Department of Health/HSE Joint Paper

NATIONAL PUBLIC HEALTH EMERGENCY TEAM

Recommendation that the NPHET recommendation of 27 March in regard to pausing of all non-essential health services be replaced from now on, in regard to acute care, with a recommendation that delivery of acute care should be determined by appropriate clinical and operational decision-making.

5 May 2020

Action required

☐ For noting
☐ For discussion
☒`For decision

PROVISION OF NON-COVID CARE

Recommendation that the NPHET recommendation of 27 March in regard to pausing of all non-essential health services be replaced from now on, in regard to acute care, with a recommendation that delivery of acute care should be determined by appropriate clinical and operational decision-making.

On 27 March 2020, NPHET wrote to the Minister setting out recommendations and decisions of NPHET regarding further measures aimed at interrupting transmission of Covid-19 and related steps. In regard to health considerations, this included that all non-essential surgery, health procedures and other non-essential health services were postponed.

This paper sets out key challenges arising in relation to delivery of essential non-covid acute care and the ongoing work in this regard. It recommends that NPHET agree that general acute care delivery be determined from now on by appropriate clinical and operational decision-making.

Context

As set out in the letter of 27 March, ECDC on 25 March published an updated risk assessment for the EU/EEA and the UK noting that the risk of healthcare system capacity being exceed in the EU/EEA and the UK was high.

The postponement of non-essential surgery, health procedures and other non-essential health services reflected both capacity concerns and risks associated with infection to patients and healthcare workers. These postponements have been accompanied by a fall-off in presentations in GP and acute settings, which initial research indicates is overwhelmingly due to fear of infection.

The postponements accord with the National Action Plan published 16 March, which sets out that elective and OPD activity should be restricted in order to maximise patient flow through hospitals and ensure the most efficient use of existing resources. At the same time, the Action Plan emphasises that essential clinical services will be maintained and is clear that critical and ongoing services for time-essential patient care across the primary, social and acute care sectors should be maintained throughout the Covid-19 pandemic. Actions in this regard include:

- Ensure ongoing services for specialties including trauma, cancer, obstetrics, CF and organ transplant services
- Maintain urgent (elective) activity including urgent diagnostics, cancer rapid access clinics and dialysis
- Maintain community care for socially vulnerable groups, community palliative care, mental health, home support and short-term/transitional/long-term care for older people and those within our specialist disability services
- Support general practice in delivering ongoing essential care of patients
- Support community pharmacists in delivering ongoing care of patients

Progress to date

The initial focus of the Acute Hospitals Preparedness Subgroup of the NPHET has been on building surge capacity to ensure the maximum possible number of critical care and general acute beds to cope with the predicted number of Covid-19 cases requiring hospitalisation.

The focus on bed capacity has involved intensive work, in collaboration with colleagues in the HSE, the NTPF and the clinical programmes. The outcome of this work was an increase in critical care capacity from a baseline of 266 adult beds as reported to NPHET to the currently reported 415 open, staffed critical care beds in public hospitals, with the potential to surge to over 542 if required[1].

[1] HSE daily report, 3 May 2020

Training was provided to over 1,500 nursing staff to allow them to provide support to critical care as required.
Infection control has been a second key focus of the work, and progress in this regard is described later in this paper.

In parallel, the need for delivery of an increased level of non-covid care has been the subject of discussion at the Acute Preparedness Steering Group over a number of weeks. Recommendations of the subgroup aimed at protecting essential care were approved by NPHET on 27 and 31 March.

These discussions have also considered opportunity for the resumption of more routine care, including through the use of private hospitals. At the end of March, the HSE, in conjunction with the Department's Governance and Performance Division, agreed Heads of Terms to an arrangement with the 18 private acute hospitals to gain access to all of their capacity to support the public hospital system. A Steering Group has been established within the HSE, which includes representation from the Department's Governance and Performance Division, to oversee the implementation of the arrangement with the private hospitals. The additional capacity provides an additional 1,900 inpatient beds, 600 day beds, 47 ICU and 54 HDU beds as well as 194 ventilators and 9 laboratory services on sites. Under the agreement the private hospitals will link up with Hospitals Groups in their region and all patients treated in them will be treated as public patients. The intention was to use these facilities primarily to treat non-Covid-19 patients requiring urgent surgery i.e. urgent non-Covid-19 cases and non-urgent scheduled care when it resumed. This was to ensure best use was made of existing skills and experience within the private sector and other more specific Covid-19 skills were centralised in public facilities best placed to deal with these in the shorter term. The arrangement is for three months with an option for the HSE to extend it for a further month if it gives the private hospitals notice of its intent by the end of May. Thereafter the arrangement can continue but only by mutual agreement.

Increasing the delivery of non-covid care is becoming of growing importance as we recognise that the pandemic will not be short-lived. This was reflected in discussion at the Medical Leaders' Forum on 25 April. As we move forward, there will be a requirement to deliver other care that is not as time-critical but is nevertheless essential, in particular where not having access to this care could have a significant impact on quality of life, could lead to deterioration with a significant impact on outcome, or could result in a delay in diagnosis and treatment or similar adverse effects.

Challenges

It is recognised that resumption of more routine care will require further consideration and assurance in a number of areas.

Capacity

Most recent data (3 May) shows 1,664 vacant acute beds across our public hospitals (3 May) and 143 vacant critical care beds. Occupancy is estimated at just over 85% based on inpatient beds. Hospital occupancy will need to remain at a level that allows for surge capacity to respond to increased demand for covid care periodically, currently recommended at 80-85%.

At the same time, occupancy in our private hospitals is estimated to be lower. The HSE and NTPF are working to roll out a Patient Administration Management System to track patients in private hospitals. In the interim the HSE has collected data which indicates that in the larger private hospitals on average 33% of capacity was being used at 1 May. These facilities offer a significant opportunity for delivery of non-covid care in designated non-covid environments, in line with recommendations previously approved by NPHET.

Implementing the arrangement between the HSE and the private hospitals has been a slower process than originally anticipated. The finalising of the Service Level Agreement with individual or groups of

hospitals has proved to be more complicated than was originally envisaged. However, it is expected that Service Level Agreements will be concluded with the hospitals shortly. The process of offering the consultants who work wholly for the private sector locum public only contracts for the duration of the arrangement has also proved to be complex. However, a substantial proportion have now signed up, with 241 having accepted at the end of last week. Notwithstanding the delays, patients are being transferred from the public hospital system to the private hospitals at an increasing rate. It is proposed to increase the level of activity which will be monitored by the NTPF's PAMS. In addition, as the work of the Scheduled Care Data Group in regard to unmet scheduled care demand is concluded and subject to guidances on mitigating risk in carrying out procedures (detailed further below), it is envisaged that the private hospitals will be used in support of the resumption of more routine scheduled care in order to tackle the increasing waiting lists for such care. This may be dependent on the decision on whether or not to extend the arrangement. This will be subject to sanction by the Minister, with the agreement of the Minister for Public Expenditure and Reform.

In regard to critical care capacity, non-covid activity has decreased markedly since March as has been identified by the National Clinical Lead for Critical Care; as of 3 May, there are 271 number of patients in critical care, of whom 93 are confirmed Covid-positive. A preliminary paper was discussed at the Acute Hospital Preparedness Subgroup meeting of 30 April, and high level requirements have been set out by the HSE. The Department and the HSE will continue to work collaboratively to develop a proposal in that regard.

The IEMAG subgroup on demand and capacity has developed a predictive model which has been presented to the Acute Preparedness Subgroup. The model offers the potential to predict general acute bed and critical care bed demand for different scenarios. It is intended to engage further in fully utilising this work to support capacity planning over the coming weeks and months.

Infection outbreak control in acute hospitals

Following NPHET's consideration of HIQA's desktop review of infection and prevention control (IPC) programmes in acute hospitals, the Department wrote to the HSE in relation to the implementation of practical measures to address the risks identified by HIQA, and to explore and agree the supports which are required to be put in place immediately to mitigate the risks identified in certain Hospital Groups. In response the HSE has indicated that all Hospital Groups are providing updates on a range of actions which provide assurance on governance, risk management, outbreak management, staff symptom declaration, staff segregation and adoption of social distancing guidelines.

While the results are still being collated, it has been confirmed that all hospitals have well developed pathways for the separation of Covid-19 and non Covid-19 patients (assessment, ward admission and diagnostics), and, generally, staff have been specifically allocated and deployed to work exclusively in designated areas.

In addition, the HSE has advised it is clear that systems are in place to provide training on PPE use and a variety of measures have been implemented to support physical distancing. Of particular note is the confirmation of a high level of compliance with guidelines on outbreak management, risk management and escalation procedures.

The HSE has however identified the need for significant additional investment to augment IPC resources in order to sustain current services as hospitals return to normal activity, and for the roll-out of an ICT system across all acute hospitals to maintain and increase efficiency in infection surveillance. The HSE has also drawn attention to the requirement for permanent appropriate critical care capacity to ensure an ongoing service response to COVID-19. The Department will engage with the HSE in relation to the capacity and infrastructural deficits identified. The Department will also engage with HIQA and the HSE in relation to the potential to undertake a review of IPC capacity in private hospitals.

The National Clinical Lead for Acute Hospitals has, under the auspices of the Expert Advisory Group, led the work of a subgroup to develop guidance to support the continued delivery of non-covid care. This is designed to mitigate risk for patients and for healthcare workers. The guidance refers to the evidence that surgery and immunosuppressant treatments such as chemotherapy or radiotherapy co-inciding with acute Covid-19 may be associated with increased mortality.

The interim nature of the guidances reflect the fact that this will require to be iterative to reflect developments and increased understanding over time, as well as learnings from implementation. The interim guidances address the management of day-case procedures, both AGP and non-AGP; planning for a hospital stay or planned interventions; and outpatient clinics. For these different requirements, the guidances describe methods to mitigate risks to patients and healthcare workers associated with delivering non-Covid care in an environment where SARS-CoV_2 is prevalent. The guidances do not supersede clinical judgment. They provide a framework for services that will need to be tailored to local conditions and specialty needs.

Application of the risk mitigating steps set out in the interim guidances will have operational implications, for instance to ensure patients spend the minimum required time in the outpatient setting, or are cohorted in wards with planned care patients. This is expected to have implications for throughput.

This work was assisted by evidence reviews undertaken by HIQA, which show the challenges in resuming services, and the challenges in patient flow, staff/patient protection and throughput in the next phase.

Recommendation and next steps

- The Department and the HSE will continue to work with the IEMAG subgroup on demand and capacity with the aim of fully utilising its model to support capacity planning in line with current recommended occupancy of 80-85%, and to predict surge capacity requirements.

- The arrangement with the private hospitals will be reviewed before the end of the month to assess its effectiveness in supporting the public system and in the context of the prevalence of the disease. Given the level of funding involved, any extension will require the approval of the Minister for Public Expenditure and Reform.

- The Department and the HSE will continue to work collaboratively to develop a proposal in regard to permanent critical care capacity.

- The Department will engage with the HSE in relation to the range of other capacity and infrastructural deficits identified in the context of infection control.

- The Department will engage with HIQA and the HSE in relation to the potential to undertake a review of IPC capacity in private hospitals.

- Operational implications of the interim guidance aimed at mitigation of risks of delivery of non-covid care, which has been developed under the auspices of the Expert Advisory Group, require consideration of patient flow, staff/patient protection and throughput. Hospital Groups have been requested to consider these issues, and work nationally in this regard is being led by the Chief Clinical Officer in conjunction with the National Clinical Lead for Acute Hospitals. The Department will continue to engage with the HSE in this regard.

These steps are aimed at managing the challenges of non-covid care delivery set out in this paper. Subject to these, and to maintenance of necessary surge capacity for covid care, it is recommended

that NPHET agree to the recommendation that general acute care delivery be determined from now on by appropriate clinical and operational decision-making. ENDS