Paper ref:	TB (08/20) 009

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	COVID-19: Overview		
Sponsoring Executive	David Carruthers – Medical Director		
Report Author	David Carruthers – Medical Director		
Meeting	Trust Board (Public)	**Date**	6th August 2020

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

The report reflects on our current position in the Trust with respect to patient flows and the processes to reduce the risk of nosocomial infection. Clinical allocation of red ward space is changed based on admission rates as well as community infection rates.

In-patient numbers are falling but vigilance remains high to create a safe environment for patients and staff through use of PPE in all clinical areas. Increasing capacity for diagnostics and returning theatre capacity back to pre-covid levels is a priority. Work to explore co-working across the Black Country in respect of important diagnostics delayed by COVID is underway and clinical prioritisation of long wait patients is of high importance at bi-weekly recovery meetings.

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

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

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

Gold Command

4. Recommendation(s)

The Trust Board is asked to:

a.	**Note** the progress in admission process for emergency patients
b.	**Consider** the changes in service provision via recovery plan
c.	

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

Trust Risk Register	x	Risks logged on safeguard						
Board Assurance Framework								
Equality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board (Public): 6th August 2020

Update on COVID-19 position

1. Introduction or background

1.1 The Paper outlines the Trust response to COVID-19 pandemic with an update on current data related to cases, swabbing, PPE, Risk assessment and recovery plan.

1.2 As of the 30th July there were 16 patients who were COVID swab positive with two of those being cared for within our intensive care units. On average, we have been admitting two swab positive patients per week with only one patient per week becoming swab positive on blue or lilac wards having been admitted through the AMU. Care around infection control processes needs to be maintained to minimise the risk of ward based outbreaks.

1.3 There are still 10 patients on average at each site daily where the clinical teams think on first impression that symptoms may be related to COVID infection. However, swabs and clinical assessment are negative and these patients move to the lilac wards. Patients who are admitted to blue ward or to lilac wards get repeat swabbing on day five or three respectively to make sure that they remain swab negative thus reducing their risk to other patients and staff. Patients admitted via ED through the red stream or those who develop symptoms on blue or lilac wards get swabs undertaken with a process that has a shorter turnaround time (2 hour test time), depending on reagent availability. Discussions regionally and nationally suggest that reagents are becoming harder to acquire and if this impacts on our stock levels we will have to reconsider either our diagnostic criteria or patient pathways. Audits of A+E pathways are regularly undertaken to identify where change can occur in the initial clinical assessment.

1.4 Patients admitted through a blue admission stream and those with routine repeat swabbing on blue or lilac wards get 24 hour turnaround swabs carried out by Black Country pathology service. As mentioned the accessibility of the two hour turnaround swabs is reducing but there is discussion around a new platform being introduced at SWBH that will provide some improvement on the 24 hour turnaround swabbing. More information is awaited on this.

1.5 We are keeping a close eye on Community COVID-19 cases and are requesting more regular reports from Public Health England to indicate if there are increased cases in the community which suggests localised outbreak that may have an impact on the Hospital

admissions but also help feed into any discussions we have on lifting restrictions on visitors (see later). There are 3 small community outbreaks currently being managed by PHE in the Black Country.

1.6 Review of patient flow and alignment of wards at each site have allowed Red AMU beds on each site and a trial of having just one Red ward for swab positive patients at the City site. This has seen some delays in transfer of patients out of ED into AMU at Sandwell and then onto the deeper bed base. This partly reflects delays in swab results as well as clinician uncertainty about the underlying cause of admitting symptoms. Opening of more lilac beds has improved flow and hopefully will mean that re-opening of a Red ward in the deeper medical bed base at Sandwell can be avoided, but community infection rates are being watched closely and the impact that may have on ED attendances.

1.7 A planning meeting reviewed the changes that might be needed based on an increase or progressive decline in covid-19 admissions. The latter would allow a return to a single stream AMU admission process as well as in ED, rather than the dual red/blue staffed streams, which continue to put pressure on space for patients and staffing levels. With an increase in COVID admissions, careful thought needs to be given to impact on other services in the medium and long-term as well as ITU staffing and capacity.

1.8 There is a rotating deep clean process which is initially focused on the ITU areas, allowing creation of additional isolation beds in these units on both sites. This therefore allows for non-COVID ITU beds but it must be remembered that when there is clinical uncertainty, full PPE must be continued with because of a potential of false negative swab results and the risk that comes from AGP in an ICU environment.

2. PPE provision

2.1 There are still no issues with PPE provision and we have been able to accommodate the increase use of fluid resistant surgical masks which are now worn by all staff and any visitors within communal areas within the clinical blocks in the organisation as well as in the wards. Many clinical staff now have reusable single user silicon based FFP3 masks which they can be used particularly within the areas with potential AGP. This has reduced the rate of use of disposable FFP3 masks and in the long term will reduce cost. It should be noted that we continue to support a range of local providers with PPE through mutual aid as part of our cohesive system response to Covid.

2.2 The review of office space is to be completed over the next week or two with advice given to local managers over safe room capacity to maintain social distancing. This

estates review needs to be linked with the developing proposals for working from home, personal risk assessments and removal of restrictions on those who were shielding. Provision of appropriate office equipment may have to be made to facilitate longer term home working.

2.3 We are not yet fully open to visitors with the exception of visitors to patients in end-of-life, children, maternity and learning disability. We do need to consider options for this so when the community infection rate is low enough and that we have not been having in-hospital infection. We can then consider reopening to some visitors in a planned, staged fashion so that for a short period of time individuals can visit relatives whilst not having too many visitors on a ward at any one particular time.

3. Individual risk assessment

3.1 We hope this will be completed this month on all staff. Four thousand have undertaken the online risk assessment with information about their personal risk status being provided to managers so that any appropriate changes that are needed to their working environment or PPE can be made. We still have 100 staff members shielding until the end of July and they will all undergo this assessment with discussions about appropriate work for them to undertake and in which environment.

3.2 We have 25 staff members still off with COVID related illness and have conducted over 12000 antibody tests, 49% of which have been on our staff members.

4. Clinical services

4.1 Independent sector working for Theatre activity continues, but we hope that more work will be able to come back to the Trust during August and September. We are finalising training of Theatre Staff in ICU which should be completed by the end of July. They can then return to Theatres and support a full return of Surgery to Trust premises.

4.2 Output from restoration work by the clinical groups is now going to be measured against the Trust Production Plan and not the Recovery Plan to give a clearer indication of where we are and how we are progressing against our activity plans submitted pre covid.

4.3 The working hours in some areas are being increased such as cardiac catheter lab and cardiac rehabilitation to allow increased productivity. An endoscopy review is underway with local options being looked at for parallel working of two rooms to try and improve productivity and reduce waiting lists sooner. There is a wider STP review planned to see if approaches to joint working may allow more rapid reduction in waiting lists. This may

be around creating more space or finding ways for staff to work together more productively.

4.4 There is an improving position in Radiology with a 7 day service within the Treatment Centre and now a mobile scanner MRI on each site.

4.5 Work is occurring around out-patient clinics to establish the best balance for face-to-face appointments verses Telephone verses Visionable video links.

4.6 The Clinical Reference Group formed by the Medical Directors and Chief Operating Officers from the 4 Acute and Mental Health Trust will oversee working groups which will look at clinical areas of concern. There will be an initial focus on endoscopy with representatives from each Trust to explore alternative ways for service delivery across the Black Country STP. Further working groups will be developed which may initially be based on other diagnostic modalities within imaging.

4.7 Each clinical group has completed a clinical prioritisation of their backlogs and an overall risk assessment of the service. Any high risk patients are discussed at the twice weekly recovery programme and plans are put in place to ensure that they are treated. The risk assessments will be reviewed by the executive team and added to the trust risk register if suggesting a high level of risk post mitigation. Ophthalmology remains a concern with the number of 52 weeks awaiting treatment, but this is an improving position. Feedback from the STP on the submission of funding for vanguard theatres is still awaited.

4.8 Data on clinical prioritisation for specialties based on category of risk is monitored and specialties undertake risk assessments and harm reviews of long wait patients. This data now needs to be co-ordinated centrally, recording the process undertaken for assessment of clinical prioritisation and the outcome of the risk assessments and harm reviews. This will allow accurate monitoring of the progress of the recovery phase.

5. Recommendations

5.1 The Trust Board is asked to:

a. **Note** the progress in admission process for emergency patients
b. **Consider** the changes in service provision via recovery plan

David Carruthers
Medical Director
31st July 2020