

NPHET Subgroup on Acute Hospital Preparedness Update for NPHET Meeting on 24 March 2020

Key points in relation to the work of the Acute Hospitals Preparedness subgroup which should be noted by the NPHET are as follows (further detail, as well as agreed actions of the last subgroup meeting can be found in **Appendix 1**).

Acute and critical care capacity

The HSE reports a significant increase in the number of empty beds in hospitals (1,700 as of 19 March), and a reduction in the number of delayed transfers of care (347 as of 21 March), which reflects the Covid-19 preparations which are underway in acute hospitals. The HSE has undertaken to share a detailed breakdown of current and surge ICU and acute bed capacity, by hospital and hospital group, early w/b 23 March. This will allow for a greater understanding of acute and critical care bed capacity, as well as identification of any gaps which need to be addressed.

A new ICU bed information system was due to go online on 20 March, which will allow for real-time reporting on bed capacity and occupancy (further consideration is needed on how data from ICU beds outside current ICU settings will be captured). This system will also be expanded to the private hospital system by the end of the month.

Private hospital sector

Engagement with the private hospital sector is ongoing, with a meeting held on 19 March between the Department, HSE and the private hospitals. A draft framework document which will govern engagement between public and private hospitals is currently under discussion and will be submitted to Government for approval once finalised and agreed.

Overarching framework for acute care

This has been developed by the National Clinical Lead for Acute Hospitals and is described in a separate paper for NPHET provided today. This is within the context of the overall clinical model of care which has now been finalised and shared by HSE.

Maintenance of key specialties

Work is ongoing across the services to identify approaches to maintaining critical and time-dependent work on key specialties, including by the NCCP, the Trauma Programme, and across the national clinical programmes. This includes transfer of work to alternative locations and reconfiguration within hospitals.

National Ambulance Service

Static testing sites which were previously run by NAS are being handed over to community services, and this is reported to be progressing well. NAS will continue to provide testing in the community for specific cohorts, including healthcare workers and those who are unable to attend the static testing sites. GPs will be prioritised for testing by the NAS where required, and there has also been engagement with Gardaí, prison services and nursing homes to determine how they can be looked after. An online, cloud-based test booking system is being set up in collaboration with Microsoft. This sophisticated system will help to streamline the booking process for testing.

Mortuary facilities

The Expert Group on Mass Fatalities led by D/Housing has been reformed following an initial teleconference with the coronial services on 15 March. The Expert Group will meet again on 24 March. In the intervening days, Department and HSE are continuing to work together on a service model for fatalities. HSE is finalising a summary statement which will be shared with the Department along with an audit of mortuary facilities to include details of storage, throughput and work patterns.

Next steps

1. Finalisation of arrangements to bring private hospital capacity onstream, with continued engagement between Department and HSE on progress of operational level arrangements.
2. Finalised hospital surge plans to be shared with the Department, recognising these may continue to adapt.
3. Clarity to be provided on the volume of elective work cancelled or postponed, to underpin longer term planning to meet demand over time.
4. Continued engagement between the Department and HSE /relevant programmes on the progress of preparations to protect critical, time-dependent services.
5. Continued engagement on progress in regard to implementation of measures to separate covid work and transfer non-covid work to private hospitals, as these are implemented locally by hospitals.
6. A key focus is the requirement to agree on a standard format for reporting and monitoring that will ensure sharing of key data while minimising the administrative burden.

Appendix 1: Detailed update on the work of the Acute Hospitals Preparedness Subgroup of the NPHE

The Acute Hospitals Preparedness subgroup of the NPHE will provide oversight and assurance that preparedness plans are in place and are being implemented across the public hospital system. It includes clinical and senior management representations from the Department, HSE and private hospital sector. The group has now met twice. The subgroup met for a second time on 19 March to update on progress over the two weeks since its previous meeting. Agreed actions from the most recent meeting are as follows:

- Department and HSE will continue to engage on the detailed actions underpinning the published Action Plan, and the immediate data requirements required to feed into NPHE's work.
- HSE will provide a report of current and surge bed capacity, by hospital and hospital group, by early w/b Monday 23 March.
- The required framework for participation of private hospitals in meeting overall requirements will be agreed in the week commencing 23 March.
- The Department will engage further with HSE on the model of care within the acute services, to provide an update for the NPHE on this including response on the question of cohorting Covid-19 positive patients in designated hospitals.
- An update on the ethical framework for resource prioritisation will be provided to the subgroup.
- The NAS will share any update on a possible DFB surge plan with the Department as available.
- The HSE will share its statement updating on planning relating to the deceased, including audit of existing mortuary facilities with associated detail as requested.
- The Department and the HSE will work within the overall comms framework to feed in on communications issues for the subgroup as they arise.

National Action Plan

There has been intensive work on the finalisation of the National Action Plan in response to COVID 19. These high-level actions set out the overall approach of maintaining critical essential work while freeing up and increasing existing capacity through a number of measures. These include patient flow measures, postponement of non-essential work, transfer of work to private hospitals where feasible, hospital avoidance, and increasing numbers of general medical and critical care beds.

Engagement between the Department and the HSE is ongoing in regard to the detailed work underpinning each action. Recognising the intensity of preparations and the fluid situation, these updates have evolved on a day by day basis.

This work is side by side with the parallel work to ensure immediate data requirements are provided to track progression and operational response capacity.

Acute and critical care capacity

As of 19 March, the HSE reported approximately 1700 beds empty reflecting the preparations being made including cancellation of routine electives and a fall-off in presentations at ED.

As of 21 March, the number of delayed transfers of care stood at 347. This reflects a significant reduction to date.

The initial funding approved (€430m of which €160m is provided for acute care) provides for c.200 general medical hospital beds and an increase in critical care capacity of 38 beds in our public hospitals. Hospital Groups are working to put these in place, and it is understood formal requests to proceed

were issued by the HSE approximately ten days ago. Hospitals with ICU facilities have also been asked to identify ICU surge space for up to ten beds each.

The Department and the HSE remain engaged in tracking the progress of bringing new beds onstream which is staffing-dependent and accordingly may well fluctuate day to day given the expectation of significant absenteeism.

The HSE has undertaken to share a detailed breakdown of current and surge ICU and acute bed capacity, by hospital and hospital group, early w/b 23 March.

A new ICU bed information system was due to go online on March 20, which will allow for real-time reporting on bed capacity and occupancy (further consideration is needed on how data from ICU beds outside current ICU settings will be captured). This system will also be expanded to the private hospital system by the end of the month.

Private hospital sector

Engagement with the private hospital sector is ongoing, with a meeting held on 19 March between HSE and the private hospitals. A draft framework document is currently under discussion.

Gordon Dunne has emphasised the private hospitals' willingness to support in meeting overall requirements, and their desire for clarity on the position as soon as possible.

Once finalised, the draft framework document will be submitted to Government.

HSE has advised there are 400-500 private consultants in Ireland, who can provide valuable services in the response to Covid-19.

HSE has requested that Hospital Groups engage bilaterally with private hospitals in anticipation of agreements, in order to expedite and streamline operationalisation of transfers.

Overarching framework for acute care

This has been developed by the National Clinical Lead for Acute Hospitals and is described in a separate paper for NPHE provided today. This is within the context of the overall clinical model of care which has now been finalised and shared by HSE.

Maintenance of national specialties

There has been bilateral engagement with the various national programmes, while recognising the overall role of HSE Acute Operations to ensure a coherent and cohesive approach. Some updates are provided below.

Cancer: There is daily engagement with NCCP in regard to cancer services. Risk assessment is being carried out to determine for which patients' treatment can be paused, or where it must not be interrupted. The importance of this work connecting with the wider consideration led by the NCAHL for Acute Hospitals is clear and the NCCP has joined the Acute Preparedness Subgroup given the significant volume of cancer service delivery across the system.

Discussions are underway to establish what cancer services could be provided in private/alternative setting. This is broken down by specialism with the initial focus on medical oncology.

Transfer and reconfiguration of a number of oncology services is ongoing, under the guidance of the programme. Examples include transfer of inpatient and day ward services at SVUH to St Vincent's Private, and moving of day wards to appropriate areas to ensure clear separation from Covid-19 work.

Work is ongoing by the programme in regard to the role of acute oncology CNS including location, and telephone triage model.

Virtual meeting software is being rolled-out to support patient consultations and to facilitate MDMs. This model is to be used by GPs and mental health services also.

Trauma: Ambulatory trauma for Dublin is now largely transferred to Cappagh, and work is ongoing within the Trauma Programme to address the potential for similar approaches to be adopted in other regions. The National Clinical Lead is engaging with the NCAGL for Acute Hospitals.

Dialysis: Extension of hours in contracted dialysis centres around the country is being progressed.

Obstetrics: Clinical leaders who have produced material to support clinicians. Given the potential impact of absenteeism on smaller units, there is recognition of the need to remain flexible and engaged across the services.

CF: Concerns have been expressed by CFI about change in use of CF facilities nationally and the programme is clear this would only happen under the guidance/direction of the National Clinical Lead, the Programme Manager and the CF Centre Director at individual hospitals.

All the National Clinical Programmes have been asked to develop disease-specific guidance, where these are appropriate. The general HSE COVID-19 guidelines also apply to all patient groups.

National Ambulance Service

The work of the NAS includes four workstreams: access for 112/99 patients, access for COVID-19 patients, and service delivery including retrieval and flexibility in crewing models.

There has been positive engagement with voluntary organisations, private providers and the military.

Key enablers include dashboards to track activity and identify hotspots; financial tracking dashboard; ICT sustainability to ensure safety; and workforce welfare, including flexible rosters and appropriate family time for staff. The NAS has acknowledged strong support from HSE ICT.

Static testing sites are being handed over to community services, and this is reported to be progressing well. GPs will be prioritised for testing by the NAS where required, and there has also been engagement with Gardaí, prison services and nursing homes to determine how they can be looked after. An online, cloud-based test booking system is being set up in collaboration with Microsoft. This sophisticated system will help to streamline the booking process for testing.

Seven hospitals are now doing their own testing, with more coming online over the coming days and weeks.

NAS has plans in place to ensure that patients who cannot access the static testing sites will not encounter barriers to testing.

NAS has engaged with Dublin Fire Brigade, to identify what scope they have to provide surge assistance and how NAS and DFB can work together to meet overall needs.

Mortuary facilities

The Expert Group on Mass Fatalities led by D/Housing has been reformed following an initial teleconference with the coronial services on 15 March. This group had previously prepared detailed plans in a different context, such as terrorist attack or plane crash. The group will review plans for this new context which brings different considerations including throughput, storage and interment. Department and HSE are both represented on the Expert Group. Coroners have affirmed that there is no requirement for a post mortem for covid-positive patients, but this may be an issue regarding deaths in the community if there is a high suspicion of covid infection (noting that covid swabs may be taken post mortem). The Expert Group determined on 19 March that additional facilities will be procured, from an existing contract, in readiness to be put in place once required. HSE has procured 13 refrigeration devices to be located at main sites, ECDC has specified a particular type of body bag and this will be sourced by HSE.

The Expert Group will meet again on 24 March. In the intervening days, Department and HSE are continuing to work together on a service model for fatalities.

HSE is finalising a summary statement which will be shared with the Department along with an audit of mortuary facilities to include details of storage, throughput and work patterns.

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