NPHET Subgroup on Acute Hospital Preparedness
Update

The subgroup will provide oversight and assurance that preparedness plans are in place and are being implemented across the public hospital system. It includes representatives from the Department and the HSE. It met for the first time on Wednesday 4 March. Terms of reference and membership are attached at **Appendix 1**.

Progress to date

The primary focus of the subgroup is on identifying and increasing capacity in isolation facilities and ICU for delivery of services, mortuary facilities and ambulance services.

Isolation
Isolation facilities in acute hospitals are limited. Consideration is being given to cohorting affected patients in separate wards once diagnosed ('hospital in a hospital' approach) to minimise transmission. All hospitals are preparing PPE etc following on from usual practice lines. Use of hotels to support discharge and isolation was also identified as a potential approach at the subgroup meeting.

Additional capacity
HSE has advised that planning for additional capacity is underway and that surge plans are in place at hospital level. These are being revised and updated and it was agreed by the subgroup these would be shared with the Department following the HSE NCMT meeting of 6 March. Beyond individual hospital level, high level guidance from HSE centrally is required for additional actions such as hospital designation.

The HSE in its submission of Saturday 7 March has set out the following actions in regard to acute hospital capacity:

- Moving delayed discharge patients to the community. 379 of the just over 600 delayed discharges (as of Saturday 7 March) require nursing home beds. Figures provided by HIQA indicate that there are adequate vacant beds in private nursing homes. A further 113 are awaiting home care and 113 awaiting complex care. Investment in transitional care beds, home supports, complex case supports, CIT, GP ooh services, in-home respite services will be required.

- Opening an additional 194 acute beds, and up to 100 beds in the National Rehabilitation Hospital

- Reduction in elective activity and diversion of staff where possible to COVID-19 and unscheduled care. This will draw on previous exercises to consider what activity can be deferred for specific periods of time

- Funding has been approved for additional ICU capacity on foot of a proposal from the HSE. The ICU bed census gives an audited account of existing ICU capacity (approximately 250). Staffing resource for this service requires greater certainty, having regard to the need for training or retraining of staff.

Private hospital sector
Further consideration is being given to the potential role of the private hospital sector in supporting the response to covid-19. This includes consideration of what activity is most appropriate to be provided by private facilities. There are existing local arrangements and agreements with private

hospitals and these will be taken account of in considering the best approach to ensure timely deployment.

Preparedness of mortuary facilities
The modelling currently taking place will provide a basis for determining resource requirements such as refrigeration. The HSE is making contact with the coronial services. There is a specified type of body bags per the ECDC and these will be sourced.

National Ambulance Service
Home testing for suspect cases has been rolled out by the NAS.

To assist with hospital avoidance, the control centre will determine if an ambulance is required, and advice re "self-treating" will be given by a nurse over the phone, in cases where transport to a hospital is not required. The NAS will also be in a position to transport very sick patients as required.

Specific proposals include expansion of the NAS Clinical Hub Desk hear and treat services with additional nurses and GPs from retired ranks; expansion of the Mental Health support desk, expansion of dedicated COVID-19 desk and expansion of existing paramedic mobile medical services through overtime, Defence Force personnel, retired returnees and the deployment of Voluntary Ambulance Services (e.g. Irish Red Cross and St. John's).

Staffing
While HR resources are subject of a separate subgroup, this group noted that it is anticipated there will be a staff absence rate of between 15-20% over the period of the outbreak. The likelihood is that this will not be possible to backfill all of absenteeism, but that a mixture of recruitment, extra hours for staff working short hours, overtime and return of retirees will contribute to fill the gap.

Clinical model of care
The HSE has advised that the clinical model of care to support the management of the overall response to COVID-19 at a total population level is still subject to final review and agreement. The final decisions on the preferred model of care and clinical pathways will require further input and consultation with clinical leadership of the system. This will involve consideration of the role of the public health nurse and of GPs.

Next steps

1. A key step is the finalisation of the clinical model of care which will underpin the detailed operational plans for acute hospitals and for the community.

2. HSE is to revert with a completed containment and mitigation checklist as requested by the NPHET, as is NAS separately.

3. Further detail and likely timelines on integrated acute hospital plans is required including:

- Confirmation of proposals for reduction in elective activity in certain areas where clinically acceptable in the current context.
- Assurance on the protection of certain key elective work including cancer treatment, urgent diagnostics, dialysis and on the development of guidance and protocols in regard to eg isolation for COVID-19 patients.
- Proposals for relocation of any continuing elective work to alternative settings where clinically appropriate.

- Further detail on proposals for moving the approximately 600 delayed discharge patients to the community, particularly those requiring home supports and the maintenance of delayed discharges at as close to zero as possible.
- Proposal on the services that can most appropriately be provided in private hospital capacity, to inform planning in that regard. This should include some assessment of the extent to which this approach will alleviate pressure on public hospital facilities and support delivery of services.
- Further proposals for expansion of ICU beds beyond the approved proposal for 22 beds.
- Risks and dependencies, including in regard to staffing resource for additional acute and ICU beds.
- Further discussion of mortuary facilities and appropriate preparedness.
- Consideration of potential for support for necessary transport from civil defence or other supports, and private ambulance capacity.

4. The subgroup will give ongoing attention to the approaches being used by countries which are one to two weeks or more ahead of Ireland, in terms of freeing up capacity and deploying resources as effectively as possible. This may include approaches such as fever clinics separate to ED facilities, and swabbing of respiratory patients as standard.

5. Early provision of information and guidance on protocols and contingency planning for clinical leads and frontline healthcare professionals is required, as a key part of the overall communications framework.

ENDS

Appendix 1:
Terms of Reference and Membership of NPHET SubGroup on Acute Hospital Preparedness
3 March 2020

Purpose
The ECDC has revised the risk for healthcare system capacity in the EU/EEA and the UK in the coming weeks is considered moderate to high. This subgroup of NPHET will provide oversight and assurance on the preparedness of the acute hospital system to deal with a significant increase in hospital admissions and for the reception and care of those presenting with COVID-19.

Terms of reference
This group will provide oversight and assurance that preparedness plans are in place and are being implemented across the public hospital system. In particular this subgroup will provide assurance to the NPHET that the HSE has:

- Developed a delivery model for the management of COVID-19 with a focus on isolation facilities in acute hospitals and developed proposals to access additional capacity.
- Established a baseline of the critical care capacity and developed specific surge critical care capacity plans for each hospital and identified additional major surge critical care capacity. These plans should include consideration of ethical guidelines on patient pathways.
- Has considered the role of private hospitals to support business as usual, as well as additional capacity for treatment of COVID-19 patients.
- Reviewed the preparedness of mortuary facilities.
- Assessed the capacity and responsiveness of the NAS and any issues that arise in relation to national ambulance services.

Membership

- Ms. Tracey Conroy, Acute Hospitals Policy Division, DoH (Chair)
- Mr. Liam Woods, National Director Acute Operations, HSE
- Dr. Vida Hamilton, National Clinical Adviser and Group Lead, Acute Hospitals, HSE
- Dr Michael Power, National Clinical Lead, Critical Care Programme, HSE
- Mr. Martin Dunne, National Director, National Ambulance Service, HSE
- Mr. Gordon Dunne, CEO, Hermitage Clinic
- Ms. Joan Regan, Principal Officer, Acute Hospitals Policy Division, DoH
- Mr. Liam Morris, Principal Officer, Acute Hospitals Policy Division, DoH
- Ms. Rachel Kenna, Deputy Chief Nursing Officer, DoH
- Mr. David Smith, Director, Scheduled and Unscheduled Care Performance Unit, DoH
- Mr. David Noonan, Principal Officer, Primary Care Division, DoH
- Ms. Sarah Cooney, Principal Officer, Social Care Division, DoH

Term and Meetings
Sub-Group to be established from 3 March 2020 and will be ongoing until terminated by agreement with NPHET.