduction in length of stay. He was pleased however with the reduction in medical outliers which was seeing an increase in surgical activity.

Sir David stated that it was important to monitor the length of time it took to obtain a specialist opinion. He wondered what was going to be different now the data showed clearly that Sunday was the most difficult day. Mr Hopkins stated that the relationship with our partners was crucial as it was very difficult for discharges to take place on a Friday, Saturday or Sunday. Mr Brennan added that he was working with therapists to ensure a less risk-based approach.

In response to a question from Sir David, Mr Hopkins confirmed that a programme has been launched to focus on criteria led discharge. Mr Brennan confirmed that there was a clear target for numbers of patients for discharge and the number for nursing homes.

Sir David agreed to write to the Chair of the System Improvement board to request information about the actions being taken with respect to discharges over the weekend.

ACTION: Sir David to write to the Chair of the System Improvement Board

RESOLVED that
The Board
- Received the report for assurance

181/19/2 **Integrated Performance Report**

181/19/2/1 **Executive summary**

Mr Hopkins introduced the IPR. He stated that the four critical areas were:
- BAF risk 4 – CQC inspection and Home First Worcestershire
- BAF risk 3 – Infection Control
- BAF risk 2 - Mortality
- BAF 6 - finance

140/19/2/2 **Quality Performance Report**

Mrs Edwards reported that the key infection prevention and control metrics were not met in February. There continues to be a huge amount of work being undertaken. particularly with respect to learning from cases. She was pleased that the Trust had met the flu vaccination target. NHS E/I is due for a return visit in April. She also reported that there is a continued focus on antimicrobial prescribing.

Mr Haynes left the meeting

Sir David asked why the targets were not being met. Mrs Edwards stated that it was multifactorial and included hand washing and antimicrobial stewardship.

Dr Tunnicliffe reported that this area had received close scrutiny at QGC and he agreed with Mrs Edwards' analysis. He went through the detail of the key infections, concluding the e-prescribing will support the better management of antimicrobial prescribing and will have a dramatic affect.

Mr Hallissey stated that with respect to mortality, SHMI was now within the normal limits. HSMR remained slightly raised. Overall mortality was declining. Associate director adverts will be out in the next week. Dr Tunnicliffe supported the work that Mr Hallissey was undertaking in this area.

140/19/2/3 **Quality Governance Committee Assurance Report**

RESOLVED that:
The Board:
- Received the Committee report for assurance

140/19/2/4 **Financial report**

Mr Toole reported that month 11 was on track. He stated that it would be a challenge to maintain activity over the next month due to covid-19.

Mr Brennan returned to the meeting.

RESOLVED that:
The Board:
- Received the Committee report for assurance

181/19/2/5 **Operational Performance Report**

RESOLVED that
The Board
- Received the report for assurance

181/19/2/6 **Finance and Performance Committee Assurance Report**
Mr Oosterom highlighted the risks to the digital programme contained within his report.

RESOLVED that:
The Board
- Received the report for assurance

181/19/2/7 **People and Culture Performance**

RESOLVED that:
The Board
- Received the report for assurance

181/19/2/8 **People and Culture Assurance Report**

RESOLVED that:
The Board
- Received the report for assurance

182/19 **GOVERNANCE**

182/19/1 **Report on Nursing and Midwifery Staffing Levels**
Mrs Edwards reported that staffing was safe with mitigations.

Mr Haynes returned to the meeting.

RESOLVED that:
The Board
- Received the report for assurance.

182/19/2 **Local Maternity and Neonatal Service**
Mr Hopkins stated that there had been good progress on the national directed priorities with a small team working alongside the local teams. There was good working with and support to Wyre Valley. The vibrant service user group was a big asset.

The progress across the STP was highlighted. There is a clear plan for next year. A key action is to identify obstetricians to influence colleagues. By 2021, 51% of mothers will have continuity of carer, a key metric.

He confirmed to Mr Horwath that the programme is within the Clinical Services Strategy. Centralisation of the service has impacted on a reduced mortality.

Sir David praised the organisation of the project and wished other STP projects to learn from it.

Dr Tunnicliffe also praised the work undertaken. The paper had been considered at a recent QGC. He stated that the targets set were challenging.

RESOLVED that:
The Board

- Received the report for assurance

182/19/3 **Learning from Deaths**

Mr Hallissey stated that the detailed report was for information.

Mr Oosterom wished to see a more detailed structured report. Mr Hallissey agreed and stated that this was in train. Dr Tunnicliffe was concerned that the focus on non infective gastro enteritis (which was due to coding errors) was diverting resources. Mr Hallissey agreed.

RESOLVED that:
The Board

- Received the report for assurance

182/19/4 **Communications and Engagement Update**

Mr Haynes stated that the report highlighted the support for Home First Worcestershire and the work being done with TicTok to engage with younger people. He warned that covid-19 would significantly drain his resources. Finally he highlighted the report concerning mother and son who had both recovered from cancer and had received national attention.

RESOLVED that:
The Board

- Received the report for assurance

182/19/5 **Staff Survey**

Ms Ricketts presented the staff survey. She reported that the survey showed a step change in improvements moving the Trust out of the bottom quartile to just below average overall. Presentations have been made to staff and a comprehensive action plan developed.

Mr Yates stated that the results show the amount of work undertaken by the leaders in the Trust and he complimented the executive.

Sir David acknowledged that it was very difficult to shift numbers and he praised everyone involved.

RESOLVED that:
The Board

- Noted the findings of the 2019 NHS staff survey
- Supported the implementation of the “next steps” as identified within this report

182/19/6 **Trust Management Executive**

Mr Hopkins confirmed that the agenda for the TME would change to reflect the main risks for the Trust.

RESOLVED that:
The Board

- Received the report for assurance

182/19/6 **Going Concern**

RESOLVED that:
The Board

- Endorsed the Chief Finance Officer's recommendation that the Trust is a going concern (in line with published guidance), despite the significant cash requirement within the 2020/21 draft financial plan.

183/18 **REPORTS FROM ASSURANCE COMMITTEES**

183/19/1 **Audit and Assurance**

RESOLVED that:
The Board
- Received the report for assurance.

183/19/2 **Remuneration Committee**

RESOLVED that:
The Board
- Received the report for assurance.

184/19/3 **Terms of Reference**
Mrs Sharp[e stated that there had been minimal changes to the Terms of Reference. She advocated that estates be added to the Finance and Performance agenda. This was agreed.

RESOLVED that:
The Board
- Approved the terms of reference

DATE OF NEXT MEETING
The next Public Trust Board meeting will be held on Thursday 23 April 2020 at 10:00. The meeting will be held virtually.

The meeting closed at 12:56 hours.

Signed _____ **Date** _____

Sir David Nicholson, Chairman

Enc B

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – APRIL 2020

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
13-2-20	IPR	166/19/3	Draft a report for the ICS executive on the roles and expectations of partners in respect of HFW	PB/ SS	Feb 2020	Mar 2020 April 2020	PB/SS will discuss this with DN/MH	
12-3-20	Annual Plan 2020/21	180/19/1	Restructure appendix 2	TR	April 2020		Detailed information was presented to the People and Culture Committee on 312 March 2020. The Plan remains to be completed.	
12-3-20	Home First Worcestershire	181/19/1	Write to the Chair of the System Improvement Board	DN	April 2020	TDD	The System Improvement Board has not met since the last Trust Board meeting and this remains to be undertaken	
12-9-19	Patient Story	63/19	Arrange dementia training for Trust Board members.	CNO (VM)	Oct 2019		To be programmed into a Board seminar.	
13-2-20	CEO report	166/19/1	Escalation process – discuss at ICS executive on 27 Feb	PB	Feb 2020	Mar 2020	The system plan was approved in March 2020	
12-3-20	Chairman's Report	178/19	Investigate how members of the public could participate in a virtual board	KS	April 2020		A pilot is happening at this meeting with Healthwatch joining the virtual meeting	

			meeting					
12-3-20	Covid-19	180/19/4	Review the timing of the Alexandra Theatre refurbishment and any other suitable major capital projects	SS	April 2020		AGH theatres contract will be finalised end April 2020. NHSI/E initial COVID Incident modelling precluded bringing forward the theatres refurbishment programme. Revised modelling suggests that this can be looked at again. Contractor has been asked to provide feasibility assessment around end May start date on site.	

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	Enc C1

Governance Arrangements during COVID-19 Pandemic Incident

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	22nd April 2020	

Recommendations	TME is requested to approve this paper. The Board is requested to approve this report.

Executive summary	On the 3rd March 2020, the UK Government designated the COVID-19 outbreak as a Level 4 National Emergency. In response to this unprecedented public health incident, our standard governance arrangements have been amended to enable robust oversight, visible leadership and swift decision-making. This paper describes the key changes, summarised as follows: • Board and Committee meetings continue virtually using a recognised video conference platform with a focussed agenda. • The agendas are focused on assurance of the impact of COVID-19 on the business of the Trust, as well as elements of the normal assurance work plan. • As specified by NHS England, our Trust Board meetings will not be open to the public, but papers will be published on the Trust website. • The vast majority of Trust-wide oversight meetings have been suspended, although Executive level oversight remains to mitigate any immediate safety issues in the hospitals. • The CEO continues to fulfil his accountable officer duties by working remotely to comply with guidance for high risk patients.

Risk									
Key Risks	*BAF risk 12*								
Assurance	*See attachment 1*								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**		
Financial Risk									

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	Enc C1

Introduction/Background

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus (SARS coronavirus-2 (SARS-CoV-2)) was subsequently identified from patient samples.

The most common symptoms of coronavirus (COVID-19) are recent onset of a new continuous cough and/or high temperature. For most people, COVID-19 will be a mild infection, although significant numbers of our local population will need hospitalisation and respiratory support, particularly those who are more susceptible to illness and/or frail.

On the 3rd March 2020, the UK Government designated the COVID-19 outbreak as a Level 4 National Emergency. Therefore, in response to this unprecedented public health incident, we have ensured our local preparations and response to the predicted increasing volume of patients who are seriously ill coming into Worcestershire Acute Hospitals NHS Trust (WAHT) hospitals with the virus, enable us to provide the best quality of care possible, whilst maintaining a safe working environment for our staff, enabling them to stay well and at work.

As part of that response, our standard governance arrangements have been amended to enable robust oversight, visible Executive and clinical leadership and swift decision-making.

This paper describes the key changes during our major incident response period. Please note, the incident command and control arrangements are covered in a separate paper.

Issues and options

In early March 2020 the Executive team introduced social distancing arrangements and these have been adopted across the organisation, wherever is practicable. In discussion with the Chair, Non-Executive and Executive Directors, and the Board Secretary, the day to day ways of working and governance arrangements have been amended.

The changes described below were subsequently considered against the letter received from NHS England dated 28 March 2020 which aims to reduce the burden of reporting for NHS trusts (see Attachment 2).

1 Meetings

1.1 Board and Committee (including TME) meetings

These are held virtually using a recognised video conference platform with a focussed agenda. The meeting attendance is reduced to enable key operational leaders to focus on immediate incident response matters, although each meeting is quorate. The agendas for Committees have focused on assurance of the impact of COVID-19 on the business of the Trust, as well as elements of the normal assurance or performance management work plan of the Committees.

Minutes and actions are produced as normal together with a summary of the key issues for the Trust Board. A log will be kept of items deferred from the normal agendas and these will be considered with the lead Executive Director when the incident is scaled down. The Chairs of these meetings remain as identified on the extant terms of reference and the scheme of delegation remains.

As specified by NHS England, our Trust Board meetings will not be open to the public (publications ref 001559, 28 March 2020, letter from NHS E/I). There is a notice on our website letting the public know that we will be undertaking virtual meetings in April and May 2020, and papers will be published as normal. HealthWatch Worcestershire will be invited to participate in virtual meetings.

1.2 Other internal meetings

The vast majority of Trust-wide and Divisional quality, performance and financial oversight meetings have been suspended during the incident. The following meetings have continued as part of the overarching organisational governance arrangements:

1.2.1 Daily Executive huddle (Executive Directors, Chair - CEO). The huddle is focused on the immediate clinical and operational safety issues in the hospitals and any immediate risks emerging from the impact of increasing clinical demand, changes to service delivery, workforce or environmental factors. Digital risks and communications issues are also escalated. The huddle also presents an opportunity to check informally on leadership resilience and any staff morale concerns.

1.2.2 Weekly Chief Executive Team Meetings (CETM Chair - CEO) While focusing some of the agenda on the COVID-19 incident response, this weekly team meeting has also focused on the normal business issues such as the Annual Plan, financial performance and Digital Strategy, as well as increasingly the restoration and recovery phases post incident.

While Trust Management Executive (TME) continues to meet monthly, where necessary, CETM will take decisions in relation to normal, non-incident related organisational business. Decisions and actions are recorded.

1.2.3 Weekly meetings between the Chairman, Non-Executive Directors and CEO
These meetings have enabled discussion on the key immediate risks at national, regional and STP level and any risk mitigation planning and execution. The background and skills set from Non-Executive Directors have been brought to bear in strengthening the incident management and command and control mechanisms.

While the Trust Board and Committees continue to meet monthly, the Chairman may take 'Chairman's action' as required, with decisions and actions recorded at this meeting.

These meetings have been supplemented by thrice weekly situation update reports provided by the CEO to keep Non-Executive Directors updated. While formal safety walkabouts have been postponed, The Chairman and Non-Executive Directors remain visible within the hospitals.

1.2.4 Home First Worcestershire Programme Board
The quality, safety and efficiency of care for our emergency patients remains the top organisational priority, and the focus on eradicating corridor care caused by exit block in our emergency departments has continued unabated, not least because it is good for patients and our staff; it also helps free up capacity for our sickest COVID-19 symptomatic patients.

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1.3 System-wide meetings

The Integrated Care System Executive (ICS) met once during March 2020 to consider the system wide incident management response and will be stood up should there be any issues of escalation to consider.

While the System Improvement Board hasn't met for a few weeks, monitoring of the key work streams continues, with a major emphasis on meeting the 'Medically Fit For Discharge' timescales within the national guidance, and how new ways of working can become the 'new norm'.

Most other system wide meetings have been temporarily suspended, although contact has remained with regulators and local authority scrutiny Committees. The performance review meetings with NHS Midlands have been suspended and we have been deescalated from a quality risk perspective relating to emergency care following a recent Quality Risk Summit.

2 Accountable officer arrangements

The CEO has had to comply with the 'shielding' guidance of high risk patient groups due to his well-known past medical history. He continues to fulfil his accountable officer duties and is working remotely full time.

The Deputy CEO/Chief Operating Officer has assumed the role of Gold Incident Commander, and has regular virtual meetings with the CEO to maintain a clear line of sight of risks and issues. Additionally, the Chairman and CEO have regular contact each week. This is line with best practice guidance from Russell Reynold Associates[1] who emphasise the important of enhanced communication during a period of crisis.

The CEO has been able to maintain regular contact with front line staff via virtual 'Meet the Chief' sessions, as well as having established a group of front line staff to offer insights into their lived experience of working remotely, or in the hospitals. The senior leaders' brief continue monthly during this time.

3 Board Assurance Framework (BAF) and risk register

The BAF has been added to for 2019/20 and 2020/21. This has been approved by the board. A COVID-19 risk has been subsequently added to the BAF and is appended to this report.

Recommendations

- TME is requested to approve this paper.
- The Board is requested to approve this report.

Appendices
Attachment 1 – BAF COVID-19 risk
Attachment 2 – C0113 28 March 2020

[1] Board Leadership in a Crisis, Russell Reynold Associates, March 2020

NHS
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BAF RISK REFERENCE *Summary for Datix entry*	12 COVID - 19	**DATE OF REVIEW**	Mar 2020
DATIX REF	(Linked to corporate risks)	**NEXT REVIEW DATE**	Jun 2020

RISK DETAILS

RISK DESCRIPTION	RATING	L	C	R	CHANGE
If COVID -19 manifests itself as is modelled by the Government, then there is a serious risk that the safety of patients will be compromised due to the lack of medical and nursing staff and equipment to enable treatment of the most seriously ill resulting in excess deaths	INITIAL	5	5	25	
	TARGET 2021	1	1	1	
	PREVIOUS				
	CURRENT	5	5	25	

CONTEXT

STRATEGIC OBJECTIVE	Best Services for Local People
GOAL (S)	Strategy
RISK APPETITE	High

ACCOUNTABILITY

CHIEF OFFICER LEAD	Chief Executive
RESPONSIBLE COMMITTEE	Board

CONTROLS AND ASSURANCE

REF	CONTROL	ASSURANCE	LEVEL
1	Major incident control group	Board reporting	
2	Revised HR systems and processes to enable tracking of staff absence	Real-time reporting reported to incident group, managed through workforce group	
3	Implementation of National guidance	Incident Group	
4	Implementation of Business Continuity Plan	Incident group	
5	Stopping elective activity	Incident group	
6	Redeployment of staff from non-essential activity	Workforce group Incident group	

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ACTIONS

REF	GAP	ACTION	BY WHEN	PROGRESS
1	Availability of staffing for the continuation of front-line services	• Redeployment of staff from other services and areas as required. • Ensuring staff absence/requests for flexible working are accurately recorded and coordinated as appropriate.	Ongoing	
2	Availability of appropriately trained staff for the continuation of front-line services	All relevant staff to access appropriate training to be able to care for the deteriorating patient, the use of personal protective equipment etc	30 April 2020	
3	Availability of equipment from the NHS supply chain	• Quantification of equipment requirements. • Escalation of any gaps in equipment supply. • Consideration of alternative ways of working to reduce the requirement for equipment or in the event that equipment is not available for any period of time.	Ongoing	
	Loss of staff through self-isolation & ill health	• Understanding where those staff are usually deployed and ensuring that other non-essential staff are redeployed as appropriate	Ongoing	

Publications approval reference: 001559

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers

Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Chairs of ICSs and STPs
NHS Regional Directors

28 March 2020

Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic

We wrote to you on 17 March 2020 setting out important and urgent next steps on the NHS response to COVID-19. Following this letter and detailed guidance to GPs we are writing today to provide further guidance to support you to free-up management capacity and resources.

During this challenging period NHS England and NHS Improvement is committed to doing all it can to support providers and commissioners, allowing them to free up as much capacity as possible and prioritise their workload to be focused on doing what is necessary to manage the response to the COVID-19 pandemic. Further information is provided on the following pages.

We will continue to review and monitor the situation and will remain agile in making further changes where necessary.

We appreciate the incredible amount of commitment and hard work going on across the NHS in these challenging times.

Yours sincerely

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

The system actions

Changing NHS England and NHS Improvement engagement approaches with systems and organisations

Oversight meetings will now be held by phone or video conference and will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis. For our improvement resource, we have reprioritised their work to focus on areas directly relevant to the COVID-19 response:

- GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge coordination
- The outpatient transformation work is focused on video consultation and patient-initiated follow up
- We have prioritised our special measures support in agreement with CQC to ensure we support the most challenged in the right way to help them manage the COVID-19 pressures.

1) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually not face-to-face. No sanctions for technical quorum breaches (eg because of self-isolation) For board committee meetings, trusts should continue quality committees, but consider streamlining other committees (eg Audit and Risk and Remuneration committees) and where possible delay meetings till later in the year. While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation All system meetings to be virtual by default	Organisation to inform audit firms where necessary
2.	FT Governor meetings	Face-to-face meetings should be stopped at the current time[1] but ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 eg via webinars/emails	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary Annual members' meetings should be deferred Membership engagement should be limited to COVID-19 purposes	FTs to inform lead governor
4.	Annual accounts and audit	Deadlines for preparation and audit of accounts in 2019/20 are being extended. Detail was issued on 23 March 2020.	Organisation to inform external auditors where necessary
5.	Quality accounts - preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. We intend it will be deferred	NHSE/I to inform DHSC
6.	Quality accounts and quality	This work can be stopped	Organisations to inform external auditors where necessary

[1] This may be a technical breach of FTs' constitution but acceptable given Government guidance on social isolation

No.	Areas of activity	Detail	Actions
	reports – assurance		
7.	Annual report	We are working with DHSC and HM Treasury on streamlining the annual report requirements – further guidance forthcoming	NHSE/I and DHSC to prepare guidance in due course
8	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

2) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, Cancer, Ambulance waits, MH LD measures)	See Annex B
2.	Friends and Family test	Stop reporting requirement to NHS England and NHS Improvement
3.	Long-Term Plan: operational planning	Paused
4.	Long-term Plan: system by default	Put on hold all national System by Default development work (including work on CCG mergers and 20/21 guidance). However, NHSE/I actively encourages system working where it helps manage the response to COVID-19, providing support where possible.
5.	Long-Term Plan: Mental Health	NHSE/I will maintain Mental Health Investment guarantee.
6.	Long-Term Plan: Learning Disability and Autism	As for Mental Health, NHSE/I will maintain the investment guarantee.
7.	Long-Term Plan: Cancer	NHSE/I will maintain its commitment and investment through the Cancer Alliances to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response.
8.	NHSE/I Oversight meetings	Be held online. Streamlined agendas and focus on COVID-19 issues and support needs
9.	Corporate Data Collections (eg licence self-certs, Annual Governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements Delay the Forward Plan documents FTs are required to submit We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.
10.	Use of Resources assessments	With the CQC suspending routine assessments, NHSE/I will suspend the Use of Resources assessments
11.	Continuing Healthcare Assessments	Stop CHC assessments. Capacity tracker, currently mandated for care homes, is now also mandated for hospices and intermediate care facilities
12.	Provider transaction appraisals	Complete April 2020 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors

No.	Areas of activity	Detail
	CCG mergers Service reconfigurations	Complete April 2020 CCG Mergers but delay work post April 2020. Expect no new public consultations except in cases to support COVID-19 or build agreed new facilities. We will also streamline or waive, as appropriate, the process to review any reconfiguration proposals designed in response to COVID-19
13.	7-day Services assurance	Suspend the 7-day hospital services board assurance framework self-cert statement
14.	Clinical audit	All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. Data collection for the child death database and MBRRACE-UK-perinatal surveillance data will continue as this is important in understanding the impact of COVID-19.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID -19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables.

3) Other areas including HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate
2.	Appraisals and revalidation	Recommendation that appraisals are suspended from the date of this letter, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice. The GMC has now deferred revalidation for all doctors who are due to be revalidated by September 2020. We request that all non-urgent or non-essential professional standards activity be suspended until further notice including medical appraisal and continuous professional development (CPD) The Nursing and Midwifery Council (NMC) is to initially extend the revalidation period for current registered nurses and midwives by an additional three months and is seeking further flexibility from the UK Government for the future.
3.	CCG clinical staff deployment	Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline CCG Governing Body GP to focus on primary care provision
4.	Repurposing of non clinical staff	Non-clinical staff to focus on supporting primary care and providers
5.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc

Annex A

Whilst existing performance standards remain in place, we acknowledge that the way these are managed will need to change for the duration of the COVID-19 response. Our approach to those standards most directly impacted by the COVID-19 situation is set out below:

A&E and Ambulance performance - monitoring and management against the 4-hour standard and ambulance performance (Ambulance Quality Indicators: System Indicators) will continue nationally and locally, to support system resilience. Simultaneously, local teams should maintain flexibility to manage demand for urgent care during the emergency period.

RTT – Monitoring and management of our RTT ambitions will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. The wider announcements on suspension of the usual PBR national tariff payment architecture and associated administrative / transactional processes mean that, financial sanctions for breaches of 52+ week waiting patients occurring from 1st April 2020 onwards will also be suspended.

Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital. The existing RTT recording and reporting guidance is recognised across the country as the key reference point for counting RTT activity and specific clarification of how this should be applied, in the scenarios described above, will be provided in due course.

Cancer – Cancer treatment should continue, and that close attention should continue to be paid to referral and treatment volumes to make sure that cancer cases continue to be identified, diagnosed and treated in a timely manner. Clarification has already been released to the system through the COVID-19 incident SPOC to confirm that appropriate clinical priority should continue to be given to the diagnosis and treatment of cancer with appropriate flexibility of provision to account for infection control. We have also confirmed modifications to v10 Cancer Waiting Times guidance to allow for this to be appropriately recorded. In addition, it has been agreed that the 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1 April) will still have data collected, but will not be subject to formal performance management. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Annex B

Data collections/reporting

NHS Digital maintains a significant volume of data which is mandated for return from commissioners and providers[2]. Much of this data is routinely submitted and imposes minimal burden on local systems.

It will be important to maintain a flow of core operational intelligence to provide continued understanding of system pressure and how this translates into changes in coronavirus and other demand, activity, capacity and performance – and in some areas it may be necessary to go further to add to and extend existing collections. For this reason, and to ensure effective performance recovery efforts can begin immediately after the intense period of COVID-19 response activity has subsided, the majority of data collections remain in place.

Notwithstanding the above, a subset of the existing central collections will be suspended, and these returns will not need to be submitted between 1 April 2020 to 30 June 2020:

- Urgent Operations Cancelled (monthly sitrep)
- Delayed Transfers of Care (monthly return)
- Diagnostics PTL
- RTT PTL
- Cancelled elective operations
- Audiology
- Mixed-Sex Accommodation
- Venous Thromboembolism (VTE)
- 26-Week Choice
- Pensions impact data collection
- Ambulance Quality Indicators (Clinical Outcomes)
- Dementia Assessment and Referral (DAR)

[2] https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections

Annex C

Data Security and Protection Toolkit Submission 2019/20

It is critically important that the NHS and Social Care remains resilient to cyber-attacks during this period of COVID-19 response. The Data Security & Protection Toolkit helps organisations check that they are in a good position to do that. Most organisations will already have completed, or be near completion of, their DSPT return for 2019/20.

The submission date for 2019/20 DSPT remains 31 March 2020. However, in light of events NHSX recognises that it is likely to be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSX has therefore taken the decision that:

- Organisations that have completed and fully meet the standard will be given 'Standards Met' status, as in previous years.
- Where NHS trusts, CCGs, CSUs, Local Authorities (including Social Care providers), Primary care providers (GP, Optometry, dentist and pharmacies) and DHSC ALBS **do not fully complete or meet the standard because doing so would impact their COVID-19 response this will be considered sufficient and they will be awarded 'Approaching Standards' status** and will face no compliance action. It will be possible to upgrade from 'Approaching Standards' status to 'Standards Met' status through the year. The cyber risk remains high. All organisations must continue to maintain their patching regimes and Trusts, CSUs and CCGs must continue to comply with the strict 48hr and 14 day requirements in relation to acknowledgment of, and mitigation for, any High Severity Alerts issued by NHS Digital (allowing for frontline service continuity).
- Organisations that have not taken reasonable steps to complete their toolkit submission for 2019/20 will be given 'Standards Not Met' and may face compliance activity, as per previous years.

For any queries please contact or for further information please go to https://www.dsptoolkit.nhs.uk/News

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	C2

COVID-19 Pandemic Incident Preparedness and Response

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Matthew Hopkins CEO		
Presented by	Matthew Hopkins CEO	**Author /s**	Various

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	22nd April 2020	

Recommendations	TME is requested to approve this report. The Board is requested to approve this report.

Executive summary	On 30 January 2020, national NHS leaders internally declared COVID-19 a serious incident and on 3rd March 2020, the UK Government designated the COVID-19 outbreak a Level 4 National Emergency. In response to this unprecedented public health incident, we initiated formal emergency preparedness, resilience and response (EPRR) arrangements from the week commencing 2nd March 2020. Our incident response has focused on four key objectives: 1. Managing the COVID-19 outbreak and saving the lives of patients suffering from it. 2. Managing the business continuity of running our hospitals. 3. Providing and receiving mutual aid from our partners and the region. 4. Keeping our staff motivated and safe. Our strategy has dovetailed with the incident response co-ordinated across the Herefordshire and Worcestershire Sustainability and Transformation Partnership, and been informed by the guidance received from Public Health England (PHE) and NHS England (NHSE). Key points to note: • Our staff should be commended for being responsive, flexible and totally focused on putting patients first. • Effective incident management arrangements are in place and the command and control systems have a regular operational

	rhythm seven days a week. • Our Incident Control Centre is led by a Divisional Director of Operations as the central hub for all incident activity. • Incident working groups have been established to implement multiple elements of this complex incident, each led by a senior leader. • There have been significant levels of clinical leadership and engagement in this incident. • There have been a number of emergent risks and issues which have generally mirrored the experience of trusts nationally; including oxygen supply, personal protective equipment supply and workforce absence. This paper, and the associated appendices, describes the Worcestershire Acute Hospitals NHS Trust (WAHT) pandemic response to date.

Risk								
Key Risks	*BAF risk 12*							
Assurance								
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**	
Financial Risk								

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Introduction/Background

On 30 January 2020, national NHS leaders internally declared COVID-19 a serious incident, and on the 3rd March 2020, the UK Government designated the COVID-19 outbreak as a Level 4 National Emergency. Therefore, in response to this unprecedented public health incident, we initiated formal emergency preparedness, resilience and response (EPRR) arrangements from the week commencing 2nd March 2020.

We have ensured our local preparations and response to the predicted increasing volume of patients who are seriously ill coming into Worcestershire Acute Hospitals NHS Trust (WAHT) hospitals with Coronavirus symptoms, enable us to provide the best quality of care possible, whilst maintaining a safe working environment for our staff, enabling them to stay well and at work.

Our strategy has dovetailed with the incident response co-ordinated across the Herefordshire and Worcestershire Sustainability and Transformation Partnership (H&WSTP) and led by their Emergency Preparedness, Resilience and Response team (EPRR).

Our strategy has also been informed by the guidance received from Public Health England (PHE) and NHS England (NHSE) and their modelling information, which has been developed and refreshed based on the emerging information from the COVID-19 pandemic experience in China, Italy and London.

Our incident response has been extensive and wide ranging, focused on four key objectives:

1. Managing the COVID-19 outbreak and saving the lives of patients suffering from it.
2. Managing the business continuity of our hospitals, in particular enabling the timely treatment of our acutely ill patients requiring urgent and cancer surgery.
3. Providing and receiving mutual aid from our partners and the region.
4. Keeping our staff motivated and safe.

The specific approach taken to successfully achieving each of these objectives is outlined in the appendices to this overarching paper. The appendices cover the following key actions:

- Appendix 1 – Treating our COVID-19 Patients - our strategy for building additional patient care capacity, our strategy for managing patients with respiratory problems. Our approach to ensuring adequate personal protective equipment (PPE) supply and appropriate usage.
- Appendix 2 – Treating our COVID-19 Patients – our business intelligence reports covering prevalence of COVID-19, our activity levels, our staff absence levels and the STP modelling analysis
- Appendix 3 – Caring for other sick patients – our strategy for relocation of and changes to services, our strategy for continuing urgent and cancer surgery, our plans for harm reviews, and a summary of new ways of working
- Appendix 4 – Working with partners, stakeholders and regulators – our internal and external communications strategy and how we have maintained constructive engagement with key stakeholders.
- Appendix 5 – Keeping our staff motivated and safe – our strategy for safe staffing, redeployment, associated training and remote working. Our approach to staff testing processes and the comprehensive offer for our staff.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	23 April 2020
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Issues and options

1. National Guidance

On 30 January 2020, national NHS leaders internally declared COVID-19 a serious, level 4, incident. This led to the gradual adoption of a centralised command and control approach to information and guidance sharing, supply chain distribution, equipment and infrastructure management and media management.

The NHS Emergency Preparedness Lead, along with PHE colleagues, have held weekly briefing webinars for NHS leaders and a similar approach has been adopted by NHS Midlands, focusing on key emerging issues including capacity surge plans, PPE supply, staff testing and so on. Our senior leaders have been involved in these briefings and information has been shared through the internal incident control structures.

The multifarious guidance documents and letters of clarification were originally managed and distributed through the CEO's office but are now co-ordinated via the Incident Control Room.

2. Local Resilience Forum

The Local Resilience Forum covering Herefordshire, Shropshire, Telford and Worcestershire (West Mercia) meets regularly to ensure effective multi-agency arrangements and response to the pandemic, to minimise the impact on the public, property and environment, and to satisfy fully the requirements of the Civil Contingencies Act 2004.

The EPRR team for the county represent NHS provider organisations on the Local Resilience Forum as well as the county Strategic Command Group, and feedback through the H&WSTP command structure.

3. H&WSTP Command Structure

The Bronze, Silver and Gold command structure was established to ensure that the health and social care providers of H&WSTP were ready, able and supported to deliver the core standards as set out in the eight domains of the EPRR National Framework.

The Herefordshire and Worcestershire systems are acting within the Treatment and Escalation phase of the pandemic due to the transmission status of the virus. The partner organisations have worked effectively together and have developed an operating model informed by local analysis and modelling of the demand and capacity impact, using the published parameters, NHSE/I model outputs and the learning from the national incident.

National guidance has been implemented and local changes to models of care have been implemented at speed from primary care, social care, community services and acute care with support from the county councils and voluntary sector.

4. WAHT Incident Management

Our response to the COVID-19 National Emergency has been to establish an incident management structure and processes, based on the EPRR National Framework and recognised best practice, which reports through to our Trust Management Executive.

4.1 The incident management structure

The incident governance structure as outlined in Figure 1 is becoming well embedded and is regularly reviewed for further improvement.

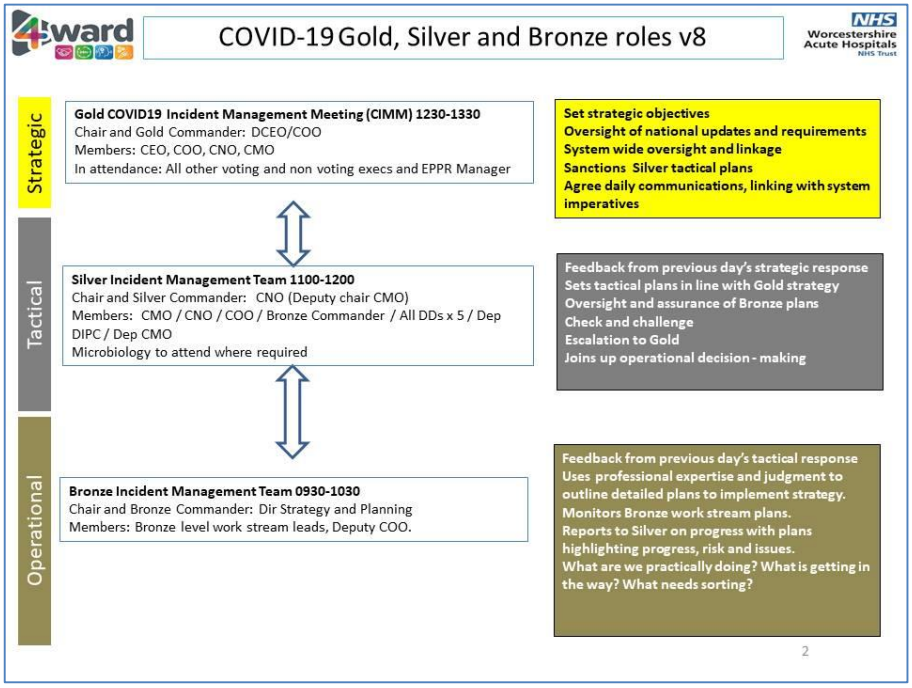

Fig 1 COVID-19 Incident Management Governance

4.2 The Incident Control Centre

The centre is led by a Divisional Director of Operations and incorporates our EPRR as well as a number of volunteers from the clinical and corporate teams. It is the central hub for all incident activity and has a number of roles as set out in Figure 2 below.

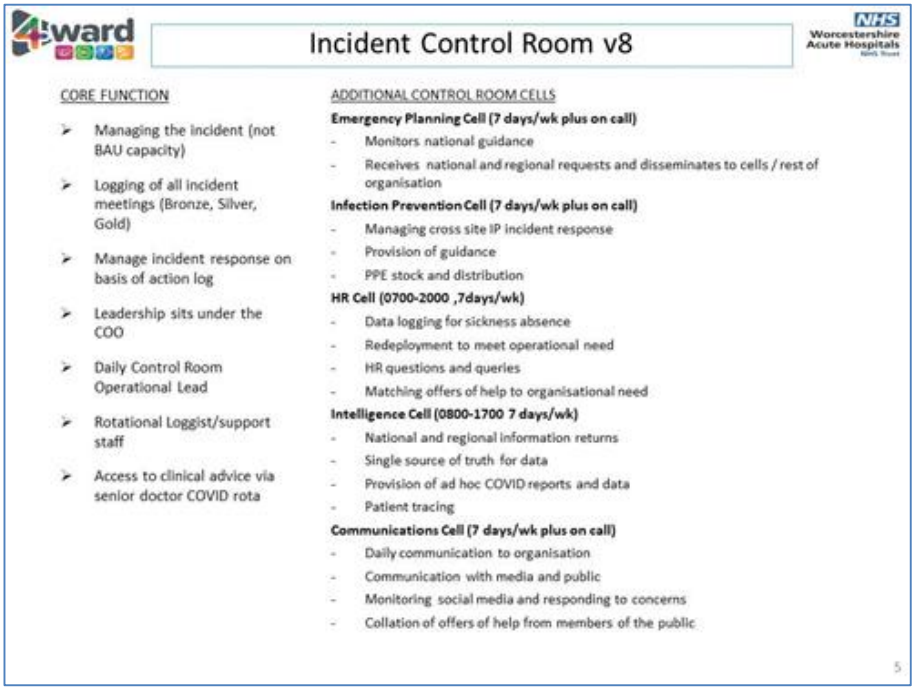

Fig 2 Incident Control Centre

The Control Centre has produced regular information reports, via the Intelligence Cell, to enable rapid decision making and risk mitigation. The reports have tracked patient numbers, staff absence and other key metrics such as ventilator usage (see Appendix 2)

These effective incident management arrangements have been in place for a number of weeks and the command and control systems have a regular operational rhythm seven days a week. We have made use of external support from NHSE and Worcestershire Fire Service to further strengthen our command and control systems and processes.

4.3 Incident management working groups

These groups have been established to oversee the multiple elements of this complex incident. Each is led by an Executive Director or senior clinical/operational leader. Their main line of reporting is to the Bronze Commander, and their main functions are outlined in Figure 3 below:

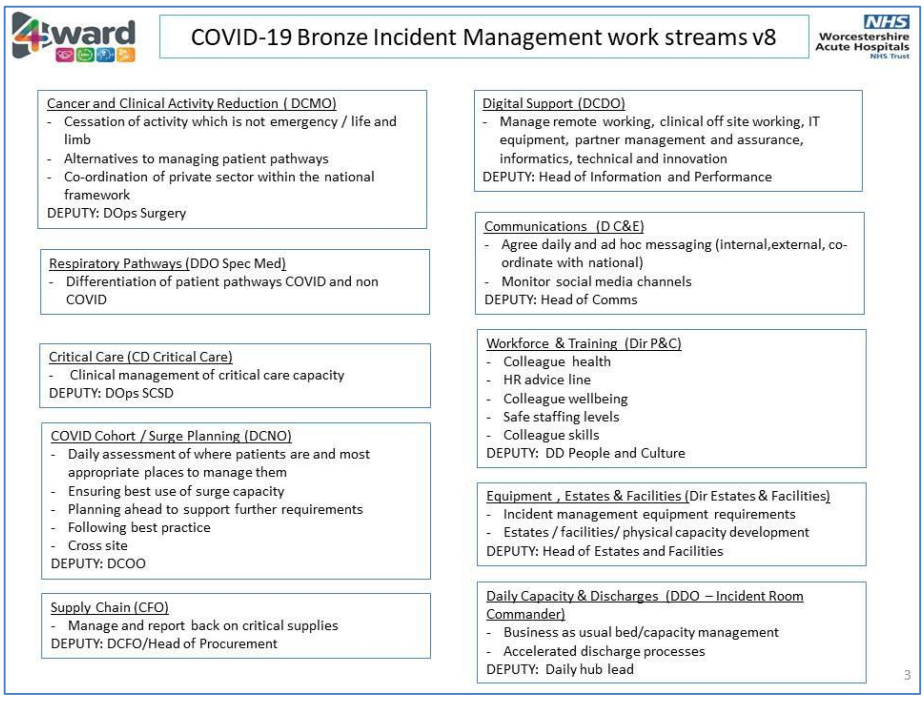

Fig 3 Incident management working groups

4.4 Clinical Leadership

There have been significant levels of clinical leadership and engagement throughout the past six weeks with Divisional and Clinical Directors, Divisional Nursing Directors and Matrons, as well as healthcare scientists and allied health professionals taking on mission critical leadership roles.

The planning for surge capacity in our Intensive Care Units and across the bed base has been clinically led, as has the oversight of personal protective equipment and other surge capacity equipment (see Appendix 1).

We have seen an impressive level of involvement; team work and flexibility from our workforce, with our clinical workforce maintaining their focus on patient safety and the best

care for patients (see Appendix 3).

4.5 Staff Support and Engagement
A comprehensive staff offer and communications strategy have been in place alongside these arrangements, as outlined in Appendices 4&5.

5. Key Risks and Issues
There have been a number of emergent risks and issues over the course of the incident which has generally mirrored the experience of trusts nationally. A risk register has been developed by The Control Centre, with the main themes of risk being:

- Infection prevention and control.
- Workforce availability.
- Workforce health and well-being.
- Equipment availability.
- Personal protective equipment supply.
- Cyber security.

A number of headline issues have been encountered which have impacted on the planning and execution of services. These are detailed in Appendix 1, 3 and 5, and are summarised in Table 1 below:

ISSUE	IMPACT	SOLUTION	RESOLVED
1.Sub optimal piped oxygen supply at the Alexandra Hospital (AH)	• Limited number of invasive and non-invasive ventilated patients on the site • Transfer of a small number of patients to the Worcestershire Royal Hospital (WRH)	• Supplied with 120 oxygen compressors for use with non-invasive ventilated patients • Strict limit on the number of patients on oxygen therapy • Awaiting BOC engineers to relocate VIE units from Kidderminster Treatment Centre (KTC)	Mitigated not resolved
2. Sub optimal piped oxygen supply in the Aconbury building at the WRH	• Reduced our maximum surge capacity for ventilated beds on the site	• Awaiting BOC engineers to install VIE units alongside Aconbury building • Requested additional c.300 oxygen compressors	Mitigated not resolved
3. Sub optimal nurse staffing levels at AH	• Redeployment of staff and reduction in the number of open wards	• Staff testing capacity has been increased to reduce the number of staff self-isolating or unwell	Mitigated not fully resolved
4. Reduced elective surgery, diagnostic tests and outpatient activity	• Longer waiting times for patients and potential for increased harm	• Independent sector capacity has been secured to treat cancer patients • Planning is now underway to increase activity levels	Mitigated not resolved

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We have been fortunate that none of these issues has led to patient safety being compromised, due to the level of demand for ventilated and general acute beds being lower than originally anticipated. We are establishing a harm review process to assure us that increased waiting times in the short term have not led to patient harm (see Appendix 3).

We are also closely monitoring any impact on staff safety and wellbeing.

6. Restoration and Recovery Phase
We are beginning to plan for the restoration of services once the peak in demand related to the pandemic is over. Progress on the planning for this phase will be reported to the next TME and Trust Board.

7. Conclusion
In summary, the incident management arrangements so far have been effectively planned and executed. Our leadership teams have worked tirelessly to protect patient and staff safety whilst maintaining strong corporate communications channels.

Our staff have been flexible, positive and totally focused on putting patients first, and they are to be commended for their fantastic efforts in the face of unprecedented challenges.

Recommendations

- TME is requested to approve this paper.
- The Board is requested to approve this report.

Appendices
Attachment 1 Treating our COVID-19 Patients - our strategy for building patient care capacity
Attachment 2 Treating our COVID-19 Patients – our business intelligence reports
Attachment 3 Caring for other sick patients – our strategy for changes to services
Attachment 4 Working with partners, stakeholders and regulators – our communications strategy
Appendix 5 – Keeping our staff motivated and safe – our strategy for safe staffing and our comprehensive staff offer

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COVID-19 Incident Response – Strategy for treating our COVID 19 patients

Accountable Director	Paul Brennan – Chief Operating Officer / Deputy Chief Executive		
Presented by	Paul Brennan – Deputy Chief Executive & Chief Operating Officer	**Author /s**	Paul Brennan – Deputy Chief Executive & Chief Operating Officer

Introduction

The Pandemic Flu and Major Incident Plans are designed in such a way as to protect services that in turn protect life and reduce harm. In response to the major incident, the configuration of services across the 3 Trust sites has changed to ensure continuity of urgent and emergency care services and to create sufficient capacity to care for and treat COVID-19 symptomatic patients.

Progress to date

In the preparatory phase PODs were created either on or close to the Alexandra Hospital and Worcestershire Royal Hospital sites to support community testing of symptomatic patients. Testing capacity was then switched to testing of patients presenting to hospital and is now being rolled out to symptomatic staff and their relatives.

As the Trust moved into the 'Treatment and Escalation phase' of the major incident, one of the first service changes introduced was to close the Minor Injury Unit at Kidderminster overnight (8pm until 8am). This decision was taken to enable the redeployment of highly skilled and trained staff to support urgent and emergency care services on the other 2 hospital sites and as a result of staff shortages from high staff sickness absence rates. The number of patients attending the MIU had been small overnight, so the impact of the service change was considered to be minimal and was a decision supported by the CCG. At this time, adjustments were also made to the patient pathway in the A&E departments on the 2 main sites to separate COVID-19 symptomatic patients from asymptomatic COVID-19 patients.

A key piece of work in the early stages of the Trusts' incident response was to develop Intensive Care Unit capacity plans to accommodate the predicted surge in demand for ventilated beds. The Divisional teams led this piece of work and created a phased surge capacity plan. The initial planning assumptions were subsequently adjusted to reflect the oxygen flow constraints on the Alexandra Hospital site which is being managed through careful monitoring of oxygen utilisation, the use of oxygen compressors as appropriate and the availability of staffing and specialist equipment. Whilst additional oxygen compressors were supplied this did little to help the overall oxygen consumption to the clinical areas. The British Oxygen Company engineers have been on site to ensure that we can accurately monitor the utilisation of oxygen on the Alexandra Hospital site. We have requested an evaporator oxygen condensing unit which will improve the oxygen flow to the clinical areas by increasing flow capacity from 917 to approximately 1,800 litres per minute, but it is not yet clear when this will arrive.

Table 1: Summary of additional capacity that could be opened if needed

Phase and (additional capacity location)	Trust
Starting position	15
Phase 1 (Main Dept)	23
Phase 2 (Cedar/Aconbury 2)	38
Phase 3 (Aconbury 2)	48
Phase 4 (Aconbury 4)	58
Phase 5 (Aconbury 4)	68

Data source: Intelligence cell_WAHT

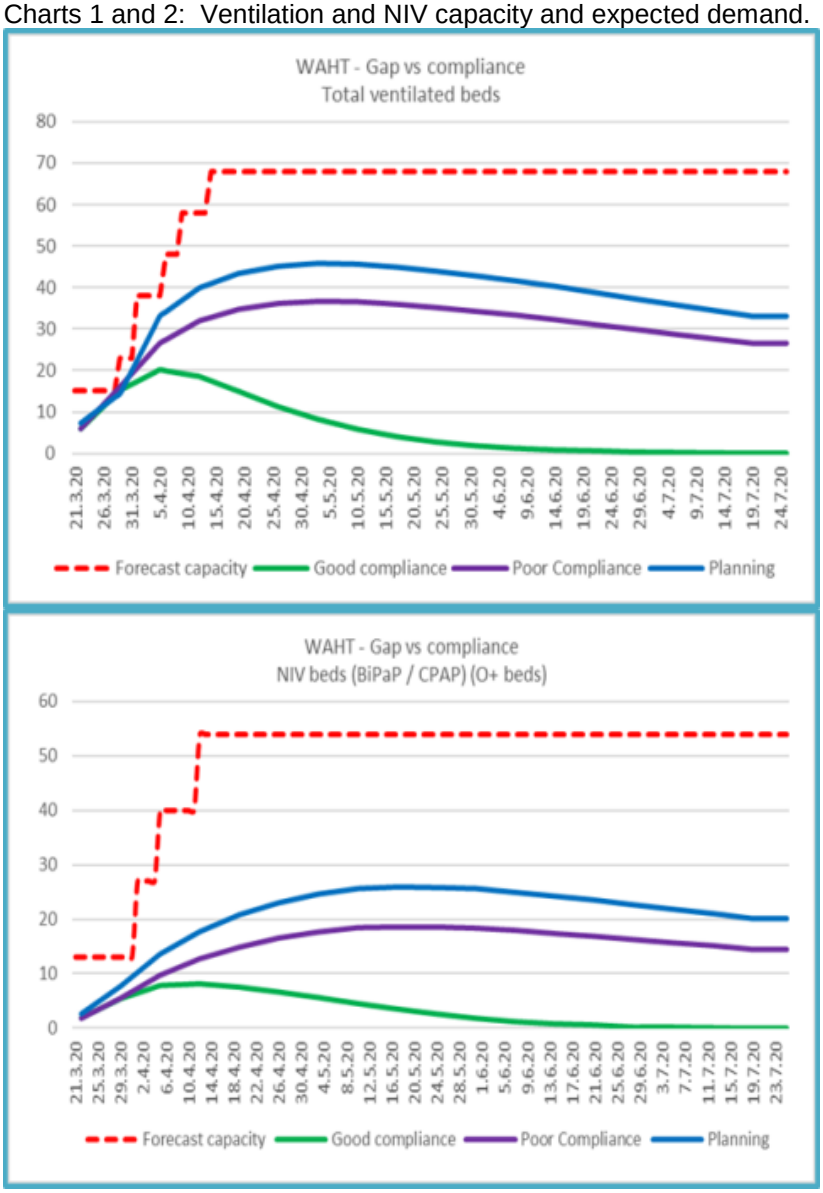
We are currently on phase 2 of this plan and to date, we have been able to accommodate all COVID-19 patients requiring a ventilator and none invasive ventilation across the 2 main sites within existing Trust capacity. Staff have however, had to be redeployed from elsewhere within the Trust to support this.

Across both sites we have the maximum capacity based on oxygen supply for 68 patients to have ventilation and 25 patients to have continuous positive airway pressure (CPAP) / Non Invasive Ventilation (NIV).

The constraints to the oxygen supply at the Alexandra Hospital mean that we can only accommodate a maximum of 13 patients on ventilation and 4 NIV/CPAP patients (upper limits due to Oxygen). If any additional patients required breathing support then they would need to be transferred to the Worcestershire Royal Hospital site. There is a clear patient management protocol in place describing this.

From the latest modelling of predicted demand using a version of the Public Health England methodology it is anticipated that the Trust will have sufficient capacity to accommodate the predicted peak in demand. Based on the latest modelling it is also unlikely that the Trust will need to access capacity at the Nightingale Hospital in Birmingham even after factoring in additional patient flows from Wales.

Charts 1 and 2: Ventilation and NIV capacity and expected demand.



Data source: STP system intelligence cell supported by WAHT

Some of the wards have been reassigned as COVID-19 positive patient cohort wards. Initially the turnaround time for patient testing was delayed so COVID-19 positive and COVID-19 negative patients were being cared for in the same clinical space until the test results were known and the patients could be transferred to the appropriate clinical setting for ongoing treatment and care. Great care continues to be taken to care for the most vulnerable patients presenting as an emergency to prevent them from contracting the virus if they are not showing any signs and symptoms of COVID-19 infection. A summary of the all the ward changes is at the back of this paper (Appendix 1) We are currently at Phase 3 of this plan.

Challenges

In responding to the COVID-19 major incident we have encountered a number of operational challenges including but not limited to:

- Availability of specialist equipment,
- Changes to the method of ordering and the delivery of equipment,
- Availability of personal protective equipment,
- Oxygen flow capacity,
- Altering the designation of clinical areas,
- Transferring and suspending some services,
- Redeploying staff,
- Overlaying the Divisional management structures with the incident response infrastructure and,
- Implementing new ways of working.

A key operational challenge has been the supply of Personal Protective Equipment (PPE). This has been an evolving and changing situation from the outset of the COVID-19 major incident. As more was known and understood about the virus and its transmission, the guidance was revised and may be subject to further revision throughout the incident. Understandably this has been one of the major causes of concern, fear and anxiety amongst our staff. This was amplified initially by an apparent deviation nationally, from guidance issued the World Health Organization Guidance and the Royal Colleges. NHS England and NHS Improvement have maintained that Trusts should adhere to the guidance issued by Public Health England, which we have endeavoured to do. However, getting a consistent message out to our staff in all areas and then being able to supply these areas with the specified equipment has been an ongoing challenge. The Procurement Team and Stores have worked tirelessly to supply our clinical areas with the personal protective equipment they need. There has been supply chain issues but appreciate that is a national and international issue rather than a local issue. Overall, the Trust has been well supplied with equipment to date, albeit that we have had to be creative and innovative. Guidance is likely to be issued to advise clinical areas on what they should do in the event that PPE is not available. We will keep our staff informed as this picture evolves.

Our ability to respond has highlighted gaps in our internal capacity and capability for example the absence of an Emergency Preparedness Response lead and experienced Health and Safety expertise which we will address, but otherwise the staff have responded well and we have been able to sustain services across the 3 hospital sites despite the high staff sickness absence rate.

Summary

The Trust has identified and is using some of the additional capacity created to treat COVID-19 positive patients. Creating comprehensive surge plans and enacting the associated service changes as part of the incident response, whilst not without challenges, could not have been achieved without the dedication, commitment and support of our staff and our partners. To date we are managing to accommodate all COVID-19 symptomatic patients within the capacity we have created and do not expect demand to exceed our surge capacity plans. We will continue to keep our capacity plans under review and make changes to the configuration of services on the hospital sites as required.

At the time of reporting, we remain in the treatment and escalation phase of the major incident.

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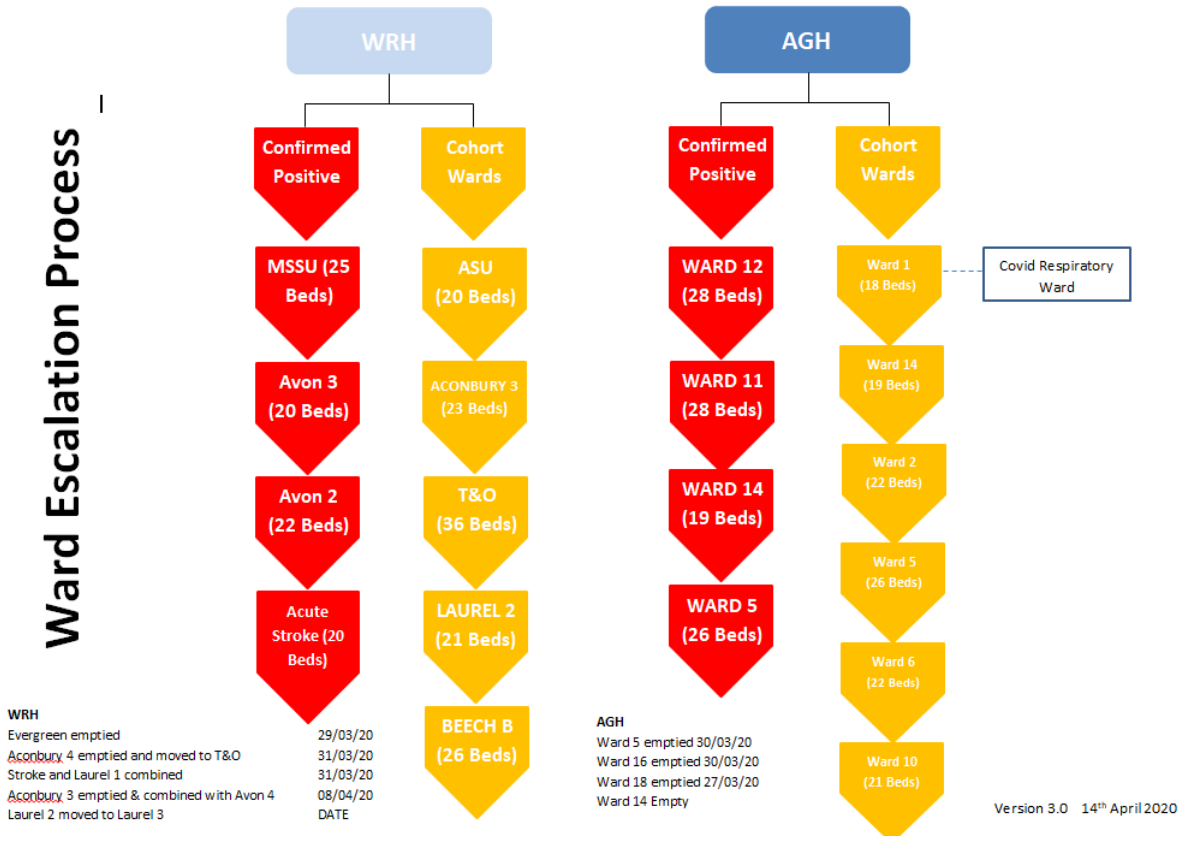
Appendix 1 – Escalation Wards in response to Covid 19 pandemic.



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COVID-19 Incident Response – Delivery of treatment to our COVID 19 patients

Accountable Director	Paul Brennan – Chief Operating Officer / Deputy Chief Executive		
Presented by	Paul Brennan – Deputy Chief Executive & Chief Operating Officer	**Author /s**	Paul Brennan – Deputy Chief Executive & Chief Operating Officer

Introduction

Like many other Trusts, we started to experience the first tangible impact of the global pandemic in mid-March. We have now experienced the impact for 4-5 weeks and this paper provides an overview of what we have seen so far and what further internal analysis we need to undertake.

Below is a brief overview of COVID-19 related activity, up to and including 17th April 2020 (most recent available data).

- We have had 785 detected samples come back to the Trust.
- Of the 785 detected samples we have 524 patients who have been admitted to one of our hospitals and 113 are currently an inpatient.
- On the 17th April, we had 40 inpatients awaiting results of a COVID-19 sample.
- The maximum number of COVID-19 detected patients who have received oxygen therapy on one single day peaked at 97 across both sites on 10th April. 44 inpatients at the Alexandra Hospital and 53 at the Worcestershire Royal Hospital.
- We have 261 patients who have recovered and have been discharged to either their usual place of residence or another care provider.
- Of the 261 patients who have recovered and been discharged, we have had less than 5 readmitted with respiratory symptoms.
- Sadly, 144 patients have passed away in the hospital and had tested positive for COVID-19, 1 of these was a readmission.
- In line with the national guidance, we have increased the volume of swabbing undertaken to support staff that are symptomatic or isolating due to a symptomatic household member, to determine whether they have the virus and if they can return to work; and as of mid-April will be swabbing patients who will be discharged to a care home.
- Our mortuary is currently above standard capacity at the Alexandra Hospital and is using the escalation capacity; the Worcestershire Royal Hospital has not yet moved into its escalation capacity. We are currently using just less than 50% of our maximum escalation capacity.
- COVID-19 related staff absence levels peaked at 21.6% in early April and have now stabilised at c18% (18.58% on 16 April 2020).

At the start of April, enough data had been collected for early modelling for demand at peak. In line with best statistical practice, this was based on the rate of 'doubling'. We provided forecast information on what the peak would look like if the trends continued, so that we could ensure our plans were robust enough to cope with demand.

COVID-19 testing

As mentioned in the paper **'Strategy for treating our COVID-19 patients'**, in our preparatory phase we set up dedicated areas for swabbing (PODs) on the Alexandra Hospital and Worcestershire Royal Hospital sites, testing symptomatic members of the community. In line with national guidance, and as the pandemic progressed, we modified the testing capacity to test those people presenting at our hospitals, and have since rolled out additional testing for symptomatic staff and their relatives.

The initial Public Health England modelling predicted we would experience our first expected peak around 11th/12th April, and our internal modelling indicated that we could expect to have had 900 people where COVID-19 had been detected. This modelling was based on various scenarios of compliance with the social distancing rules imposed centrally. In line with the national modelling, Worcestershire is currently a few weeks behind this prediction with 785 detected samples so far (as at 17th April).

Public Health England has since revised the expected dates for the first initial peak in Worcestershire to mid-May, although at present our data does not support this (see Chart 1).
We have a cohort of patients in the hospital at any one time awaiting test results. In the initial days whilst the regional response to testing was getting underway, we did experience high volumes of patients awaiting results. Some of this delay was due to capacity at Heartlands Hospital (where our samples are sent for testing) and some due a delay in utilising technology for real time transfer of results between Heartlands and ourselves. However, the technology is now in place and the turnaround time has improved from 5 days to 24 hours. We now have between 30-40 inpatients awaiting results at any one time.

Our staff and household samples are being sent to the Royal Wolverhampton Hospital and the technology is in place to enable real time result transfer for this cohort also. The staff and household testing began in earnest at the start of April and following a phased implementation we now have the staff capacity to test 50 people and can increase this to 108 when staff are available to carry out the swabbing. We routinely test between 25 – 40 staff and household members per day, and as at 17th April we have tested 267 staff and/or symptomatic household members. We are currently investigating the DNA rate to appointments for the staff and household tests. The staff and household member swabbing process is still in its infancy and will continue to be refined during the coming weeks.

COVID-19 detected inpatients

Based on the our internal modelling using the 'doubling' methodology, and considering the first initial expected peak was expected by 11th/12th April, we predicted that we would have approximately 350 inpatients across the two sites at any one time. However, the volume of newly detected patients slowed down following a peak on April 2nd/3rd and we have not seen these numbers. We have not had more than 144 inpatients with a COVID-19 detected sample in our hospitals at any one time, and as at 17th April we have 113 inpatients (54 at the Alexandra Hospital and 59 at the Worcestershire Royal Hospital).

We have had sufficient bed, equipment and oxygen capacity so far to provide all inpatients with the oxygenation that they have required, although we have been close to capacity in terms of litres per minute on the Alexandra site on a number of occasions. We have therefore restricted the number of patients receiving CPAP on this site with patients being transferred to the Worcester site if the cap is reached.

The current profile, as indicated below in Chart 1, has shown a plateauing of newly detected inpatients and in the last week a slow, but steady decline. If this trend continues then we may be able to confidently state that we are over the initial first peak.

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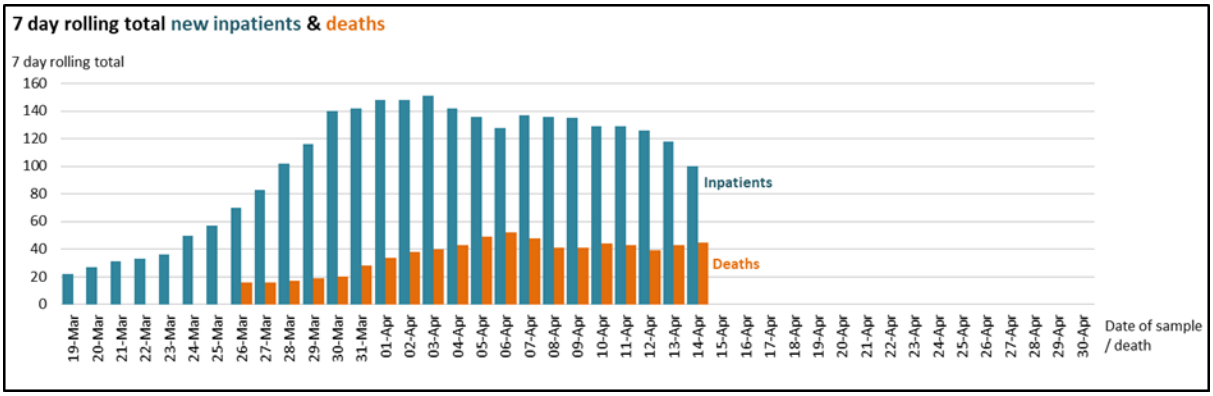
Chart 1:



Data source: Intelligence cell/lab data/Oasis

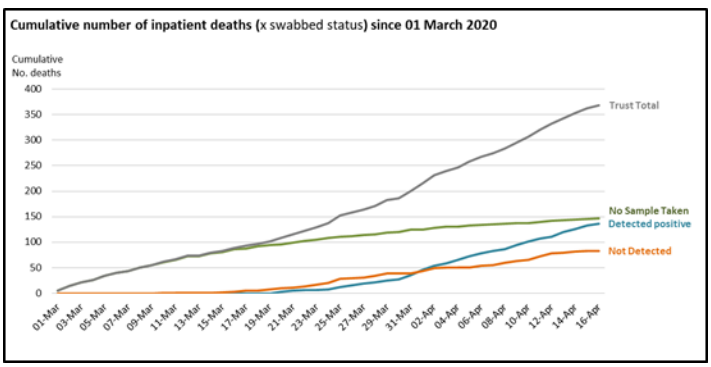
Patients who have deceased and had a COVID-19 detected sample.

Based on the our internal modelling using the 'doubling' methodology we predicted that we would have approximately 150 inpatients die across the two sites by 11th/12th April. We are about 7 days behind this prediction with 144 inpatients, who have sadly deceased (as at 17th April).

The profile of deaths as indicated Chart 1 earlier shows the peak so far being a few days behind the newly detected inpatients. Chart 2 below shows the COVID-19 deaths compared to the not detected and no sample taken deaths.

Chart 2 shows the steepening of COVID-19 detected deaths since 22nd March to the start of April where the detected deaths exceed the non-detected. If the current trend continues, the gradual increase in deaths of COVID-19 patients will soon exceed the patients where no sample was taken, which are the patients who are not presumed to have a COVID-19 related condition.

Chart 2



Detected – had sample taken where the result indicated the presence of Covid 19.
Not Detected – had sample taken as suspected condition – result no detected presence of Covid 19.
No sample taken – not suspected on Covid 19 condition.

Data source: Intelligence cell / Lab data / Oasis

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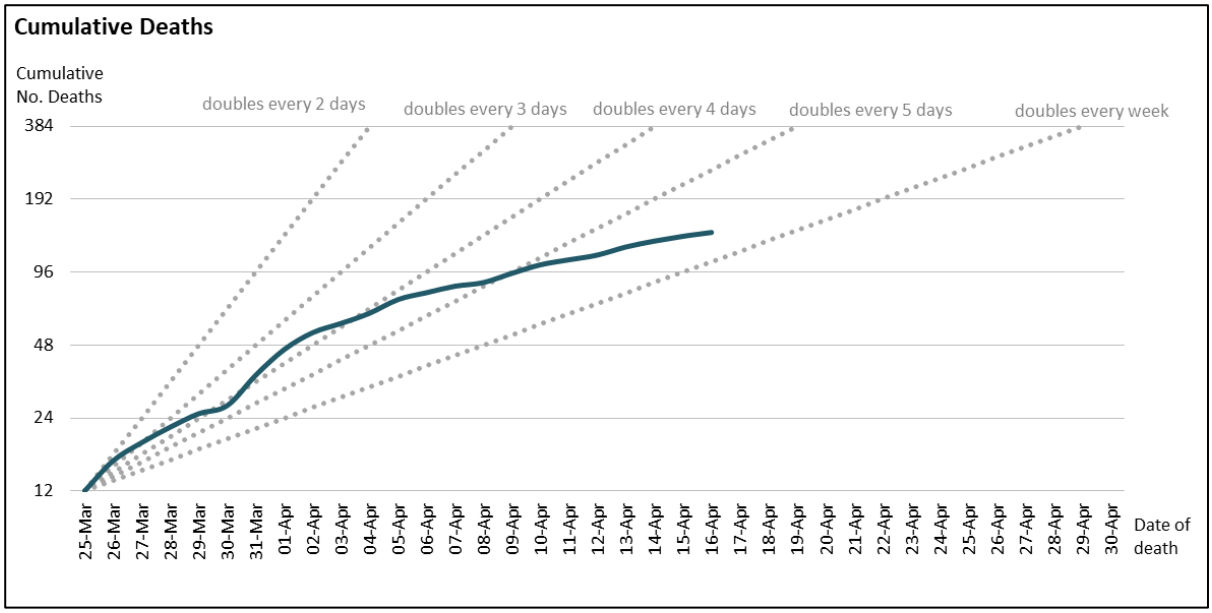
Chart 3 below shows that the rate of 'doubling' has slowed. Initially, we saw doubling every 2 days at the start pandemic. This has moved to every 5 days and is currently moving towards a doubling every week. The lengthening of the doubling period is positive.

Chart 3



The average length of stay so far for a patient with COVID-19 is 14 days, so we must expect that the deaths will continue at a similar level for several more days before we see a decline mirroring the decline in new detected inpatients being admitted that we have seen in the last few days.

Obviously if we experience a change in circumstances such as significant internal transmission of the virus then these predictions would be impacted.

Normally we would show the HSMR and Crude mortality using the HED system, but this system reports a number of months in arrears. We can show how the crude mortality profile differs to previous years in chart 4 below, with 2020 being below that of 2019 until week 10 which in this chart is w/e March 22nd where the impact of COVID-19 can clearly be seen.

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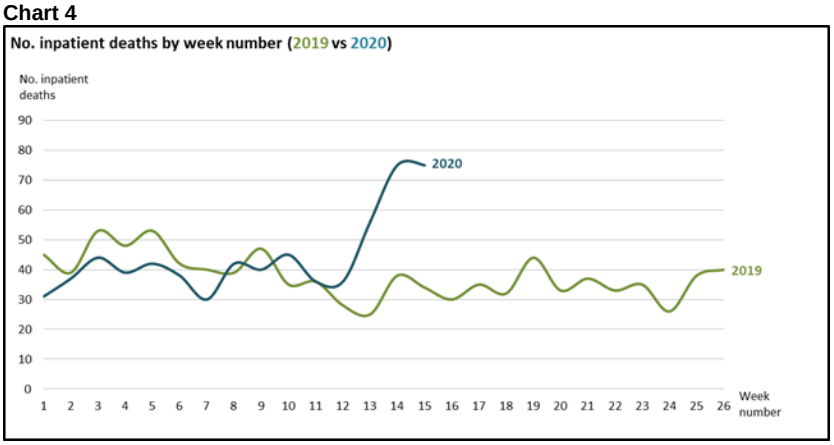
Chart 4



Data source: OASIS

Oxygen supply

As mentioned in the '**Strategy for treating our COVID-19 patients'** paper, the modelling below in chart 5,6 and 7 shows at Trust level we have sufficient escalation plans of oxygen capacity to cope with the demand identified using the various models.

Chart 5

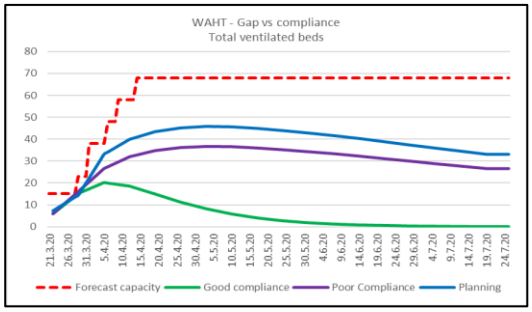


Chart 6

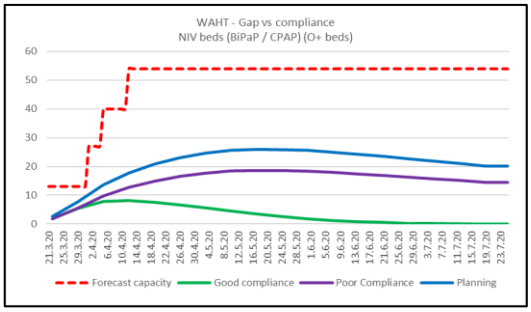
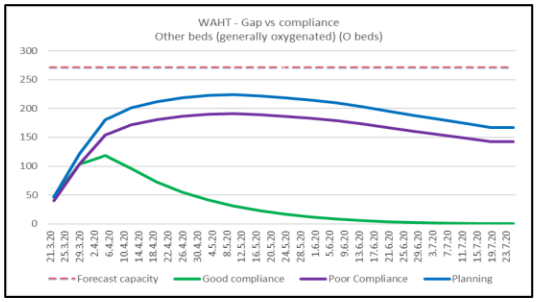


Chart 7



Data source: STP intelligence cell

However, at site level there has been concern raised regarding the maximum capacity at the Alexandra Hospital.

There has been some mutual aid reported for patients requiring critical care level where we have transferred or diverted patients from the Alexandra Hospital to the Worcestershire Royal Hospital. So far, this has been infrequent and small numbers.

The total number of COVID-19 patients who have needed mechanical ventilation on the same day has remained below 20 throughout the pandemic so far. We are currently in Phase 2 of the escalation plan which will provide up to capacity for 38 ITU beds, although 23 of these beds are at the Worcestershire Royal Hospital site.

We are monitoring the oxygen flow requirements at both sites daily and continue to pay special attention to the oxygen capacity at the Alexandra Hospital.

Mortuary capacity

We have standard mortuary capacity across the Trust of 118 spaces, and as part of the escalation plans we have the ability to utilise an additional 120 spaces should they be needed. As at 17th April we are using 45 spaces at the Alexandra Hospital and 55 at the Worcestershire Royal Hospital. There are no immediate concerns regarding mortuary capacity.

Next steps

- We will continue to review the newly detected inpatients and potential for internal hospital spread of the virus.
- We will continue to re-visit the predictions and re-model where necessary.
- We will be looking in more granular detail at the profile of discharges i.e. whether patients are being discharged to their usual place of residence or utilising the increased system pathway capacity.
- We will also be able to provide more granular analysis and predictions for the oxygen usage within each site.
- We will be looking to profile and predict any gaps with workforce skillset that may occur as a result of COVID-19 related absences.

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COVID-19 Incident Response – Caring for our other acutely ill patients

Accountable Director	Paul Brennan – Chief Operating Officer / Deputy Chief Executive		
Presented by	Paul Brennan – Deputy Chief Executive & Chief Operating Officer	**Author /s**	Paul Brennan – Deputy Chief Executive & Chief Operating Officer

Introduction

To help protect our other sick and vulnerable patients whilst responding to the COVID-19 pandemic, we have reconfigured our services across the Trust sites and new ways of working have been introduced.

This paper outlines the changes that have been introduced to date and next steps.

Safeguarding non COVID-19 symptomatic related urgent and emergency treatment and care

Ambulatory cancer services and the Women's Centre at the Alexandra Hospital were moved to the Kidderminster Hospital site in March alongside Ante Natal services from the Worcestershire Royal Hospital. In addition, Dermatology 2 week wait clinics have moved to Kidderminster and Ante Natal services from the Alexandra Hospital have been relocated to the Princess of Wales Community Hospital, Bromsgrove.

All non-urgent and routine activity has been suspended and the Trust is only undertaking category 1a and 1b procedures on site.

Nationally, capacity has been commissioned from private sector providers and locally this has been used to ensure cancer patients can continue to access urgent surgery. A summary of the capacity commissioned from the private sector is summarised below:

- 2 theatres, 5 days a week including Bank Holidays at the Spire and endoscopy sessions are being introduced week commencing 20 April 2020,
- 8 theatre lists a week at BMI Droitwich and again endoscopy sessions are being introduced week commencing 20 April 2020,
- theatre lists at the Priory BMI which has critical care capacity subject to availability and is reviewed on a weekly basis.

During the week commencing 20th April 2020, we are planning to undertake 49 operations and 44 endoscopies.

As all planned and elective care has been suspended, a harm review process is currently being developed which will be used to review patients on the suspended elective and planned care lists. Consideration is also being given to how we ramp up planned and elective activity as we move into the recovery phase of the major incident and how patients will be prioritised on the basis of clinical need. This work will be completed by the 24th April 2020 and a full proposal will be submitted to Gold Command for approval on the 27th April 2020.

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To free up capacity, reduce unnecessary travelling and facilitate social distancing to protect our patients and staff, many of the face to face outpatient appointments have been converted to telephone consultations. 33,000 telephone consultations were undertaken in March 2020.

The Trust is in the process of evaluating the impact of this change in service delivery but anecdotally it has been suggested that virtual outpatient appointments increase productivity by as much as 40% which could free up capacity within the Trust for other clinical activity as we move into the recovery phase of the major incident. A wider piece of work will need to be completed to capture and evaluate all the service changes introduced for the Trust to determine which working practices should be retained as the new 'business as usual'.

Summary

The Trust is continuing to see and treat cancer patients albeit that the national cancer screening services are currently suspended. We have also taken steps to cohort non COVID-19 patients separate to COVID-19 symptomatic and confirmed COVID-19 positive patients to protect our patients, staff and the public.

We plan to undertake harm reviews of patients whose treatment has currently been deferred and we will agree a process for clinically prioritising patients as and when we begin to ramp up elective and planned care.

We will evaluate the changes to working practices that have been introduced and explore whether these should be adopted on a permanent basis to improve our productivity and efficiency as a Trust and provide a better experience for our patients.

We continue to work with our partners and keep them and our other key stakeholders informed of the changes we make to the services as provide.

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COVID-19 Incident Response – Keeping our staff motivated and safe			
Accountable Director	Richard Haynes – Director of Communication and Engagement		
Presented by	Richard Haynes – Director of Communication and Engagement	**Author /s**	Richard Haynes – Director of Communication and Engagement

1. Overview

As the Trust responds to the COVID-19 pandemic, effective two-way communication and engagement with our staff, our partners, patients, the public and other key stakeholders is crucial to support the delivery of the four key objectives of our incident response

1. Managing the COVID-19 outbreak and saving the lives of patients suffering from it.
2. Managing the business continuity of running our hospitals.
3. Providing and receiving mutual aid from our partners and the region.
4. Keeping our staff motivated and safe.

Key areas of focus have been:

- Making sure the latest operational information and guidance is easily available to staff (objectives 1, 2, 3 and 4).
- Effectively communicating the Trust offer on staff support and wellbeing (objective 4).
- Sharing good news stories to boost morale (objective 4).
- Briefing partners and other key stakeholders (objective 3).
- Providing clear accessible and reassuring information to patients and the public (objective 1).
- Helping to manage the huge amount of public goodwill, generosity and support which the outbreak has generated (objectives 3 and 4).

This paper outlines the work of the Communications Team working with our partners, stakeholders and regulators as part of the Trust response to COVID-19.

2. Internal Communications

Internal communications has been a priority from the beginning of the outbreak, to help us get the most up to date information and guidance to staff in the most easily accessible format we can.

This has been done with the aims of:

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- Giving our teams the information they need about critical operational aspects of our response including service changes, ward moves, issues around PPE and changes to working practice.
- Making information readily available to all staff about the package of support being offered by the Trust.
- Providing morale boosts by sharing good news stories and building a sense of togetherness and community.
- Addressing the additional challenge of increased remote working, in terms of both systems and the difficulties of maintaining face to face communications in a time of social distancing and self-isolation.

2.1 COVID-19 Updates

The main COVID-19 bulletin for staff started as an email with links to the intranet. The aim from the outset was to keep all up to date information and developments in one easily accessible message which had been subject to a clear sign off process.

Those briefings were produced as needed (daily at least - twice daily on occasions) from Monday 16 March onwards and shared with all staff by email with updates also posted on the Staff Facebook Group. That format was used up to up to briefing 8 (Thursday 19 March).

With increasing numbers of staff working remotely and struggling to access the intranet (even with Awingu) we developed the current format of Covid-19 brief which has been in daily (weekday) use since Friday 20 March.

As well as containing all the current briefings, this format offers links to all updated documents and information which can be accessed by any member of staff with an internet connection without having to go through the Trust network.

It is distributed by all staff email and also shared as a pinned post each day on the Staff Facebook Group (that group was switched from public facing to members only early on in the outbreak to support more detailed briefings than we might have felt comfortable putting in the public domain).

You can see a recent example of the Update here and also use it to access previous editions. It uses the same format and search function as Worcestershire Weekly which large number of our staff are familiar with.

Reaction so far has been generally positive and the format also enables us to track activity by bulletin and individual article.

With the implementation of a formal incident management system, there is a senior communications representative at the daily Bronze and Gold calls to identify and respond to key issues. Sign off of each daily update is via the Bronze, Silver and Gold Commanders and a communications update goes to each Bronze call.

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2.2 Worcestershire Weekly

We are continuing with this established format as required – including a special edition focussing on our support offer for staff which you can see here (we can also track and report activity on all articles in this brief).

2.3 Messages from the Chief Executive

The established weekly email message to all staff from Matthew has continued, with additional messages as required (for example to announce the first reported COVID-19-related death in the Trust and most recently to announce the death of a member of our staff).

We have also trialled the use of a shorter video message from Matthew which was shared on the Staff Facebook Group and then more widely via Twitter, which has been very positively received.

Matthew also has a small reference group of frontline staff who have regular video conferences with him and through use of the Zoom videoconferencing platform we have also been able to continue with online versions of two other well established internal communications channels – Senior Leaders' Brief and Meet the Chief as well as a special briefing from Matthew for our 4ward Advocates.

We've seen the Staff Facebook Group membership expand rapidly to (at the time of writing this appendix) 4,339.

We now have more than 24,000 followers for the Trust Facebook page and almost 7,000 followers on Twitter both of which are helping us reach significant numbers of people with positive messages about our response to the outbreak (including our own staff).

3. System Communication Partners

There is a weekly video conference between the communications leads of all system partners across Worcestershire and Herefordshire.

We have received valuable support from comms colleagues in the CCG in managing a number of media inquiries (local, national and trade) and issuing responses on behalf of the whole system, as well as representing the local NHS at, and feeding back from, meetings of the multi-agency Local Resilience Forum (LRF) communications cell.

Daily communications bulletins are also cascaded by the NHSE&I regional comms teams, who also provide daily information on which of the deaths in our hospitals will be reported in that day's national announcement.

In addition there are regular national videoconferences for NHS Communications Directors hosted by the national communications team including the NHSE&I Director of Communications Simon Enright to provide national updates on current issues of interest and concern.

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4. Engagement with Key Stakeholders

Much of the usual business of our key stakeholders has been suspended or shifted to virtual working during the pandemic, but we have made sure that our MPs, Healthwatch and the County Council's Health Overview and Scrutiny Committee (HSOC) have been briefed on key developments including any service changes or moves, restrictions on visiting and figures for COVID-19 delated deaths, as well as dealing in a timely way with any ad hoc queries or concerns they have raised.

Our Chairman and Chief Executive took part in a system wide video briefing for all our county MPs, along with the Chief Executives of the CCG and the Health & Care Trust, earlier this month, and a follow up briefing is now being planned.

5. Patients and the Public

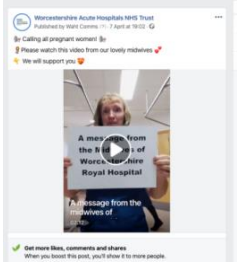
We have used all our communications channels to share public health messages as they have evolved during the outbreak, as well as producing regular updates to posters and other display materials which have been used across our sites, for example the current 'Stay at Home, Protect the NHS, Save Lives' campaign.

Detailed information has been provided on key service changes (for example the change to opening hours at Kidderminster MIU).

Restrictions on visiting have been a 'hot topic' for many patients and their families, and as well as sharing details of restriction on visitors and visiting hours we have also promoted alternatives including video calls to help keep patients and their loved ones connected remotely.

Good news stories about patients recovering from COVID-19 have been proactively shared to help provide reassurance and balance the understandable concern among the general public about the dangers of Coronavirus, and have generated significant coverage – examples include the following.

The story of Keith, our 101 year old patient who recovered from COVID-19 was seen by 1.7 million people on Facebook with more than 218,000 engagements as well as almost half a million views on Twitter and 38,000 engagements and extensive local, national and international media coverage.



Our video 'message to mums to be' from our midwives to reassure pregnant women reached 1.3 million people on Facebook with more than 138,000 engagements, with more than 94,000 views on Twitter and more than 8,000 engagements.

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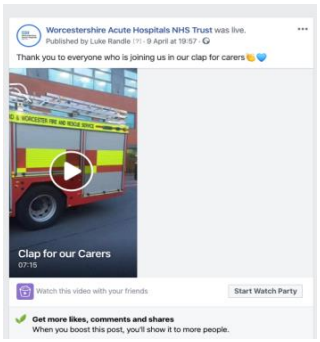

And our live stream of the local police and fire support for a 'Clap for the NHS' at WRH was watched by more than 100,000 people.

- We've had over a million individual video views across our channels.
- Stories from our social media picked up nationally and internationally, including making the 'Most Read' list on BBC News.
- We're now the seventh most followed Acute Trust on Facebook.
- Doubled our LinkedIn followers after viral post (Keith) on LinkedIn.
- On new channel TikTok, we now have almost 12,000 followers and 960,000 video views.

Current issues include sharing messages about the importance of patients continuing to access acute hospital services where appropriate for conditions other than COVID-19 related ones to ensure they receive timely treatment for potentially life threatening conditions and are not deterred from coming in to hospital where that is the best option for their treatment.

6. **Charity Update: Worcestershire Acute Hospitals Charity**

Since the outbreak and the charity establishing the helpworcsacute appeal we have seen a huge and greatly appreciated upsurge in public goodwill and generous support from individuals, organisations and business for our hospitals.

A dedicated phone line and email address wah-tr.helpworcsacute@nhs.net 01562 828869 has been set up to allow the charity to act as first port of call for would-be donors and benefactors so that their offers of support can be acknowledged and pointed in the right direction. While initially it was challenging to get internal and external buy in this preferred route, in the last 10 days there has been much better use of the dedicated email and phone line. On average the phone line would receive between 5-15 calls per day and the e-mail similar including redirected internal enquiries.

Over recent weeks we have seen a huge number of variety of donations of goods and services, including, Gifts in Kind to support the newly opened Staff Wellbeing Shops covering donations of;

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- Non-perishable foods (approx. value £5,000).
- Secured 9000 Easter Eggs from Mars.
- Secured 1500 Grenade Energy Bars, 6000 Artic Ice Coffees, £4,000 of groceries from Tesco and M&S.
- To support the Bereavement suite over £10,000 of high-quality candles.

We have also received a number of very generous cash donations including:

- Online Donations to the just giving appeal circa £5k and climbing.
- Grant donations from NHS Charities Together and cheques circa £45,000.
- Further expected donations from Grants and donations are likely to be circa £50,000.
- The Worcestershire Dioceses has raised over £3000 and funded much of the stock in the staff wellbeing shops.
- NISA Retail have donated circa £500.

In keeping with the charity's purpose which is putting patients first by working together, supporting the services and staff of Worcestershire Acute Hospitals NHS Trust we are focussing on ensuring that all these generous donations are used for the benefit of our patients and staff in ways which go above and beyond the core NHS 'offer'

We have already achieved:

For staff:

- DPD have donated food parcels to the Shops.
- EBC Group have part funded 40 IPADS to be used on COVID wards and engineers to support configuration of the hardware.
- We have collaborated with local communities groups that have supported the resizing of over 200 scrubs.
- Tarmac have provided 3M Face masks.
- Jaguar/Landrover have provided over 1000 Medical visors to date.
- Over 6000 surgical masks have been donated through Malvern College.
- Kettler have donated 60 Trikes that some will be placed in the on-site nurseries and the remaining to identify key works with young families that may benefit.

For patients:

- To support the Bereavement suite over £10,000 worth Parks Candles have been provided to families that have lost a loved one through COVID-19.
- From charitable funds over £15,000 has been spent of providing IPADS to support maintaining communication for COVID-19 patients with their families and Stands for these (part supported by the Alex LoF).
- Gemini Mobile have provided 4 phones support maintaining communication for COVID patients with their families.

Next steps

Building on what we have already achieved, we are now focussed on:

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- Putting in improved ways to enable the charity to react quicker to fund the needs of the Trust.
- We have been collaborating with H&CT building relationships to support with future working partnerships.
- We will follow up all the new business relationships that have been formed and will be encouraging the Trust to maintain close working relationships with some the local supply chain that has supported us through this time.
- We have been supported extremely well by ISS for distribution and introduction to new suppliers and aim to develop this relationship further.
- We will continually evaluate the effectiveness and need for the staff wellbeing shops, while ensuring they continue to work with appropriate guidelines.

We would like to take this opportunity to thank everyone who has supported us so generously over the past few weeks. Your generosity has been inspiring and humbling.

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COVID-19 Incident Response – Keeping our staff motivated and safe

Accountable Director	Tina Ricketts – Director of People and Culture		
Presented by	Tina Ricketts - Director of People and Culture	**Author /s**	Tina Ricketts – Director of People and Culture

Introduction

This paper provides an overview of our People and Culture Strategy during the COVID-19 pandemic. It summarises our staff offer and approach to safe staffing.

Key to our response is having a highly skilled, trained and available workforce to treat and care for COVID-19 symptomatic patients and to sustain all urgent and emergency care services at the Trust in a safe and efficient way. This requires colleagues to adopt new ways of working, including working flexibly and to work responsibly, safeguarding their own health and wellbeing and that of their co-workers, patients and the public. Given the scale, complexity and uncertainty that surrounds COVID-19, it is understandable that some colleagues are anxious, uncertain, fearful even, and as their employer it is incumbent upon us to do what we can using the wide range of resources available locally and nationally to promote and protect staff health and wellbeing and personal resilience. We want our staff to perform their role to the best of their ability throughout this major incident and beyond.

The Trust Management Executive is overseeing the workforce implications of the Trusts' response to COVID-19 which includes the impact of the revised operating models to ramp up elective and planned care when the time is right and the introduction of any changes on a more permanent basis.

This paper outlines the progress made to date in addressing the workforce implications of COVID-19 and next steps.

Staff offer

The briefing presented at the People and Culture Committee on the 31st March 2019, outlined 5 Task and Finish Groups that have been established to progress the work needed to maintain our workforce throughout the major incident. These are outlined in Table 1.

Table 1: Task and Finish Groups

Group	Progress to date
Staff Health	Staff sickness absence is a key challenge. On 16th April 2020 we had 18.58% of staff absent due to sickness, self-isolating or social distancing. We are also seeing an increase in colleagues being absent due to mental health related conditions

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	including stress. We have a staff absence reporting telephone line in place which is open from 7am to 8pm seven days a week. This line is also used for booking staff testing which, since staff testing began, has led to the overall absence rate reducing by 1% to date based on 190 tests. Following the announcement on 28th March 2020, requesting that staff undertaking work from home should not be included in the absence data, a data cleansing exercise was completed. From this we were able to ascertain that 129 members of staff were incorrectly coded thereby reducing the overall absence rate by a further 1.2%. Risk assessment forms are being completed for staff who are at high or increased risk because of COVID-19 to ascertain whether they can work from home, an alternative location or in a different role. We recognise that some ethnic minorities are disproportionately affected by the virus, and that pregnant women in the latter stages of pregnancy may also be at greater risk, so we have taken action to ensure that all staff have access to the most up to date relevant information and guidance about how to stay well. In addition, advice and guidance and top tips have been made available to those staff working from home to ensure that they have an appropriate workstation and are following a scheduled working pattern. Arrangements have been made for some staff to access alternative accommodation so that they can return to work if family members are symptomatic. Each day sickness absence hotspots are discussed at the Bronze Command meetings to agree what actions are needed to address these. As at 16th April 2020, identified hot spots included elderly medicine, endoscopy, trauma and orthopaedics and urology. We have profiled staff absence for the next 12 weeks based on the lessons learned in London Trusts so that we are able to project staffing requirements.
Staff wellbeing	This group has been set up to implement a range of measures and support to promote staff wellbeing such as: • Free 24-hour access to counselling for staff, psychological wellbeing and some practical steps to help staff respond effectively to COVID-19 using the acronym ‘FACE COVID’. • We are mindful that some staff are working for prolonged periods of time due to their specialist expertise and experience and or who are having to make very difficult clinical decisions which may impact on their mental wellbeing. Specific offers of support have been designed and put in place to meet their needs. • We also recognise that it can be stressful for those staff who are asked to

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	be redeployed to another clinical area or to take on a different role or additional duties and steps have been taken to support staff to make the transition. • There is also a recognition that some staff are having to work from home because they are shielding, and it is as important to consider the wellbeing of staff who are in work as well as those working remotely. To date over 500 welfare calls have been made with colleagues who are social distancing. Staff have been provided with additional kit such as phones and laptops. Several measures have been put in place to support staff attending Trust sites including: • Free car parking • Support with childcare • Free packed lunches and provision boxes on Covid19 wards • Improved shower facilities • Hot and cold vending machines. We are continuing with 'Thank you Thursday' via electronic cards and Matthew has introduced virtual 'Meet the Chief' sessions so that staff feel listened to. These sessions are attended by 4ward advocates and the Freedom to Speak Up Guardian. Jason Levy, the charitable funds co-ordinator has done a fantastic job in co-ordinating donations from corporate organisations which has resulted in regular donations to staff including Easter eggs, hand creams and a pop-up staff shop for basic food provisions.
HR Advice	We are maintaining employment relations through fortnightly virtual JNCC meetings. A number of temporary changes have been introduced to staff terms and conditions of employment which staff have been made aware of. These include more flexibility with the carryover of annual leave and the discounting of COVID-19 related absence when applying our sickness absence policy. A HR advice line has been established and we are holding virtual HR surgeries for managers and staff. A review of the HR casework has been undertaken and we have identified cases that need to proceed and those that can be paused (with the staff/ staffside members agreement) during the period of COVID-19.
Skills	Due to the pressures on staffing, all non-essential education and training has been suspended. However, provision has been made for staff to continue accessing essential statutory and mandatory training through e-learning. Focus has been given on providing education and training support to staff who have

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	been redeployed or who are taking on new roles or additional duties. Skills updates include infection, prevention and control, personal protection equipment, intensive care medicine, IV Therapy and resuscitation. The training team are also coordinating fit mask testing. There has been significant media coverage regarding availability of staff Personal Protection Equipment (PPE) and one of the key areas of focus for this group is to ensure that staff are aware of the latest guidance and can also access and properly use the PPE available. We have adapted our induction programme to accommodate smaller groups to support social distancing and to date we have inducted 90 third year nurse students, 23 third year and 19 fifth year medical students in this way.
Safe Staffing	This group is responsible for our workforce plan during the COVID-19 period. Staffing models are being refined for each of the operating model scenarios and we are profiling in absence, vacancy and turnover rates to identify gaps. These gaps are currently being filled through redeployment, new joiners (see below) and through bank and agency staff. All staff have been added to the allocate system which has allowed the live reporting of absence and the accurate recording of additional hours worked. In addition, allocate has enabled the setting up of multiple rotas so that we can track staff through their redeployment. The group has been pro-active in ensuring a steady supply of staff to the Trust and to date has supported the on boarding of: • 84 nursing students (69 third year and 15 second year) • 42 medical students • 20 staff through the national Bring Back Scheme Through our contract with NHS Professionals we have also increased our bank by: • 9 Medical Staff • 67 Admin and Clerical staff • 12 Allied Health Professionals • 99 Healthcare Assistants • 103 Registered Nurses In addition, we have categorised all support services staff to enable redeployment into critical areas. For example, the PMO team have been key in setting up and manning the COVID-19 incident room.

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Staff have been made aware of the above offer and are kept abreast of the latest information and guidance via several channels including a special edition of the staff newsletter which is available on the intranet.

Since the People and Culture Committee meeting on the 31st March 2020, a sixth Task and Finish Group has been established to plan beyond Covid19. This Task and Finish group will consider the workforce implications of the recovery phase of the major incident, taking account of any changes to working practices such as remote working, virtual outpatient appointments, home reporting that we will want to retain post major incident. The Terms of Reference for this group are currently being refined and an update will be presented to the next meeting.

People and Culture Risks

The people and culture risk register has been updated to highlight:

- The impact of increased staff absence on service delivery and safe staffing levels,
- The increased risk of injury at work claims due to exposure to COVID-19,
- The likely deterioration in mandatory training, job planning and appraisal compliance,
- Increased bank and agency costs during the initial COVID-19 planning phase,
- Delay in international appointments joining the Trust due to travel restrictions into the country (both medical and nursing),
- Increase in pay costs – due to key staff groups working above their contracted hours with an increase in overtime rates and unsocial hours payments,
- Possible increase in grievances and employment tribunals claims due to delay in HR casework being completed.

Summary

In summary, we have taken the necessary action to ensure that we comply with the workforce related guidance issued nationally and we have supplemented this with our own local guidance. We have tailored the national offer of health and wellbeing support to meet the needs of our staff locally. We continue to provide round the clock support, advice and guidance to our staff and we are ramping up staff and staff household testing to maximise the number of staff who are able to return to work and putting arrangements in place to enable as many staff as practically possible, and who are well enough to do so, to work from home.

Staff and patient safety remain a key priority and we continue with our efforts to ensure that staff have access to the most up to date information about how to keep themselves and others safe and well and have access to the appropriate personal protection equipment for the area/s they are working in.

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Policy for Ethical Decision Making

For approval:	X	For discussion:		For assurance:	x	To note:	

Accountable Director	Mike Hallissey, Chief Medical Officer		
Presented by	Mike Hallissey, Chief Medical Officer	**Author /s**	Mike Hallissey, Chief Medical Officer

Alignment to the Trust's strategic objectives							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	22 April 2020	TBC

Recommendations	• TME and Trust Board are requested to review and approve the policies.

Executive summary	• Fair, open and transparent decision making about care of individuals is a key ethical consideration in the delivery of care. • Clinicians need to be supported where there are challenges in making a decision on care escalation or restriction.

Risk									
Key Risks	Failure to support our staff with difficult ethical problems will impact on staff and patients.								
Assurance									
Assurance level	**Significant**		**Moderate**	*X*	**Limited**		**None**		
Reputational Risk	Risk of poor clinical decision making will impact on trust reputation.								

Introduction/Background

At times of clinical pressure there will be a need to make decisions on patient escalation with much greater frequency and this will place a greater burden on individuals than would normally be seen. There can be decisions which will be nuanced due to the complex nature of the patient characteristics. It is essential for the Trust to provide a support mechanism for clinicians to have access to so that they can express their concerns and achieve a moral balance for each case.

It is anticipated that the number of cases where an ethical issue will arise is likely to remain small but due to the large number of decisions likely to be made in the current clinical environment on whether to escalate or de-escalate care, the provision of support will aid the clinical teams in reaching these decisions. This would be beneficial to both clinicians and patients.

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The policy outlines the resource which the Trust will make available to support this process. This should facilitate the discussion of any key questions, the resolution of which will aid the definition and delivery of appropriate care.

Recommendations

- TME and Trust Board are requested to review and approve the policies.

Appendices – Policy for Ethical Decision Making

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Policy: Ethical clinical decision-making during COVID 19 pandemic

Department / Service:	Chief Medical Officer, Worcestershire Acute Hospitals NHS Trust
Originator:	Jane Ball
Accountable Director:	Mike Hallissey
Approved by:	
Date of approval:	
First Revision Due:	1 July 2020
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All wards and clinical departments
Target staff categories	All clinical staff

Policy Overview:

This document describes the Trust's policy for making ethically balanced clinical decisions during the COVID 19 pandemic and has been drafted in alignment with the Ethical framework for the Hereford and Worcester Integrated Care Network

Latest Amendments to this policy::

Final draft; 13 April 2020

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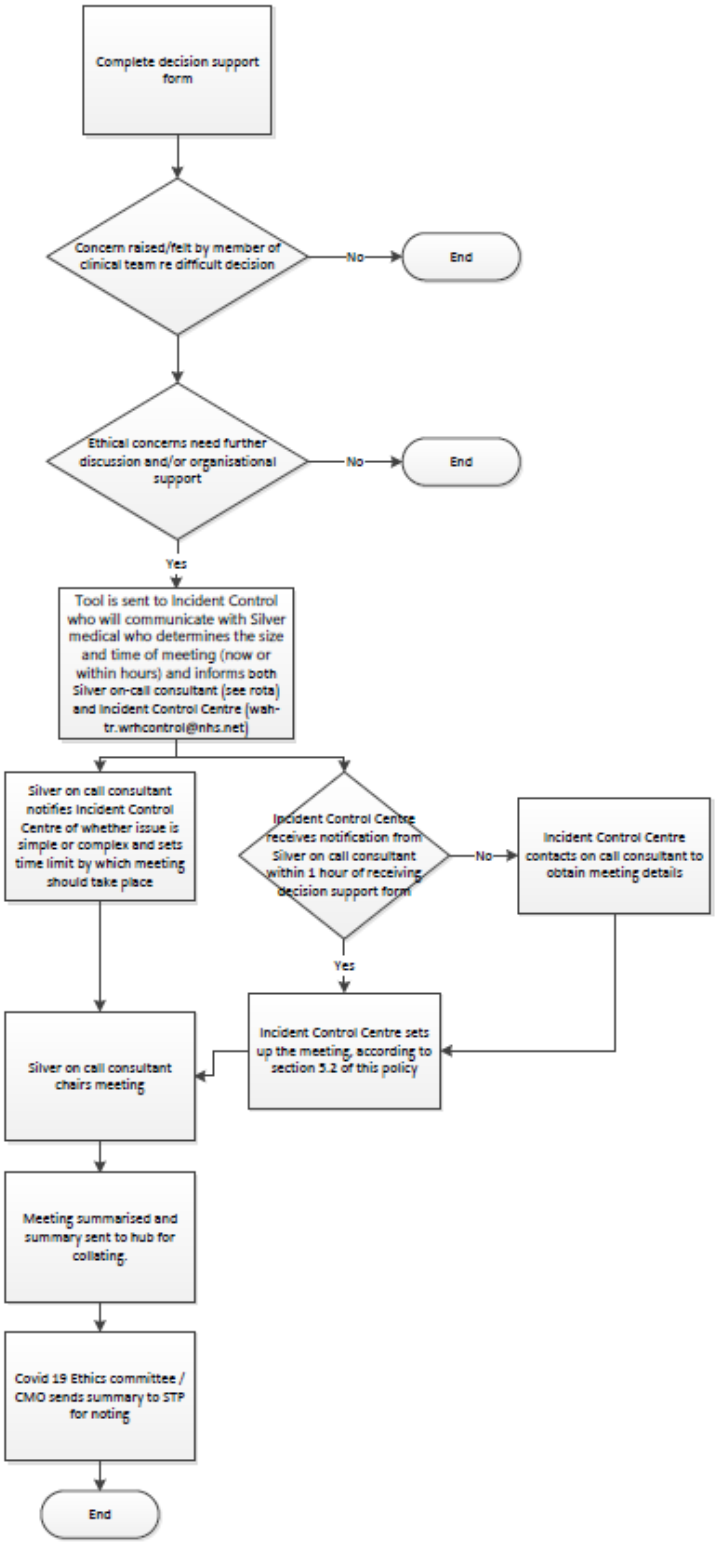

1. Introduction

The British Medical Association advises that doctors will face serious ethical challenges during the COVID 19 pandemic and has issued a guidance note[1] about what they might expect and how they should be supported, particularly whilst working in unfamiliar roles or settings. This policy describes the Trust's framework for supporting doctors and nurses to make difficult decisions and support ethical decisions during the pandemic and is in line with the Ethical Framework approved across the STP (Appendix 4).

Teamwork and mutual support across the whole healthcare team are essential to making difficult decisions. Working together and consulting colleagues regularly, including MDTs where appropriate, recognises that everyone is working in very stressful situations, in different ways and may be exhausted.

In their paper[2], doctors and ethics researchers Dan Harvey & Dale Gardiner, Critical Care Consultants at Nottingham University Hospitals NHS Trust, note that one of the factors that leads to high levels of health professional burnout is moral distress. To quote directly,

> *Moral distress can occur when clinicians feel unable to do what they perceive to be the right thing, or when faced with ethical uncertainty. It is therefore of no surprise that moral distress occurs frequently in providing critical care.*

This will be particularly true during the COVID 19 outbreak when wise clinical decisions in both critical and acute care, and consequent resource allocations, are to be made rapidly and in hitherto un-encountered clinical circumstances.

Making defensible, time-critical decisions is therefore a core requirement of critical care clinicians and those working in acute specialties[3]. Front-line clinicians should rely upon this policy both to provide confidence that ethical considerations have been made comprehensively and as a consistent way of presenting their dilemmas and decisions to colleagues to gain support and to reduce moral distress. The decision support provided and outcomes of related activities undertaken in accordance with the policy will have the support of the Trust Board.

2. Scope of this document

This policy presents a balancing tool for ethically difficult clinical decisions and describes a support framework within which the tool should be used. The tool and the framework are an adjunct to clinical decision-making. Together, they ensure that the inevitable impact of strained or over-whelmed resource availability, due to the COVID 19 outbreak, is given ethical consideration. Use of the tool balances the usual parameters of clinical efficiency and effectiveness with considerations caused by exceptional resource scarcity. When presented in accordance with this policy, the resulting analysis and consequent decision gains collaborative oversight and organisational support.

[1] https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf

[2] https://bjaed.org/article/S2058-5349(18)30145-8/pdf

[3] https://www.rcplondon.ac.uk/file/20726/download

3. Definitions

"*Moral distress*" – a recognised result of the stress of:

- being unable to do the perceived "right thing" for patients and/or
- being tasked with balancing interests of staff, patients and others in an ethically sound way.

"*Resource availability*" - used in this policy in its broadest sense to refer to:

- workforce,
- skills,
- critical care and other acute beds,
- diagnostic facilities,
- equipment
- consumables, including PPE

"*Decision Support* tool" **-** This form can be used to guide and record the decision-making process regarding the level of support an ill patient should receive based on evaluation of interventions and benefit. It is designed to support best practice in decision-making.

Moral Balance tool" - a document completed for each ethically difficult decision in which moral distress is or could be a factor or for which organisational endorsement is needed

"*Framework*"- a process within which the result of balancing ethical considerations is reviewed and supported by senior colleagues and thereby organisationally endorsed

"*Simple*" case – requires an ethical decision in which, although clinicians may be confident in their clinical judgement, support is needed to balance the wishes of the patient and/or family members and/or others in the constrained circumstances and heightened emotions of the COVID 19 outbreak

"*Complex*" case –requires an ethical decision, perhaps incorporating clinical judgement, which is a fine balance, in favour of one patient over another or one group of patients over others.

"*Silver Medical*" on call consultant

The Silver on-call consultant is the Trust's link to other medical management within the emergency response system. He/she manages tactical implementation following the strategic direction given by Gold, making sets of actions that are completed by Bronze (i.e. consultant and specialty teams). A gold–silver–bronze command structure is a command hierarchy used for major operations by the emergency services of the UK.

Emergency management hierarchy	
Gold	Strategic
Silver	Tactical
Bronze	Operational

"*Incident Control Centre*" – (from 10th April) located in the conference room on the first floor of the Worcestershire Oncology Centre, manned 8am to 8pm, responsible for answering queries, supporting Silver command and organising and noting important meetings, including virtual meetings, related to management of the COVID 19 outbreak.

4. Responsibilities and Duties

- COVID 19 Ethics Committee – implements this policy
- Silver on call consultant – manages operation of this policy
- Incident Control Centre – supports operation of this policy
- Consultant staff and their teams – follow this policy
- Nursing, ward and department staff – follow this policy

5. Ethical decision-making during COVID- 19 outbreak

Ethically defensible, balanced decisions need to be made quickly and with clarity during the outbreak. This policy outlines two steps to be taken to achieve this aim.

5.1. Step 1: Apply the *Decision Support* tool.

Based on a recognised seminal work[4] regarding ethical decision making in medical settings, the tools are at appendix 1. Clinicians should follow and document the recommended four steps:

i Establish the facts of the decision in question.
ii Decide what is in scope and out of scope.
iii Specify the outcomes within four recognised principles of ethical decision making
iv Balance the principles to give them action-guiding capacity.

Used at the bedside, these tools facilitate a structured analysis of ethical issues, helping to:

- Expose bias within decisions,
- Suggest compromise or alternative resolutions
- Aid communication.
- Clarify disagreement, which may persist but will be clear and documented.

Where ethical issues are identified which need further support these can be identified to raise with the Ethics Group for exploration. When decisions are later challenged by patients, families or external authorities, this transparent process will have led to a defensible, documented conclusion.

5.2. Step 2: Obtain review and organisational endorsement of the ethically balanced decision

The majority of decisions on patient management can be made on routine criteria. Where there is likely to be *moral distress or there are unresolved ethical issues* arising from a decision, the COVID 19 Ethics group encourages consultant teams, in collaboration with the relevant department's senior nurse/ Matron on duty to obtain review and endorsement of both simple and complex ethical decisions before taking action. These decisions should be based on the values outlined below:

Value	Description
Accountability	Measures are needed to ensure that ethical decision-making is sustained throughout the crisis and aligned to STP Ethical framework

[4] Principles of Biomedical Ethics. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. Oxford: Oxford University Press; 2001

Inclusivity	Decisions should be taken with stakeholders and their views in mind
Transparency	Decisions should be publicly defensible
Reasonableness	Decisions should be based on evidence, principles and values that stakeholders can agree are relevant to health needs, and these decisions should be made by credible and accountable members of staff
Responsiveness	Flexibility in a pandemic is key. There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis, as well as mechanisms to address disputes and complaints

The process of review is as follows:

On request, the Silver on call consultant will assemble a panel of experienced colleagues to assist and endorse balanced decision making.

Simple cases: Supported by the Incident Control Centre, the Silver consultant will convene a review panel of four clinicians, comprising him/herself, as chair of the panel, a hospital consultant, a Senior Nurse and a GP. This group will be supported by a member of the Chaplaincy service. In a virtual meeting of no more than 45 minutes duration, the panel will ask the clinical team to present their decision, using the *Moral Balance* tool as a presentation aid. Together, the panel and the clinical team will review and explore any areas of uncertainty, enabling the clinical team to define a course of action. The team will implement that agreed course.

Complex cases: the process is as that for simple cases, above. Additional panel members, will be included, namely the CMO/deputy CMO or CNO/Deputy CNO and a Divisional Director.

The quick reference guide at the beginning of this policy contains the steps required to call for a review. The roles of Incident Control Centre and the Silver on call consultant within this policy can be found at appendix 3 .

6. Implementation

6.1 Plan for implementation

The policy will be implemented once approved by the Executive team and will be a resource for cases in both secondary and primary care cases.

6.2 Dissemination

The policy will be circulated to all clinical staff within the trust and Health and Care trust. It will be made available to the Clinical Directors in the Worcester Primary Care Networks for their information.

6.3 Training and awareness

Due to constraints over meetings during the current conditions, training and awareness will be by regular communications from the central team.

7. Monitoring, compliance and risks associated with this policy

Compliance with this policy will be measured by:

- Collation of Decision Support forms for central review
- Triangulation with data from established incident and complaints management policies to identify when and if the *Moral Balance* tool has been used.
- Spot audits of a selection of notes of patients with COVID 19 and collection of anecdotal evidence to consider/establish the completeness of documentation and the frequency of use of:
  - the Decision Support tool
  - the number of *Decision Support* tool enabled decisions which were endorsed by a Silver panel

Number of referrals to the Ethics Group	
Number of decisions where ethical concern resolved or influenced	
Number of cases where resolution not achieved	
Number of complaints related to decisions	
Review of cases by the Medical Examiners	

The effectiveness of this policy will be shown by the number of cases where the ethical concerns of the clinical teams, patients and families are resolved by the panels. There will be an evaluation of responses to complaints or other challenges which rely on, or incorporate, evidence documented within the *Moral Balance* tool

The COVID 19 Ethics committee has agreed the following risk assessments with regard to this policy:

- Ethically balanced decisions are not documented – the tool's use reduces this risk
- Trust is accused of unethical decisions with regard to individual factors such as protected characteristics – use of the tool shows how these risks were balanced in the circumstances at the time the decision was made

8. System reporting

The COVID 19 Ethics Committee will summarise and report ethical decisions made according to this policy to the Herefordshire and Worcestershire COVID 19 Ethics Committee. The committee meets monthly. Reports should be made two days before the date of the meeting.

9. Policy Review

This policy is extant throughout the duration of the COVID 19 outbreak. The COVID 19 Ethics Committee will carry out an early review for practicality and amend if necessary by 31st May 2020. Thereafter, review will be 6 monthly for necessity and practicality.

10. References

References:	Code:
Other Trust policies	
Management of clinical incidents	
Management of patient complaints	
External references	
See footnotes	

11. Background

11.1 Equality requirements

See supporting document 1 (attached)

11.2 Financial risk assessment

See supporting document 2 (attached)

11.3 Consultation

The policy will be communicated to the ICS Ethics Forum

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Trust Chair
Chief Executive Officer
Executive directors
Incident Control Centre lead – Lisa Peaty
DDs
Clinical Directors

This key document has been circulated to the chair(s) of the following committees/groups for comment;

Committee
Quality Governance Committee

11.4 Approval Process

The policy will be approved by Trust Management Executive the Trust Board.

11.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

6th April 2020	First draft for comment	J Ball
7th April 2020	2nd draft for review • MH comments on 1st draft incorporated • Decision Support tool amended per MH review and new version inserted • *Moral balance* document inserted for use "as required"	J Ball
13 April	Revised flow chart inserted	M Hallissey

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Affix patient sticker here

Hospital admission date:

Date of assessment:

Time of assessment:

Appendix 1

Patient Care: Decision-Support

This form can be used to guide and record the decision-making process regarding the level of support an ill patient should receive, based on evaluation of interventions and benefit. It is designed to support best practice in decision-making.

Evidence: Clinical

Acute presentation:

Past Medical History:

Recent cardiac arrest in last 3 years		There is a recognition that an increasing number of the listed co-morbidities, increasing frailty and age will adversely impact on outcome and escalation will be associated with limited benefit.
Congestive heart failure with symptoms on minimal exertion		
Hypertension		
Severe and irreversible neurological condition inc. dementia		
Chronic Lung disease with symptoms at rest or mild exertion		
Liver disease with Child-Pugh score 7 or greater		
Dialysis		
Diabetes mellitus on medication		
Active or Uncontrolled malignancy		
More than 3 admissions in last year		
Prolonged hospital admission in last 12 months		
ICNARC outcome from pneumonia by age: **16 – 49** 14.7%, **50 – 59,** 25.9%, **60 – 69** 33.7%, **70 – 79** 42%, **80+** 51.3%		PF WR5382 Clinical Frailty Screening Too
Rockwood Frailty score:		

Evidence of discussion with patient and next-of-kin Please see my (DE) comments on previous version reviewed regarding patients with capacity and need to check for LPA, ADRT, ACP

Ensure a RESPECT form is completed see COVID Guidance:

4- ReSPECT COVID-19 Recomme

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Making ReSPECT COVID-19 Recommendations - Guidance

Assess for the presence of significant LTCs and frailty
Decide on what treatment is recommended

↓

Ask where the patient places themselves on the spectrum / line between prioritising sustaining life (at all cost) and focusing on symptom control (with no attempt to sustain life)

↓

Record this position in section 3 of the ReSPECT plan

↓

Stress the positive components of supportive care and treatment that you are recommending as below. Explain treatment on offer which is a supportive treatment

Oxygen therapy and antibiotics if clinically appropriate	Oxygen therapy and antibiotics if appropriate followed by consideration of escalation to non-invasive ventilation	Oxygen therapy, antibiotics if appropriate, non-invasive ventilation and consideration of escalation to critical care ventilation / interventions

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Balancing burdens and benefits of escalating treatment

Do the burdens of attempting CPAP outweigh the benefits for this patient?

☐ Yes
☐ No
Explanation

Do the burdens of intensive care escalation or continuation outweigh the benefits for this patient?

☐ Yes
☐ No
Explanation

Ethical concerns identified which require support: Yes ☐ No ☐

If yes list below:

1.

2.

3.

Contact Incident Control Centre if wish to arrange discussion of Ethical concerns. Forward copy of **this form to: wah-tr.wrhcontrol@nhs.net**

Recommended treatment

☐ For active treatment and admission to the intensive care unit
☐ For active treatment on the ward, with escalation to ICU if deteriorates.
☐ For active treatment with ceiling of ward-based care including CPAP. DNACPR. If deteriorates, for end-of-life care.
☐ For active treatment with ceiling of ward-based care but not CPAP. DNACPR. If deteriorates, for end-of-life care.
☐ For active symptomatic treatment. DNACPR. If deteriorates, for end-of-life care.
☐ Not a candidate for further escalation of treatment in ITU.
☐. For withdrawal of IMV/CPAP due to treatment failure and commencement of active symptomatic treatment. DNACPR. If deteriorates, for end-of-life care.

Individuals contributing to decision Please see my (DE) comments on this in previous version returned

Consultant

Name and GMC no :_____Signature:_____

Senior Clinical Decision Maker 2 if necessary (including telephone discussion)

Name:_____Signature (if available): _____

Grade:_____

Senior Clinical Decision Maker 3 if necessary (including telephone discussion)

Name:_____Signature (if available): _____

Grade:_____

If you wish, use the following tool to analyse relevant elements of your ethical decision

MORAL Balance

An Ethical Framework to aid Medical Decision-Making[5]

What is the medical decision you are trying to make?

Make sure of the Facts – refer to decision support form if sufficiently comprehensive

Outline the facts of the case and decision in question (e.g. diagnosis, prognosis, comorbidities, frailty, all treatment options, verbal or written statements, resources). Include degree of uncertainty if present.

5

Outcomes of Relevance to the Agents Involved – refer to decision support form if sufficiently comprehensive

Agents are anyone who has a moral stake in the outcome (e.g. patient, family, other patients both in the hospital and outside the hospital, hospital staff, and society). Try to outline what outcomes matter most to these agents, especially taking account of any conversations you have had.

Patient

Patient's Family

Other Agents

Level out the Arguments in a Balancing Box

Populate facts and outcomes into a Balancing Box which uses Beauchamp and Childress's[6] four principles of medical ethics.

Autonomy *(what outcomes matter to the patient)*	**Burden** *(what are the burdens and to whom)*
Benefit *(what are the benefits and to whom)*	**Justice** *(fairness in the distribution of benefits and risks)*

Level out the arguments by seeing if you can balance the calls of each principle and judging if each fact or outcome is truly commensurate?

Consider asking three questions of the Balancing Box:
(i) Anything of particular note?

(ii) Where is the greatest conflict?

(iii) Where is the greatest congruence (agreement)?

[6] Principles of Biomedical Ethics. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. Oxford: Oxford University Press; 2001

Document Decision (it can be helpful to use the framework to help guide documentation or place this sheet in the medical notes)

COVID 19 – examples of use of balance box principles in ethical decision making

Useful examples of using balancing box to make difficult ethical clinical decisions during the COVID 19 pandemic can be found at http://www.moralbalance.org/covid19/covid19hypothetical/

Role descriptions for those operating this policy –

- Presenting team
  - Identify the ethical concerns that their decision presents to them

- Silver consultant on call
  - The meeting chair

- Incident Control Centre
  - Co-ordinates the requests and establishes the meeting

- COVID 19 Ethics Group
  - Contribute to the ethical discussion to help the clinical team resolve any ethical dilemmas

Appendix 4

Meeting	**Herefordshire and Worcestershire Ethics Forum (COVID-19)**
Date Agreed	**3rd April 2020 by Martin Lee, Chair of H&W Clinical Leadership forum**
Chair	Professer Tamar Thompson – H&W CCG Lay member
Purpose	A H&W system ethics forum operating during the COVID-19 response, to review and consider the ethical implications of **national guidance** regarding the response to COVID 19, and to ensure local implementation: • Provides an objective review of decision-making frameworks for clinicians, that optimises the clinical effectiveness of our available resources, to optimise individual and population outcomes • Is undertaken with full understanding of ethical considerations – recognising provider ethics committees' establishment for effective decision making • Is undertaken with an understanding of associated risks, with clear recommendations on how the system, organisations and individual practitioners can mitigate those risks *The provider Trusts have their own ethical committees specifically related to COVID-19 to make time critical patient decisions around treatment*.
Key responsibilities	The key responsibilities of the ethics forum are: • To ensure H and W STP commissioning policies, clinical policies and practices relating to the COVID-19 response: 1. Are undertaken within an appropriate ethical framework 2. Optimise the population benefit from available resources 3. Ensure equity and fairness in access to care and services • To ensure that these policies and practices support organisations and individual clinicians with appropriate and objective decision-making frameworks at population and patient level • To collate and scrutinise decisions and underlying rationale ensuring this fits with the ethical framework • To act as an efficient and effective mechanism to share learning and implementation of best practice across the H&W system

Decision making	• All members are senior officers of health and care partners in H&W and with this bring the authority to provide a clear view from and commit to taking action on behalf of their organisation. • Forum members will work collaborateively to reach consensus where a decision is required
Membership	All members have equal standing and are required to attend each meeting. In their absence they are to nominate a constant deputy with appropriate authority. Additional attendance is invited for specific clinical topics. H&W CCG • Lay chair • Director of integration and STP Programme Director (SRO) • Interim medical director (Quality and assurance) • Secondary care clinician • Chief nursing officer H&W Providers • Medical Director – Wye Valley NHS Trust • Medical director – Worcestershire Acute Hospitals NHS Trust • Medical Director – Worcestershire Health and Care NHS Trust • GP Provider Board representative • Non-executive director - Deputy Chair WAHT • Non-executive director - Chair of ethics forum System partners • Faith Leader/Chaplain – On behalf of H&W provider chaplains • Public health • Hospices / End of life representative Contribution as required • Medical consultants with Ethics MA – Worcestershire Acute Hospitals NHS Trust **Quoracy** • Executive level clinical representation from H&W CCG and all H&W Providers • 2 lay or non-executive members
Relationships with	**Relationships with other forums**

other comittees & reporting	• There will be a direct relationship with the provider ethics / clinical comittees • There will be a timely link into regional and national structures as required **Reporting** • Into Clinical Leadership forum through to ICS Executive forum • The minutes and actions log will be shared with the H&W CCG Clinical comissioning and executive committee
Frequency and structure	**Frequency and structure:** • Meetings will be held at a required frequency from the 1st of April 2020 • Meetings will be held via video or teleconference using Microsoft Teams • Papers will be circulated atleast 2 working days before the meeting
Review of ToR	• The authority to approve and amend the ToR sits with the H&W clinical leadership forum • ToR to be formally reviewed every 3 months

Version Control:

Version Number/Date produced	Date	Brief Summary of Changes	Circulated to
0.1	31.03.2020	Drafted from initial discussions held	Chair and SRO's
0.2	31.03.2020	Updated with amendments from ATS	H&W Ethics forum
0.3	03.04.2020	Updates from HW IC 01.04.2020: • Single SRO for committee – ATS • NED for WVT added to membership • Medics with ethic MA added as contributors • Link to regional and national work • Frequency flexible • Review of ToR to be 3 monthly	ML, ATS, TT, CM
1.0	03.04.2020	Final ToR approved by TT and ML on behalf of the CLF	H&W Ethics forum members
2.0	06.04.2020	Renamed from committee to forum due joint CCG and provider membership	H&W Ethics forum members

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Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	Pt choice may be a factor in treatment decisions
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	Older patients may not be good clinical candidates for treatment
2.	**Is there any evidence that some groups are affected differently?**	Yes	Early clinical evidence re COVID 19 suggests those with existing co-morbidities may not be candidates for treatment escalation
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	Yes	Yes, all decisions justifiable according to this policy
4.	**Is the impact of the Policy/guidance likely to be negative?**	Yes	See risk section of policy
5.	**If so can the impact be avoided?**	No	Yes, by implementing this policy for ethical decision making
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**		None
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

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Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

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Putting patients first May 2019

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	Enc C4

Financial Controls during Covid-19

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Robert D Toole, Chief Finance Officer		
Presented by	Robert D Toole, Chief Finance Officer	**Author /s**	Katie Osmond, Deputy Director of Finance Jo Kirwan, Assistant Director of Finance

Alignment to the Trust's strategic objectives							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	x	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Trust Board are asked to: • Seek assurance from the approach to maintaining financial control and effective use of resources during COVID-19. • Note the spend incurred to 31 March 2020 on COVID-19

Executive summary	This report provides assurance on our financial governance, systems and processes during COVID-19, and specifically: 1. The approach to maintaining financial control; 2. COVID-19 Expenditure commitments to date; 3. Chair's action decisions; and 4. NHS Cumulative Deficit Resolution

Risk								
Key Risks	BAF Risk 6 - *If we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfil our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.* BAF Risk 7 - *IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective and efficient care to patients.*							
Assurance	We have reviewed our financial governance, systems and processes in light of our Business Continuity Plan and recognised best practice, and are assured that appropriate steps have been taken.							
Assurance level	**Significant**	*x*	**Moderate**		**Limited**		**None**	
Financial Risk	*If we do not have robust financial governance, systems, processes and controls during the COVID-19 period then there is a risk that we are not able to evidence appropriate stewardship of public funds, and that elements of cost incurred will not be reimbursed nationally.*							

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Putting patients first May 2019

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	Enc C4

Introduction/Background

On the 17th March Sir Simon Stevens - NHS Chief Executive and Amanda Pritchard - NHS Chief Operating Officer (NHS England and NHS Improvement) wrote to NHS organisations and Local Authorities regarding next steps in NHS response to COVID – 19, setting out important actions to be put in place, including the approach to financial governance and contracts. Further guidance has been published over recent weeks, and there is a regular national briefing for Chief Finance Officers.

Issues and options

1. Maintaining financial control

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance.

In response to this we have reviewed our financial governance, to ensure decisions to commit resources in response to COVID-19 are robust, and that financial information can be collected and coded that is auditable and evidenced. We have cascaded fraud awareness briefings to the wider organisation, and specific fraud alerts to relevant leads to ensure we continue to be vigilant to the risk of fraud.

The Standing Financial Instructions (SFIs) and Scheme Of Delegation (SOD) remain in force, including the procurement rules and it is expected that budget managers and holders continue to adhere to them. COVID-19 related spend follows an interim process for approvals, within the standard delegated limits as described below.

Delegated Authority – COVID-19 related spend

In terms of decision making, where the relevant voting Executive is satisfied that the request is valid, and aligned to the NHSI guidance for central reimbursement (seeking finance support as required) they will consider the appropriateness of the request assessing the need and risk. In line with the COVID-19 governance structure, delegated authority and approval routes for COVID-19 related spend are as follows:

- Up to £100k – Requires Voting Exec – approved through Bronze / Silver (*equipment requests approved via COO and reported to Bronze*)
- £100k - £250k – Requires CFO – recommendation from Silver for decision at Gold
- £250k - £500k – requires CEO – recommendation from Silver for decision at Gold or subsequent ratification by CEO
- >£500k – requires Trust Board – decision at Gold, ratify through virtual Board / Chairman Action

The decision to spend or not to spend is logged and communicated to finance and procurement colleagues. Inclusion of procurement at the point the decision is documented helps minimise delays. Inclusion of the finance team ensures that all COVID-19 related spend is captured and tracked for reporting centrally.

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Interim Financial Systems and Process changes

In response to the current situation, and the changed ways of working we have implemented a number of practical system and process changes to ensure that delays in approvals or transactions are minimised, and to increase flexibility. These are consistent with ensuring we can maintain those functions identified as critical within the Finance Directorate Business Continuity Plan. Examples include:

- Increased cross cover for critical finance processes (per the Directorate Business Continuity Plan) whilst maintaining segregation of duties.
- Increase in cash balances being held in the debit card account to ensure no delays in processing of urgent transactions.
- Increase in credit card limit.
- Streamlined tender waiver process to permit placing of orders in advance of the fully completed waiver, subject to procurement team agreement in principle.
- Reviewed cashiering / cash collection and banking procedures and introduced mitigations from a security and cash handling perspective.
- Amended payment policy to support the National request for prompt payments to suppliers.
- Introduced a new process to monitor top up stock levels, particularly for PPE through the procurement team to ensure that limited stock is robustly managed with clinical input as to its allocation to wards and departments.
- Increased support into the materials management team to ensure resilience in the supply chain function.
- Verification of all new / possible suppliers and agents/distributors/intermediaries with review of publicly available information and various searches including those introduced by friends/supporters of the Trust or who have approached the Trust's charity. No upfront payments or deposits have been endorsed or approved.

Best Practice Guidance

The Healthcare Financial Management Association (HfMA) published a briefing paper in March 2020 setting out Covid-19 financial governance considerations for the NHS. We have reviewed the briefing and are satisfied that our governance processes address the material considerations raised. We have continued to liaise closely with finance colleagues across the Midlands to share best practice and learning.

Charitable Funds

It is important to note that financial governance and control during COVID-19 applies equally to the Trust Charitable Funds. With increased donations, both of cash and products (for which we are enormously grateful to the local public and businesses), and time critical requests for support it is important that strong financial governance is maintained. Similarly to exchequer funding, the HfMA have published a guidance document in regards charitable funds governance. This has been shared with the fundraising team to ensure we are following best practice.

2. COVID-19 Expenditure Commitments

Cost Reimbursement

Additional funding to cover extra costs of responding to the coronavirus emergency is being made available to NHS Trusts. Guidance on how to estimate, report against, and be

reimbursed for these costs has been issued. Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. To date, all claims have been fully reimbursed.

The table below shows the financial implications of COVID-19 to the 31 March 2020. Costs beyond that date are being collated for the next monthly submission. The table reflects revenue expenditure items, lost directorate income and capital spend. We are not required to report any impact on healthcare income as guidance requires Providers and Commissioners to work together to mitigate impacts within the system for 2019/20.

2019/20 Summary of Covid-19 Cost Reimbursement

Total Revenue (£ms):	£1.14
Total Loss of Income (£ms):	£0.04
Total Capital (£ms):	£0.20
Total Cost Reimbursement (£ms):	**£1.38**

3. Chair's Action

To date, it has not been necessary to seek Chair's action as no individual items of expenditure have exceeded the delegated limit of £0.5m.

4. Reforms to the Capital and Cash Regime

The debt position has been of significant concern for a number of years, resulting in reliance on short term cash borrowing, increasing financial charges associated with borrowing, and the resultant implications for our assessment of Going Concern alongside significant challenges in investing in infrastructure replacement due to limited capital funds. We welcome the national announcement that new Public Dividend Capital (PDC) will be issued to repay over £13 billion of the NHS' historic debt, in effect writing off the Trust's historic debt.

Our revenue and capital borrowings (excluding PFI related debt) at the 31 March 2020 amount to £338.8m. Whilst conversion of this this debt to PDC will remove the associated interest charges, it is expected that the Trust net assets position will mean that PDC dividend is payable at its current rate of 3.5%.

We have received assurance from NHS E/I that any increase in the overall cost as a result of the change will be mitigated through the COVID-19 central top up payment arrangements, and post COVID-19, through the Financial Recovery Fund and Financial Improvement Trajectories. At a Trust and system level therefore, this does not make our financial sustainability challenge any greater.

From a capital funding perspective, removing the current requirement to repay loans as a

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first call on internally generated funds means there will be greater locally available capital to progress the most critical backlog works.

Conclusion

We have and continue to review our financial governance, systems and processes to ensure they remain robust, flexible and responsive to the needs of the Organisation during COVID-19. We have considered this in light of our Business Continuity Plan and recognised best practice, and are assured that appropriate steps have been taken.

Recommendations

Trust Board are asked to:

- Seek assurance from the approach to maintaining financial control and effective use of resources during COVID-19.
- Note the spend incurred to 31 March 2020 on COVID-19

Appendices

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Putting patients first May 2019

Meeting	Trust Board
Date of meeting	23 April 2020
Paper number	D

Integrated Performance Report – Month 12 – 2019/20

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Paul Brennan – Chief Operating Officer / Deputy Chief Executive		
Presented by	Paul Brennan – Deputy Chief Executive & Chief Operating Officer	**Author /s**	Nikki O'Brien – Associate Director of Information and Performance

Alignment to the Trust's strategic objectives							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	22nd April 2020	

Recommendations	The TME/Board is asked to note this report for assurance.

Executive summary	This paper provides the TME/Trust Board with an overview of March 2020 and financial year end performance 2019/20, against the trajectories, specifically for the NHS constitutional standards and the key operational and quality metrics. In March 2020, the performance of several key measures has been negatively impacted by the Trust's rapid implementation of emergency planning protocols. The impact of the temporary cessation of some services, restrictions of physical ward capacity and high staff absence rates have limited our ability to achieve some targets as expected.

Risk

Key Risks	BAF 1,2,3,4,5,6,7,8,10 and 11

Introduction/Background

This paper provides the Board with an overview of March 2020 and financial year end performance 2019/20, against the trajectories, specifically for the NHS constitutional standards and the key operational and quality metrics.

In March 2020, the performance of several key measures has been negatively impacted by the Trust's rapid implementation of emergency planning protocols. The impact of the temporary cessation of some services, restrictions of physical ward capacity and high staff absence rates have limited our ability to achieve some targets as expected.

Please note: All except the Emergency Access Standard and Patient Flow measures are 'unvalidated' as at the time of writing final national submissions have not been made.

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Issues and options

Operational performance
4-hour emergency standard and patient flow

- We did not achieve the March/year-end target of 86% for the 4 hours emergency standard. Our performance was 77.90%.
- Despite seeing improvements early in 2019/20, the cumulative year-end performance closely mirrored performance in 2018/19 of 77.68%.
- We did not achieve 0 ambulance handover breaches for March/year end. Our performance for March was 88 (15 of these were at the Alexandra Hospital, the others all occurred at the Worcestershire Royal Hospital).

The Worcestershire Home First Programme oversees several projects, one is responsible for developing a clearly defined streaming service (towards alternative same day emergency care within the hospital and to GPs), and another is to redesign the same day emergency care services that we provide. The successful delivery of these two projects will reduce the attendances at the Emergency Departments and will assist in reducing the number of handover delays and people waiting to be seen. At the start of March 2020, the project plan for same day emergency care had been agreed and governance arrangements had been put in place. The first drafts for pathway redesign were in place and being reviewed.
Although progress on these projects continues during the COVID-19 incident, the additional operational challenges have hindered progress and the implementation of service changes.

During the last two weeks of March, attendances at both Emergency Departments started to decrease as patients adhered to the national guidance to only undertake essential travel and to contact NHS 111 in the first instance for all none life threatening conditions.

- Comparing pre COVID-19 Emergency Department attendances (1st - 21st March) and post COVID-19 attendances (from 22nd – 31st March), we have seen a reduction of 38%.
- We had 47 patients breach the 4-hour emergency standard between 22nd-31st March.
- We have had 47% fewer patients self-presenting at the Emergency Department and 47% less ambulance arrivals between 22nd-31st March compared to the weeks prior.
- We were admitting 30.7% of attendances prior to 21st March and 36.7% between 22nd-31st March. This is indicative of attendances being more 'serious' in nature as the COVID-19 social distancing rules came into play.

The SAFER project within Home First has been providing improvements in more timely discharges (before midday), increasing usage of the Discharge Lounge and a reduction in the long length of stay patients (those staying in the Acute hospital longer than 7 days).

During March we:

- Through dedicated focus and an enhanced system support offer, we met the year-end target of having no more than 72 patients with a length of stay over 21 days. At the end of March we had 38 patients, the reduction had released significant bed days. **(Annual plan priority**)
- We achieved 30% of all discharges being before midday, with monthly performance of 31%. The implementation of criteria led discharges across all Wards, and Red to Green, influenced this metrics positive performance **(Annual plan priority**)

- Following 5 consecutive months of increased usage of the Discharge Lounge, March did not see the same volumes of patients going to the Discharge Lounge. However, we have had fewer patients than in previous months in the hospital since the COVID-19 incident started.

The internal professional standards have been launched for the Emergency Departments, however it is difficult to identify from the data, the impact of these, as pathways have been changed to accommodate suspected COVID-19 patients.

The timelier discharges of patients helped to release bed capacity with the aim of having beds available at midnight. At the re-launch of the Worcestershire Home First Programme in October 2019, we had an overnight bed capacity shortfall of 57 beds across both sites. The 'earlier in the day' discharges, successful funding bid to re-develop the Aconbury unit and reorganisation of physical ward usage to ensure that the right bed allocation is provided to meet the levels of demand at speciality level, have all contributed to reducing this gap.

- We have seen a reduction in the overnight bed capacity gap from an average of 45 (Oct 19) to 21 (Mar 20) at the Worcestershire Royal Hospital and from an average of 12 (Oct 19) to 4 (Mar 20) at the Alexandra Hospital.

The bed occupancy at both sites has undoubtedly been impacted by the COVID-19 incident in the last few weeks of March and into April. With additional capacity provided by the system, doctors being less risk adverse, and staff absences are undoubtedly influencing the timeliness of discharges and reduction of length of stay for patients who do not appear to have COVID-19.

- Bed occupancy at the Worcestershire Royal Hospital had an average March occupancy of 80%, but was 57% on the last day of March.
- Bed occupancy at the Alexandra Hospital had an average March occupancy of 72% and was 50% on the last day of March.
- Total available beds of 352 beds were unoccupied on the last day of March. (Note: that during the initial weeks of the COVID-19 incident we had 21.6% of the workforce absent, therefore our ability to have staffed these beds would have been restricted).

Referral to treatment (RTT)

- We had expected to achieve the March/year-end target of 82.43%, but due to the cancellation of all routine elective surgery and a reduction in outpatient activity in the last weeks of March, we did not achieve the target. Our 'unvalidated' performance for March 2020 was 76.71%.
- We did achieve the target of having no patients breaching 52 weeks for first definitive treatment.

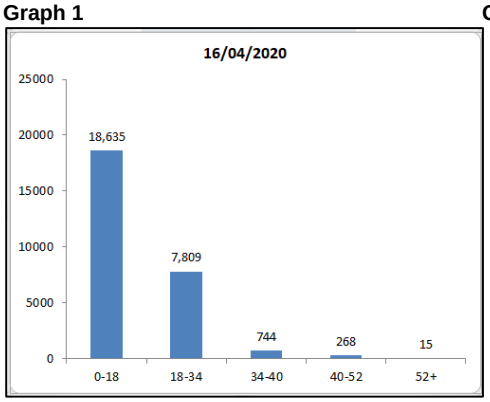
During the last two weeks of March, we had 7,198 appointments cancelled with the formally recorded reason of 'COVID-19'. 6,681 appointments were cancelled by the hospital and 517 cancelled by patients not wanting to come onto a hospital site. Note: these cancellations include all appointments types.

However, the recording of cancellation reasons has significant data quality issues, and in reality we had 10,000 more cancellations that any other month in 2019/20, therefore it is likely

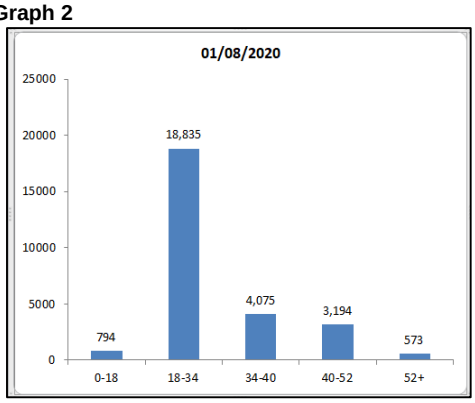
that the 7,198 is under-reporting the impact of COVID-19 (on RTT) in March.
We have modelled the impact of the current RTT PTL for the patients awaiting their first definitive treatments. Graph 1 and 2 are for routine referrals only, comparing the impact mid-April (which is when the modelling was updated) to 1st August 2020.

RTT Waiting List Distribution – Routine Patients
(as at 16th April and forecast to 1st August)

Graph 1



Graph 2



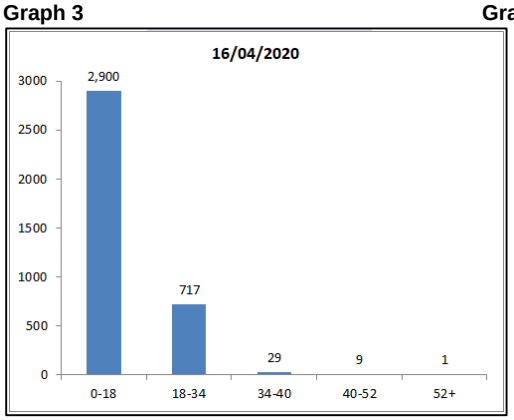
Note: These graphs are only considering the current referred patients and does not consider new referrals that may come in and be below 18 weeks.

As you can see we have the potential by August to have significant growth in patients with routine referral pathways having waited longer than 40 weeks for their first definitive treatments and have the potential for high numbers of 52 week breaches.

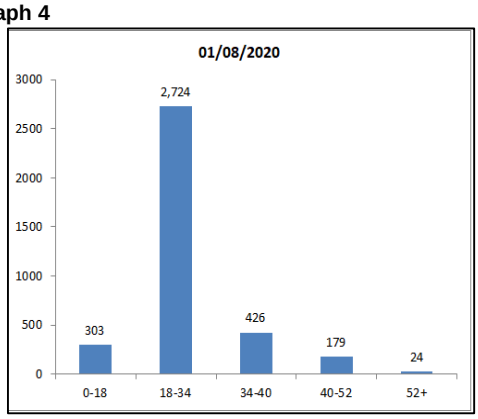
The same profiling is reflected in the Urgent elective (non-cancer referrals) - see Graph 3 and 4. These patients are being monitored by consultants and if necessary may receive treatment in the escalation capacity which is being provided by the private sector at the local private sector capacity at BMI and Priory.

RTT Waiting List Distribution – Urgent Elective Patients
(as at 16th April and forecast to 1st August)

Graph 3



Graph 4



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In order to protect our patients we have converted a number of face to face (new and follow up) outpatient appointments to telephone or video consultations. These new ways of working should continue post COVID-19 to contribute towards the national target of a 30% reduction in face to face consultations as set out in the NHS Long Term Plan.

It is likely that the number of telephone consultations is currently being under-reported as the reporting processes catch up with the reality of what is being delivered, but our activity currently shows that we delivered 33,000 telephone consultations from a total of 39,000 appointments in March 2020 (this data excludes 2ww cancer appointments).

Cancer

- Although the data is 'unvalidated' we have achieved the March/year-end target for 2ww cancer of 93.10%, with performance of 93.69%.
- Breast symptomatic performance also recovered in March and we did achieve the March/month end target of 84.80%. Our 'unvalidated' performance is 85.09%.
- We had 49 patients who had been waiting over 104 day waits for treatment at the end of March so we did not achieve the March/year-end target.
- We did not achieve the March/year-end target for Cancer 62 days (all cancers) which was 86.04%. Our 'unvalidated' performance was 73.76%.

Following some significant capacity and performance issues in 2019/20, the 2ww Breast symptomatic performance has recovered, which in turn has improved the 'all cancers' 2WW performance. There has been significant activity in Breast in recent months with a focus on recruitment and robust recovery planning. The future focus is to ensure robust management of resources to prevent the fluctuations in performance seen in the previous two years.

COVID-19 has had some impact on Cancer performance in the last few weeks of March, but as this group is one of our most vulnerable, this has been as minimalised as possible through use of private sector capacity. As mentioned in the paper **'Caring for our other acutely ill patients'** there has been a change in the physical location that Cancer surgery is being delivered from. The plan is that we can provide close to the full capacity that we have on the Trust sites and therefore we can still deliver the operative treatments these patients require. However this is dependent on the availability of PPE.

2WW outpatient appointments continue albeit using telephone consultations. We delivered 1,676 telephone consultations and 72 face to face for patients on a 2ww pathway (new and follow up).

We have been reporting that we have a backlog of patients who have been waiting longer than 62 days for Cancer treatment. During March we treated 195 patients which is the highest volume during 2019/20, but of those treated, 48.5 had already breached 62 days.
The specialties that continue to have backlogs impacting the overall performance are Urology, Head and Neck and Lung (albeit Lung is small numbers and has a high volume of tertiary referrals).

Diagnostics

- We had expected that the diagnostic performance would meet the March/year-end target of 99.03% of patients having their diagnostic within 6 weeks of referral. Our performance was 97.34% (unvalidated).

At present we are unable to provide any granular information regarding why performance has deteriorated. Unfortunately, a process used to cancel appointments from the management information systems has impacted the reporting. We are currently working hard to resolve the issue and provide detailed information on the performance. We are assured that operationally these patients are known.

For RTT, Cancer and Diagnostics, we had modelled the 20/21 trajectories ready for submission as part of the Annual Planning contracts. We are awaiting national and regional guidance about when to re-model as the performance will now look very different considering the impact of the global COVID-19 pandemic.

Stroke

- At the end of March/year end we met the target of seeing 70% of TIA patients within 24 hours from referral. We saw 87%.
- We did not meet the target (90%) of patients with a suspected Stroke being directly admitted to the Stroke Ward. Our performance was 62.2%.
- We did not meet the target (80%) of patients having a CT scan within 60 minutes of arrival. Our performance was 63.8%.
- We did not meet the target (80%) of patients with a Stroke spending 90% of their admission on the Stroke ward. Our performance was 74%.

Despite not meeting 3 of the targets, there was improvement in every measure compared to the previous month. The other therapy based performance measures for Stroke are performing well and have contributed towards achieving a Band B from the Sentinel Stroke National Audit, so further improvement will need to be based on achievements of the metrics above. The Stroke unit is part of the escalation plans for COVID-19 wards and if required these performance measures will be impacted in April onwards.

Quality

We are just completing the penultimate year of the Quality Improvement Strategy and our key points of performance from March 2020 are detailed below. Intelligence regarding ongoing improvements is limited due to the cancellation of the Clinical Governance Group and the Trust Infection and Prevention Committee to enable key staff to support the delivery of services to the COVID-19 patients.

Key points are as follows:

Infection Prevention – Embed our infection prevention and control recovery plan

- During March we had 5 C-Diff cases, 2 E-Coli cases, 1 MRSA case and 2 MSSA cases.

- We have not achieved 3 of the 4 key infection prevention year end trajectories.

Performance;

- C-Diff – 61 : Failed to Achieve Target of 53
- E-Coli – 55: Achieved below Target of 59
- MSSA – 18: Failed to Achieve Target of 10
- MRSA – 3: Failed to Achieve Target of 0

Improve our learning from death processes.

The Learning from Death Group meeting for March was cancelled due to the Coronavirus Pandemic.

- Improved HSMR: 102.47 up to December 2019 (was 105.00) and is still 'within expected range''
- Mortality reviews within 30 days fell to 53.53% for February 2020 (was 59.24%). (Please note this measure is reported one month in arrears)
- Backlog of incomplete and outstanding reviews has increased to 180 cases in February 2020 (was 139). (Please note this measure is reported one month in arrears)
- The Trust continues to show improved performance in respect of HSMR.
- The Learning from Death Group meeting for March was cancelled due to the Coronavirus Pandemic.

Complaints

The Complaints response times metric has been suspended due to the COVID-19 pandemic.

Workforce

Key performance updates from March 2020:

- Appraisal (non-medical) - Compliance has reduced by 2% to 81% this month which is the largest drop this year. A reduction is expected due to COVID-19 response. . The target is 95% from April but we will review the trajectory for 2020/21 due to the impact of COVID-19.
- Mandatory Training - compliance has dropped by 1% to 89% this month which was expected due to the cessation of face to face training as part of the COVID-19 response. The target is 95% from April 2020. A process for performance management of those who are not 100% on their appraisal is to be communicated post COVID-19.
- Medical Appraisal - has reduced by 1% this month to 93% against Model Hospital average of 85%. Reminders through ESR Self Service, implementation of Allocate e-appraisal system, and dedicated resource in HR to support medical appraisal and revalidation have been effective in improving and maintaining trajectory. However, a reduction was anticipated this month due to COVID-19 response.
- Vacancy rate - has improved again this month from 7.61% to 7.47% due to ongoing programmes for domestic and international recruitment. The national substantive NHS vacancy rate was 8.1% in March 2019 (office of national statistics). We have continued active recruitment to roles during COVID-19. Vacancy rates are expected to reduce further in April due to recruitment to BBS and student placements.
- Staff Turnover - has been reducing month on month since May 2019 and has reduced this month from 11.23% to 11.12% against a 12% target. The target will reduce to 11% from April 2020. Our monthly staff turnover reduced to 0.80% on Model Hospital in January 2020 (latest data) compared to national average of 0.89% at that time.
- Staff in Post - has increased by 35.6 wte this month primarily due to successful

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overseas and domestic nursing campaigns. There are 499.85 wte additional staff in post since April 2016 across all staff groups, which demonstrate successful recruitment campaigns. This growth has been necessary to address increased capacity and establishment growth.

- Sickness rates - have reduced by 0.13% this month from 4.58% to 4.45% against Model Hospital benchmark of 4.75% (Nov 2019) and Trust target of 4%. This is a 0.07% reduction in long term sickness but a 0.11% increase in short-term sickness. Sickness is a priority for the HR directorate who are working with managers to ensure full compliance with our policy. COVID-19 has impacted sickness rates and medical suspension rates during March. A separate SPC chart for COVID-19 Absence is included this month.

Finance

There will be a separate Finance paper provided to the Committee.

Conclusion

In summary, the performance for March 2020 has clearly been compromised in the last few weeks of March and has been in April and beyond. However, these rapid changes enforced upon us to ensure the protection of our staff and patients have highlighted that change can be made quickly which is a lesson to be considered in the future when we are looking to implement change through large scale programmes..

Recommendations

The TME/Board is asked to note this report for assurance.

Appendices

1. Improvement Statements
2. SPC Charts

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

1. Appraisal Rates – Ensure all our staff have annual appraisal (Non-Medical)

Strategic Objective: Best People

Current performance (March) against local target of 90%		April 2020 trajectory	19/20 Year end target	April 2020 target
Non-Medical Appraisal 81%		82%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Non-medical appraisal rates have reduced by 2% to 81% primarily due to Covid-19 response • HR have been requested by divisions to cease monthly reports during Covid-19 • Improvement of 4% from same period last year • We are now performing worse than Model Hospital benchmark which is 85% (December 2019)	• 1:1 training available to managers on appraisal functionality (with remote access to screens) • ESR sends email 4 months prior to expiry of appraisal to remind manager and individual • Further ESR Self Service training for managers on hold (subject to Coronavirus restrictions) • Target to be raised to 95% from April 2020
Assurance level – LEVEL 3	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

2. Mandatory Training Compliance – Ensure that all our staff are suitably trained

Strategic Objective: Best People

Current performance (March) against local target of 90%		April 2020 trajectory	19/20 Year-end target	April 2020 target
89%		90%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Mandatory training compliance has reduced by 1% to 89% primarily due to Covid-19 • Model Hospital benchmark is 90% (Sept 2019) and 88% within our peers • Automated emails from ESR and RAG rated matrix continue to be well received by staff in maintaining compliance • WRAP training has increased by a further 1% this month and is now at 85% which is higher than the same period last year • MCA and DoLS training has moved to a new Essential to Role dial and is not included in Mandatory Training numbers this month • Respect Awareness and Authorship are now reported on in the monthly divisional reports	• Performance is expected to dip due to Covid-19 • Staff who are working from home will be reminded by HR and their managers that they are expected to access their mandatory training on line and to be 100% compliant. • HR have ceased monthly reports to divisions as requested due to Covid-19 • All face to face training has been cancelled due to Covid-19 • Learning and Development department are focussing on mask fit training • Publicity for "Act on Amber" to be sent out post Covid-19 • HR BP's to push further action within divisions post Covid-19 • Target to be raised to 95% from April 2020
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

3. Medical Appraisal Rates – Ensure all our doctors have annual appraisal as part of revalidation process

Strategic Objective: Best People

Current performance (March) against local target of 90% and Model Hospital benchmark of 100%		April 2020 trajectory	19/20 Year end target	April 2020 target
Medical Appraisal 93%		94%	90% - acheived	95%

How have we been doing?	What actions are being taken to make the improvements?
• Medical appraisal has reduced by 1% this month due to Covid-19 • Compliance is 93% which is still above the current 90% target • Improvement of 4% from the same period last year • Trajectory and assurance Level reflects our confidence that we will reach 95% by 2020/21 year end • Model Hospital Benchmark is 100%	• Allocate e-appraisal and revalidation functionality implemented and embedded • Automated email notifications from Allocate system and from ESR Self Service • Dedicated resource in HR medical resourcing team • Outstanding appraisal/revalidation escalated to Divisional Directors • Target to be raised to 95% from April 2020
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

4. Consultant Job Plan Compliance – Ensure all our Consultants have up to date Job Plans

Strategic Objective: Best Use of Resources

Current performance against local target of 90%		April 2020 trajectory	19/20 Year-end target	April 2020 target
89%		90%	90%	95%

How have we been doing?	What actions are being taken to make the improvements?
• Consultant job planning compliance is not updated this month due to reprioritisation in HR • Compliance as at February was 89% which is slightly below the current 90% target • Trajectory and assurance Level adjusted to reflect performance • Model Hospital Benchmark is 100%	• Dedicated resource in HR medical resourcing team has uploaded the majority of job plans on e-job plan • Outstanding job plans escalated to Divisional Directors • E-job plan automated email notifications to be turned on from April 2020 once all job plans are live, which will support the next annual job planning round • Medics have commenced on the next job planning round • Rosters uploaded onto E-roster for Consultants and Middle Grades to facilitate safer staffing/redeployment during Covid-19 • Virtual Job Plan consistency panels for new posts to take place to ensure that agreed plans best meet service needs • Target to be raised to 95% from April 2020
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

5. Vacancy Rates – Ensure we have adequate staff to ensure patient safety

Strategic Objective: Best Use of Resources

Current performance (March) against local target of 7% and national benchmark of 8.1%		April 2020 trajectory	19/20 Year end target	April 2020 target
7.47% Substantive plus bank and agency for new wards		7.25%	7%	7%
6.36% Substantive vacancies only		6.35%	7% - achieved	7%

How have we been doing?	What actions are being taken to make the improvements?
• Successful domestic and international recruitment campaigns continue to show impact • Our overall vacancy rate including funded bank and agency for new wards has reduced by 0.14% since last month despite difficulties due to Covid-19 • Our overall vacancy rate (including funded bank and agency for new wards) is now at 7.47% which is 2.28% lower than our substantive vacancy rate for same period last year • Our substantive vacancy rate (excluding new wards) has reduced to 6.36% which meets local target and is better than the NHS average of 8.1% (source ONS survey/NHSI) • This has been achieved despite opening Aconbury 2 and Aconbury 3 in February 2020 which increased establishment to staff 33 new beds with the resultant increase in vacancies.	• Arrangements made for Skype interviews, online assessment centre tests, and electronic ID checks to address COVID-19 concerns have been successful • The cancellation of flights for overseas nurses due to Covid-19 has impacted on our recruitment trajectory • Clinical fellow programme in place to reduce career grade vacancies • The Trust has been working with HEE and Universities on various Covid-19 contingencies including Bring Back Scheme for leavers, student nurse placements and medical student placements • The Recruitment team were dispersed across 3 sites from March to improve business continuity during COVID-19. The centralised recruitment is on hold during Covid-19
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

6. Staff Turnover Rates – Make this a good place to work so that we can retain our staff

Strategic Objective: Best Use of Resources

Current performance (March) against national benchmark of 0.89% (Monthly rate)		April 2020 trajectory	19/20 Year end target	April 2020 target
Monthly Turnover 0.96%		0.90%	0.89%	0.89%
Annual Turnover rate 11.12%		11%	12%	11%

How have we been doing?	What actions are being taken to make the improvements?
• Our monthly turnover has increased by 0.04% to 0.96% this month • Our monthly turnover for January 2020 (latest rates on Model Hospital) was favourable at 0.80% against Model Hospital average of 0.92% • Annual turnover rates have reduced by 0.11% to 11.12% this month • Annual Turnover is 1.26% lower than same period last year and has been improving since May 2019 (with the exception of February 2020)	• Results of 2019 Staff Opinion Survey publicised in Worcestershire Weekly on 25th February • Education Academy continuing • Timewise project continuing • Exit interview process continuing • Target to be reduced from 12% to 11% from April 2020
Assurance level – LEVEL 5	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

7. Total Hours Worked – Ensure we have adequate staff to meet patient needs within financial envelope.

Strategic Objective: Best Use of Resources

Current performance (March) against budgeted establishment of 6017.98wte		April 2020 trajectory	19/20 Year end target	April 2020 target
Hours worked (substantive, bank and agency) 6279.77wte		6200 wte	6017.98 (funded establishment)	6017.98 wte plus 33 beds for Avon 5 tbc

How have we been doing?	What actions are being taken to make the improvements?
• Our total hours worked by substantive bank and agency staff has increased by 92.8 wte this month and 315.15 wte from same period last year • This is partly due to new wards and increased fill rates through NHSP interface, as well as Section 31 ED capacity and Coronavirus pods • The impact of Covid-19 including increased sickness and special leave due to social distancing (shielding) and self isolation for symptomatic staff and those with symptomatic family members have increased hours paid • Our total hours worked for substantive staff are 190 wte above our funded establishment this month. This is the third month running that hours worked have exceeded establishment	• Review of NHSP bookings to ensure that where we have BBS staff and students joining us, there is a correlating drop in agency bookings • Covid-19 response has led to implementation of Emergency Planning module on Allocate which enables safe staffing/redeployment of medics and nurses • Business plan developed to resource implementation of Allocate Clinical Activity Manager module which will give greater grip and control of outpatient clinics and theatre activity • Further rollout of Medics on duty to improve utilisation of medics, including better governance on leave booking and backfill • Plan for rollout of Locum on Duty module which will enable better reporting on temporary medic cover • Business plan developed to move payment for all additional hours for all staff groups through NHSP, to move WLI payments onto Allocate system so that there is more transparency and greater reporting ability. However this has been delayed due to Covid-19
Assurance level – LEVEL 2	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

8. Sickness Absence Rates – Ensure that sickness absence is managed and that our staff are supported to maintain their health and wellbeing at work

Strategic Objective: Best Use of Resources

Current performance (March) against local target of 4%		April 2020 trajectory	19/20 Year end target	April 2020 target
Monthly Absence rate 4.45%		4.25%	4%	4.0%

How have we been doing?	What actions are being taken to make the improvements?
• Our monthly sickness absence rate has reduced by 0.03% to 4.45% this month compared to 4.19% for same period last year • Latest Model Hospital average is 4.75% (November 2019) at which point we were reported favourably at 4.38% • HEE Regional average is 5% • Short term sickness has increased by 0.11% to 2.07% which is slightly above target • Long term sickness has reduced by 0.07% to 2.38% this month which is above target • Main increase in sickness absence continues to be due to stress/anxiety and S27 Covid related absence	• Support from Occupational Health available to support all staff • Specific support for those reporting stress anxiety or depression and musculoskeletal issues, or Covid related concerns • HR absence hub established 7 days per week with advice for staff on self-isolation, and taking swabbing bookings, as a specific response to Covid-19 • Change in practice so that all absence reported “live” on E-roster for all staff groups to enable safe staffing, and to ensure that NHSP bookings are adjusted as necessary. More than 3000 staff records uploaded onto roster system to facilitate this functionality • Daily SitRep and absence reporting established • COVID-19 has not had the anticipated impact on sickness rates due to the self isolation rules which are recorded as medical suspension rather than sickness and are covered in a separate statement • HR Advisory team providing an HR Advice Line and undertaking welfare calls to staff who are social distancing • Sickness absence target to remain at 4% from April 2020
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

9. Agency Spend as a % of gross cost – Ensure that we have enough of our own substantive and bank staff to reduce reliance on agency spend

Strategic Objective: Best Use of Resources

Current performance (March) against local target of 7%		April 2020 trajectory	19/20 Year end target	April 2020 target
Monthly Agency spend as a % of gross cost 10.29%		10%	7%	7%

How have we been doing?	What actions are being taken to make the improvements?
• Our agency spend had been showing improvement since the implementation of Allocate suite of solutions and NHSP interface • Use of agency has however increased by 0.92% this month to 10.29% of gross cost. This is primarily due to the Covid-19 response to cover staff absence. Agency spend has also been impacted by Section 31 notice in ED and Coronavirus Pods which required staffing at short notice.	• Review of NHSP bookings to ensure that where we have BBS staff and students joining us, there is a correlating drop in agency bookings • Further rollout of Medics on duty to improve utilisation of medics, including better governance on leave booking and backfill • Utilisation of allocate emergency planning module to enabled redeployment of medics across wards whilst ensuring full transparency and safe staffing • Continuation of both domestic and international recruitment • Work with NHSP to increase the nurse and medic banks • Embedding of 12 week roster lockdown to improve opportunity of more cost effective bank cover
Assurance level – LEVEL 3	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

10. Bank Spend as a % of gross cost – Ensure that we have enough of our own substantive and bank staff to reduce reliance on agency spend				
Strategic Objective: Best Use of Resources				
Current performance (March) against local target of 7%		April 2020 trajectory	19/20 Year end target	April 2020 target
Monthly Bank spend as % of gross cost 9.03%		9%	7%	7%

How have we been doing?	What actions are being taken to make the improvements?
• Use of bank is improving upon implementation of the Allocate suite of solutions and NHSP interface • During March our use of bank has increased by 1.62% to 9.03% of gross cost • The total hours have increased as anticipated due to the opening of a further beds and cover for Covid-19 absence • Bank spend has also been impacted by Section 31 notice in ED and Coronavirus Pods	• Review of NHSP bookings to ensure that where we have BBS staff and students joining us, there is a correlating drop in agency bookings • Work with NHSP to increase the Nurse and Medic banks so that we can avoid agency spend wherever possible • Embedding of 12 week roster lockdown to improve opportunity of bank cover
Assurance level – LEVEL 3	**SRO: Tina Ricketts (DPC)**

PEOPLE & CULTURE IMPROVEMENT STATEMENTS – M12

Worcestershire Acute Hospitals NHS Trust

11. Covid Absence Rates – Ensure that Covid absence (through sickness, self isolation and shielding) is managed and that our staff are supported to maintain their health and wellbeing at work

Strategic Objective: Best Use of Resources

Current performance (March) against local target of 18% (which is average annual leave and sickness rate)		April 2020 trajectory	19/20 Year end target	April 2020 target
Monthly Covid Absence rate 18.6%		18%	18%	18%

How have we been doing?	What actions are being taken to make the improvements?
• Covid absence rates peaked at 21.9% on 4th April • Since then rates have reduced to 18.6% • Some Trusts are reporting Covid absence in excess of 25% • We have 928 staff absent due to Covid. Of these 425 are currently social distancing for up to 12 weeks under the initial government guidance • Revised government/PHE guidance states that those in very high risk categories who have had a letter from NHS Digital are required to shield at home • Codes for COVID-19 were added to ESR and e-Roster so that the Trust can report on impact • Daily SitRep reports submitted and absence tracked live through e-roster.	• HR Advisory team are contacting all staff who are off with Covid-19 related reasons as part of welfare calls • Focus is on the 425 staff who are currently social distancing to ensure that their manager has undertaken a risk assessment • Support is available from Occupational Health including 24hr counselling • Staff and relative swabbing has commenced to reassure staff that they are not infectious and can return to work • Staff are encouraged to operate 2m social distancing rules at work and to work from home where this is possible • COVID-19 is anticipated to continue to impact on sickness and medical suspension rates next month
Assurance level – LEVEL 4	**SRO: Tina Ricketts (DPC)**

Appendix: Assurance Levels

RAG Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of the desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of the desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of the desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

The table above provides the detail in relation to the assurance levels being applied in the improvement statements shown earlier in this report