Paper ref:	TB (11/20) 010

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	Public Trust Board	Date	4th November 2020

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

An increase in COVID cases in the community and how that is impacting on hospital admissions are discussed, as are implications for bed management. Data on recent admissions and comparison with wave 1 is made.

The possible effect on restoration and recovery is discussed, considering whether we have to enter the next phase of the surge plan in ITU and across the hospital bed base.

Trust Board is invited to discuss issues around COVID.

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

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

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

N/A

4. Recommendation(s)

The Quality and Safety Committee is asked to:

a.	Discuss COVID Hospital Admissions
b.	Discuss implications for service recovery
c.	

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

Trust Risk Register	x	Multiple COVID risks					
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 Public Trust Board: 4th November 2020

COVID-19 Overview

1. Community rates

1.1 Increase in community infection rates have been seen in Birmingham and also Sandwell. The rate is lower in Dudley but rising in Wolverhampton. Generally a younger age group and more children were affected but the mean age of patients is increasing now. There is now an increase pressure on hospital attendances and admissions. As of 29/10/20 there are 130 patients on medical wards and 16 on ICU. Small numbers of paediatric admissions only at this time though. Our peak of new COVID swab positive patients was 63 on 28/10/20 in community and ward environments, with a 7 day rolling average of 39.7, a level not seen since April 2020. The community rate for Sandwell is 240/100,000 new infections which is similar to Birmingham.

2. Lock down

2.1 Birmingham and Sandwell are in tier 2 of the lockdown. Cases of staff off with COVID have increased with additional staff now also isolating because of family or work contacts with COVID patients. The number of isolating staff reinforces the need to adhere to PPE guidance and social distancing, while the Trust continues to provide swabbing for symptomatic households family members to allow a return to work where the swab is negative.

3. COVID beds

3.1 The Trust has reviewed its bed allocations which were previously of 4 admission streams for planned and urgent care admissions through ED and AMUs at both sites. Although the aim was to concentrate COVID admissions in the substantive bed base on one site (City respiratory hub), this has now changed due to increasing admissions to the Trust and asymptomatic patients being subsequently identified as COVID positive.

3.2 Due to these increasing COVID admissions we have increased our red base capacity, including opening a red ward at Sandwell. As non-COVID admissions also remain high this has led to assistance from surgery in reducing non-essential orthopaedic surgery for a 2 week period, to create bed capacity. We have also reduced our lilac bed stream and incorporated these within the amber (medium risk group) to improve patient flow. This has required enhanced PPE advice for clinical areas, including the request for patients to wear a surgical mask when able to and mobile within the ward area. Consideration is being given to how other clinical activity can be modified to support our medical ward base, NIC/CPAP beds on the respiratory hub and out ICU.

3.3 ICU capacity is closely monitored both within the trust and regionally so that mutual aid can be provided where required. Inter-hospital transfers both into and out of SWBH ICU have meant that capacity and bed availability has been maintained with good system collaboration being undertaken. Our reservists are now back on ICU due to increase patient numbers, supported by appropriate PPE and ventilator equipment.

4. Treatment pathways

4.1 Pathways include a focus on O_2 therapy escalation (and de-escalation), proning, NIV use on the wards, VTE assessment and prophylaxis, and early use of both steroid (dexamethasone) and anti-virals (remdesivir) have been reviewed and updated. Patients requiring NIV are either admitted to ICU or the respiratory hub depending on agreed levels of escalation of care. The pathway from AMU, to NIV or ICU needs to be integrated as much as possible for appropriate escalation of patients with no limit on escalation of therapy.

5. New IPC guidance

5.1 The new IPC guidance is settling with in reminders to staff over need for compliance. The four streams at SWBHT (green, amber, lilac and red) with lilac needed initially to cohort patients who have had contact with COVID +ve patients, have been modified t oreflect the admission patterns of patients to the Trust and incidence of COVID 19 within asymptomatic patients. Altered IPC advice for ward staff and our patient's aims to reduce in-hospital infection transmission to both patients and staff. Low numbers of side rooms makes the appropriate use of PPE all the more important.

5.2 Our greatest number of patients having a positive swab on the wards were those in amber streams where the day 5 monitoring swab turns +ve (these are generally patients who are asymptomatic from COVID). This I think reflects the high community prevalence and possibly some influence of swabbing process at point of admission which is being reviewed. This re-inforces the position on visiting which remains limited to a small number of indications but will help reduce the risk of hospital infection from asymptomatic carriers.

6. Swabbing

6.1 BCPS continues to be challenged by supply issues but are maintaining its 24 hour turnaround for samples on arrival. We have a high number of on-site 2hr TAT tests but no POCT is available for overnight testing when labs are unavailable.

7. Provisional look at the data for hospital admissions since the start of September shows a younger age group admitted to now, reflecting the lower age of community cases now compared with previously. No difference in gender ratio (50:50). Ethnicity data reflects local population demographics but a high proportion of patients with ethnicity not documented means interpretation is difficult. Current mortality of admitted patients appears less than in wave 1, perhaps reflecting the younger mean age of admissions so far but may also be a response to rigorous application of treatment pathways such as proning, NIV and use of steroids at appropriate time points. As number of cases and mean age of community cases increases, we will keep a close eye on this data.

8. Well-being support

8.1 The support provided to colleagues during the pandemic was well received but it is important to realise the concern that some may have about a return to unfamiliar environments and stressful working practices if needed in the future. The provision of PPE, including silicon FFP3 masks and data showing that those in higher risk areas, but provided with correct equipment, used

appropriately have a lower incidence of COVD infection may offer some reassurance. The staff risk assessments, stress assessment and workplace stress assessment are important aspects, as are the well-being resources available within the organisation.

9. Recommendations

9.1 The Public Trust Board is asked to:

a. Discuss COVID Hospital Admission
b. Discuss implications for services recovery

David Carruthers
Medical Director

November 2020

Annex 1: IPC summary

Annex 1:

INFECTION CONTROL DECISION SUPPORT TOOL FOR PLANNED AND UNPLANNED ADMSISSONS

Patients are classed as Low, Medium and High risk. Physical distancing of 2 metres is considered standard practice in all health and care settings. A s*taff member may choose to wear higher levels of PPE following their individual risk assessment.*