Paper ref:	TB (12/20) 011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	COVID-19 overview		
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Report Author	David Carruthers, Medical Director and acting CEO		
Meeting	Trust Board	Date	3rd December 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.

Staffing, vaccination and lateral flow testing are discussed.

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	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?]*

CLE 24/11/2020 and Q+S 27/11/20

4. Recommendation(s)

The trust Board is asked to:

a.	Discuss COVID Hospital Admissions
b.	Discuss implications for service recovery
c.	Note wider work ongoing in respect to COVID wave 2

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

Trust Risk Register	x	Numerous covid risks on register					
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: 3rd December 2020

COVID-19 update

1. Community rates

1.1 Increase in community infection rates have been seen in all areas in the Black Country and Birmingham. The community rate for Sandwell is 419/100,000 new infections per week which is higher now than Birmingham (343/100,000 date 26/11/20) but reassuringly both areas are reducing in incidence. The mean age of patients is increasing now. There is an increase pressure on hospital attendances and admissions, but perhaps a suggestion of a plateau of admissions. As of 26/11/20 there are 224 patients on medical wards and 12 on ICU who tested +v for covid. There are small numbers of paediatric admissions only at this time though. Daily swab test positive patients was still over 60 on 25/11/20 from community and hospital environments, with 29 new inpatients. Total admissions remain at expected levels for the time of year, with on average there being a 1:2 split between covid and non-covid related admissions, but numbers can vary from day to day.

2. Lock down

2.1 Like the rest of the country we are in national lockdown. Cases of staff off with COVID have increased to 100 with a similar number off due to self-isolation due to family or work contact. We await the decision on national tier system for our area. The number of staff infections and those who are self-isolating reinforces the need to adhere to PPE guidance and social distancing. The Trust continues to provide swabbing for symptomatic household family members to allow a return to work where the swab is negative. Wearing masks in office areas when not alone and patients wearing masks will hopefully help.

3. COVID beds

3.1 We have had to reconfigure the bed allocation, closing the lilac stream to allow better patient flow from ED and AMU. The number of red beds has increased gradually in parallel with admission numbers to the Trust. This has been accommodated by an increase in total bed number in line with our winter plans as well as a reduction in routine surgical activity allowing an increase in available beds. There is a continued focus on infection control to limit nosocomial outbreaks which can lead to ward closures. Daily outbreak meetings are held with infection control team and NHSe/i. The necessary loss of lilac wards means that there have had to be some temporary ward closures where outbreaks have been declared. This puts pressure on the bed capacity within our Trust.

3.2 We have increase accessibility to 2 hour swabs for the next 2 weeks, and are focusing our efforts on the transfer pathway to ensure efficient transfer of the samples to the labs for analysis or onward conveyance to BCP labs.

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. Recent evidence from trials we have contributed to show the benefit of the immunomodulatory agent, tocilizumab, normally used for rheumatic disease, in improving the outcome for severely ill patients within the ITU environment. More information and guidance is needed to see whether this therapy could also be applied for other groups of patients with decompensation due to active systemic disease, such as those on the respiratory hub. Our clinical advisory group will be looking at this for early adoption of any national advice.

4.2 Pressure on ICU beds remains high with thoughtful capacity management and redeployment of staffing allowing the work to be accommodated without having to expand into our additional surge capacity on D16. Transfer of some patients out to other units has been necessary but limited due to capacity pressures in most other units in the STP and wider midlands region. Agreement has been reached over activation of surge plans in all midlands trusts to allow an increase in ICU capacity to help those trusts under most pressure. We are in a position to help other organisations and offer support where possible directly to units we know are under pressure.

4.3 We are also seeing an increase in patients within the respiratory hub needing NIV/CPAP, reflecting the increase incidence in the older population. This is increasing the pressure on specialised staffing for these more complex patients and is requiring more staff to be redeployed from the additional closure of day case surgery and reassessing the balance with staffing to be moved to support iCU and the outreach team. As patient numbers increase, the respiratory team are reviewing their work schedule for medical support, particularly around the initiation of therapy and defining escalation plans for all patients. Visiting advice is being reviewed for relatives to these areas with thought also being given to the Christmas holiday as well.

5. Clinical outcomes

5.1 We are watching our demographic data around admission and mortality profiles as we did in the first wave to identify any change in patterns. The gender split remains at 50:50 for both time periods and age profile shows the trend towards a younger group being admitted for the second wave: (wave 1 v wave 2) age < 64 years = 43 v 59%, 65 – 85 years = 37 v 28% and > 85 years = 19 v 12%, but this is dynamic data with some increase in older age group being admitted more recently. Ethnicity data shows a slight change from wave one, perhaps reflecting the younger age group that has required admission in the early phase of the 2nd wave.

5.2 Our mortality data shows that the incidence of diabetes (DM) and hypertension (HT) in those who subsequently die remains high HT = 73 v 63%, DM = 52 v 44% (wave 1 v wave 2 data) but mortality rate is reduced from an initial analysis, though we still have over 200 in-patients. Male gender and increasing age are also associations in line with wave1 data.

5.3 The impact of new therapies, thrombophrophylaxis, 02/NIV therapy and younger age group may be factors contributing to any change in outcome.

6. Lateral flow testing

6.1 This has been introduced in the last few days, asking patient facing staff to self-test twice a week. The logistics of distribution and recording of test results has been established, with a phased approach to distribution being taken. There is concern whether this will result in an increase sickness initially from over sensitivity of the test to those who are recovering from (asymptomatic) infection but in the medium to long term it should be a useful approach to protect staff and patients from infection. Any +ve results through lateral flow have to have a secondary path lab analysed PCR swab undertaken. An early indication of impact of this test can be provided to the Board.

7. Vaccination

7.1 Planning is in place for when the covid vaccines become available. In the meantime we are pushing to deliver on the seasonal flu vaccination. The logistics of the covid vaccine need consideration of x2 injections per individual, complex storage and reconstitution processes. We are considering whether the same pathway that has been used for the seasonal flu vaccine process can be applied for covid vaccine but the logistics may mean that a more centralised (booked) process needs to be followed. Regional co-ordination is being undertaken, involving PCNs for at risk groups and care homes (mobile approach) with large scale community vaccination sites required where there will be complex staffing considerations to be undertaken. A verbal update can be provided as this is a rapidly changing situation.

8. Nightingale hospital

8.1 Consideration is being given to open this facility in the near future to act as a step down unit from acute trusts. It is difficult to predict our own requirement for the unit capacity with our own community beds but we are looking at ways to contribute to the staffing model, having already offered some of the staff previously accepted as 'roster' ready from wave 1. The presence of senior medical, nursing and trainee staff groups is being considered as well, with most impact on our services from the effect of nurse allocation. Options around staff from some of our stepped down clinical services who are unable to work within the ICU/NIV areas are one group being explored. Trainees have been identified as has an option to provide a consultant session. The reducing community case incidence will hopefully soon have a knock on effect on hospital admissions reducing the pressure on all services across the midlands.

9. Staffing

9.1 Staff numbers for the wards have been a challenge due to sickness and there is an increase reliance on bank and agency support. To encourage staff to undertake bank shifts there has been a further change in bank shift rates and payment process, to keep in line with neighbouring organisations. Clear messaging about bank rates is being redeveloped so there is clarity and fairness in bank shift rates, focusing on hard to fill roles.

9.2 Annual leave for all staff is encouraged but there is a risk that leave is not fully taken in a balanced away across the financial year, leading to risk of high levels of leave late in the year, staff not taking leave thus affecting their wellbeing or several days of untaken leave at the end of the year. This is being reviewed to consider options of carryover of a proportion of untaken leave, through promoting staff to take leave during the year or buy back of some of this untaken leave. The financial implications are also being considered for these different options. Leave

over the xmas period is also being reviewed to consider the ward team requirements over this period and the role of redeployed staff at this time.

9.3 Working from home guidance has been extended until the end of March while a full review is undertaken to consider the longer term strategy, providing appropriate support for staff who can work from home, while maintaining regular contact with colleagues on site (one day a week or fortnight on site, for example).

10. Well-being support

10.1 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.

11. Recommendations

11.1 Trust Board is asked to:

a. Discuss COVID Hospital Admission
b. Discuss implications for services recovery
c. Note wider work ongoing in respect to COVID wave 2

David Carruthers
Medical Director and acting CEO

December 2020