National Public Health Emergency Team

Acute Hospitals Preparedness Subgroup
Overview of the Work of the Subgroup and Next Steps

18 June 2020

Action required
☒ For noting
☐ For discussion
☐ For decision

1. Introduction

NPHET was convened in January 2020 following initial reports of a novel coronavirus in China. Over the following weeks there was a focus on readying the acute hospital system for what could be potentially a very large number of cases requiring hospitalisation or critical care.

The National Action Plan on Covid-19, published on 16 March, set out a range of action areas across the system. These included protection of time-critical essential care, patient flow and capacity, and postponement of routine care. From an acute hospital perspective, the focus initially was to drive up critical care capacity as much as possible in anticipation of fast increase in demand.

The public health measures put in place at the outset of the Covid-19 pandemic were effective in 'flattening the curve', reducing demand both for Covid and non-Covid care. The challenge now, over the coming weeks and months and into next year, is managing side-by-side delivery of Covid and non-Covid care over a more prolonged period[1]. It is clear we have to maintain the capacity in our acute system to respond to Covid-19 care needs as they move up and down, and at the same time deliver at least an essential level of non-Covid care[2]. The capacity available at any time will need to be used as effectively as possible across the entire system, including critical care capacity, to meet this challenge.

The Acute Hospital Preparedness Subgroup was established on 3 March and held its first meeting on 4 March, with a total of seven meetings held. There have been 46 agreed actions, of which 41 are complete or are ongoing, with five in progress. Terms of reference and membership are set out at Appendix 1. A table setting out actions is attached at Appendix 2, with a timeline of decisions taken by the Subgroup in the context of the Covid-19 pandemic attached at Appendix 3.

With the suppression of the disease (at this point in time) and as we seek to move forward in lifting the public health measures, it is timely to review the work of the Subgroup and consider next steps as the "new normal" is established.

2. Capacity

In preparation for the pandemic, and in the context of an acknowledged capacity deficit in critical care and general acute bed capacity, there was deep concern about hospital capacity to meet care needs. The NTPF supported the HSE in detailing plans for general and critical care surge capacity across all hospitals, including staff, ventilators and oxygen flow. This included intensive work on the part of HSE Estates in regard to isolation and critical care physical capacity as well as oxygen supplies. The general acute and critical care capacity plan developed was noted by NPHET on 14 April.

A key element was the willingness of all staff, and in particular nursing staff, to undertake training and to support the intensive surge capacity preparations to care for a potential significant number of Covid patients. Training was provided to over 1,500 nursing staff to allow them to provide support to critical care as required.

Potential critical care capacity including surge capacity was identified as nearing the 800 mark, although it is acknowledged that this would not have represented an acceptable level of risk in terms of critical care delivery. Baseline critical care capacity was 255 with an additional 42 beds (of which

[1] The European Medicines Agency has launched a strategy paper in which it states it may take at least a year before a vaccine for Covid-19 is ready for approval and available in sufficient quantities to enable wide spread and safe use.

[2] The European Commission has outlined three recommended criteria needed to ease restrictions for EU Member States. These are: Sound epidemiological criteria that shows a significant decrease in the spread of Covid-19, a built-in reserve or capacity in health care systems, including capacity for patients with other acute diseases and large-scale testing capabilities to monitor the virus.

two are paediatric) to be opened alongside the temporary surge capacity put in place. At the peak so far, approximately 160 patients confirmed to have Covid-19 were in ICU. ICU occupancy demonstrated significant regional variation, in the provision of both Covid and non-Covid care, with particular pressure in the Dublin area and utilisation of surge ICU bed capacity.

Well over 800 patients were in our acute hospitals with confirmed Covid-19 at the peak. However, data throughout March and April also showed significant available general acute beds, reflecting both a fall-off in attendance and the postponement of routine care, and lowering occupancy rates to around 84%. However, absenteeism and redeployment impacted staffing availability for these beds; staff absenteeism peaked at about 4,000, due to illness and requirement to self-isolate, and staff were redeployed to support critical care delivery and contact tracing and testing.

The number of Covid-positive patients in hospitals has been falling steadily in recent weeks, as has the number in critical care. As of 16 June, there were 62 confirmed positive patients admitted on site at acute hospitals, of whom 20 were in critical care. As of 16 June, the HSE is reporting that there are 372 critical care beds open and staffed, out of an overall total of 451 (including surge capacity which is expected to fall back as staff redeployed to critical care return to usual roles).

Reflecting the reduced level of non-Covid activity, the number of available general acute hospital beds is reported to be approximately 450. However, this is significantly down from the reported approximately 2,000 beds at earlier phases of the pandemic. ED attendances remain lower than normal, although attendance has increased significantly in recent weeks - attendance in the week to 9 June was 23,402. Attendance at this time of year would be expected to be between 25,000- 26, 000. Delayed transfers of care are reported as being at 392 on 15 June, compared to 213 on 6th April.

In line with the National Action Plan on Covid-19, there was a significant reduction in all non-urgent elective scheduled care activity in the last three months. As a result, scheduled care waiting lists have increased. The Department's Scheduled and Unscheduled Care Unit reports that, at the end of May, there were 575,863 patients on the outpatient (OPD) waiting list, an increase of 4% (+22,429) compared to end of December last year. In the last month the OPD figure for those waiting less than three months has fallen by 27,766, a reflection of the decrease in referrals by GPs. Preliminary information available from the NTPF indicates that OPD referrals for May were 43,516 compared to 97,038 in May 2019, a decrease of 55%.

The inpatient and daycase (IPDC) waiting list numbers for the end of May 2020 were 86,943, an increase of 31% (+20,383) year to date. While the overall growth of the IPDC waiting list figure in the last month is indicative of fewer patients being treated, it is of note that there were also fewer patients seen in outpatient clinics in the same period and as a consequence fewer patients were referred for procedures. Preliminary data available from the NTPF indicates that IPDC referral figures have reduced by 40% (-7,184) for May 2020 compared to May 2019. Meanwhile, the number awaiting GI scopes at the end of May 2020 was 35,307, an increase of 59% (+13,063) since the end of last year.

The Department, the HSE and the National Treatment Purchase Fund continue to work together to estimate the impact of Covid-19 on scheduled care waiting lists with a view to informing activity going forward.

3. Protection of essential non-Covid care

The provision of essential, time-critical care has continued throughout the pandemic. The Subgroup has focused strongly on how to provide care to all patients who require it, as safely as possible. Given the highly transmissible nature of the virus, this has been challenging. An overview of key areas of work is set out below.

Protection of time-critical care
Recommendations from the Subgroup to NPHET have focused on seeking to protect non-Covid care. On 27 March, NPHET approved the approach of a Parallel System Framework for the identification of Covid-care hospitals with key partners to provide non-Covid care, for local implementation subject to local constraints, opportunities and differences.

NPHET approved further recommendations on 31 March including a national-level approach to ensuring the optimal utilisation of available capacity, including designation of non-Covid hospitals for the maintenance of critical essential services, with the aim of ensuring consistency for patients across the country.

The Subgroup also engaged with the RCSI in regard to planning to support continued delivery of time-critical surgery, including utilisation of private hospitals where appropriate.

Mitigation of risk in the delivery of non-Covid care
Guidance on patient pathways to mitigate the risks associated with the delivery of non-Covid care, for patients and healthcare workers, and support safe delivery of care, was developed under the auspices of the Expert Advisory Subgroup of NPHET (EAG) and approved in principle by NPHET on 5 May, with the support of the Acute Hospitals Preparedness Subgroup. This guidance includes, for example, guidance on screening, swabbing and use of PPE.

Infection prevention and control
Noting the critical importance of infection prevention and control (IPC) practices to protect both staff and patients, NPHET mandated the implementation of a suite of 29 measures to prevent transmission of the virus in acute hospitals; to slow the demand for specialised healthcare; safeguard risk groups; protect healthcare workers; and minimise the export of cases to other healthcare facilities and the wider community. The HSE was asked to implement these measures as a priority and to date significant progress has been made including;

- an overarching governance structure has been established in the HSE to provide oversight for all issues relating to COVID-19 infection control;
- a range of staff surveillance measures have been implemented across the acute hospital sector; systems to monitor staff training are being put in place;
- processes are in place in all hospitals to monitor compliance with standard precautions;
- outbreak control teams are in place in all Hospital Groups and public health departments have been notified of all hospital outbreaks;
- all Hospital Groups have implemented measures which provide assurance on governance, risk management, staff symptom declaration, staff segregation and adoption of social distancing guidelines;
- a general interim outbreak plan for COVID-19 has been developed under the governance of the National Pandemic Incident Control Team and published on the HPSC website.

HIQA has undertaken a desk top review of acute hospital IPC preparedness for COVID-19 and submitted a report to NPHET. While the report highlighted the progress which has been made in recent times to expand IPC capacity and capability in acute hospitals, deficits in IPC capacity were identified. The Department has engaged with the HSE in relation to these deficits. It is now clear that in order to safely and sustainably manage the provision of COVID-19 and non COVID-19 health services into the future, significant investment will be required to build staffing and ICT capacity

incrementally in the coming years. The Department will engage with the HSE in relation to these longer-term development funding requirements in the context of the Estimates 2021 process.

In addition, the HSE has identified a range of short-term proposals for urgent IPC improvements which can be implemented immediately and will help minimise and mitigate the risk to staff and patients, and facilitate the delivery of safe health services. These proposals encompass recruitment of specialist staff in IPC and occupational health, minor capital improvements to support good IPC practice, and certain IPC-related ICT projects. The Department is seeking to secure the additional funding required to address these immediate IPC/occupational health needs, and will continue to engage with the HSE in that regard.

Virtual consultations

Many acute hospitals have undertaken to develop and expand on virtual outpatient consultations. This includes engaging with patients through phone calls and the use of additional technologies that support face to face virtual engagements. Since the beginning of the pandemic an extensive body of work has been undertaken to support mobilising and expanding the use of telehealth for outpatient services to support virtual consultations in acute hospitals. The primary focus is on outpatient services, but the technology can be used for other virtual engagements as required. A solution has been identified, workflows and processes to support swift implementation of the solution are established, and implementation work has commenced with the Hospital Groups.

Demand-capacity modelling

The Subgroup and subgroup members have engaged on an ongoing basis with the demand-capacity modelling subgroup of the IEMAG, with the aim of supporting the refinement and finalisation of its assumptions. This will support its effective use to model the impact of varying levels of demand for acute care in different epidemiological scenarios. This model has potential to support ongoing scenario planning and demand-capacity projections.

Research on public reluctance to attend acute services

The Subgroup identified the need for research on public reluctance to attend acute services and this was undertaken through a survey and focus groups. Findings indicate that fear of infection has been one of the primary factors influencing this trend. Informed by the results, a communications campaign is ongoing across radio and social media, designed to assure the public that health services are open and to encourage the public not delay in seeking medical help. The impact of the campaign is monitored in the context of activity levels in GP surgeries and acute hospitals, and HSE survey data, and will be revised/concluded in line with impacts on the ground.

Work is underway on bespoke campaigns for specific diseases including ongoing campaigns for cancer signs and symptoms, as well as communications targeted at cancer patients currently undergoing treatment. The possibility of developing a campaign for stroke signs and symptoms is also being examined.

National specialties

In addition to these overarching pieces of work, particular service areas have responded to the challenges presented by Covid-19.

National Ambulance Service

On 2 March, NPHET agreed a proposal from the NAS in regard to home testing. NAS is continuing to support the ongoing testing requirements of the HSE and is actively engaging in developing new ways of working and delivering services in this changing environment. The ongoing evolution of the service from an Emergency Medical Service to a Mobile Medical Service is an integral part of this development and will deliver enhanced system integration and patient care.

Alongside extensive support for testing, with over 88,000 tests completed to date, NAS normal activity has continued with approximately 850 emergency and urgent call outs per day currently, and approximately 90 calls per day being completed by the NAS Intermediate Care Service. NAS has implemented a dedicated Covid-19 dispatch centre with increased clinical capacity, supported by the introduction of an identification system called Protocol 36, which allows staff on the 112/999 call system to assess patients who may be Covid-19 positive.

Trauma services

At the beginning of the crisis, the Department requested the National Clinical Lead for Trauma Services (NCLTS) to develop a national plan for the reconfiguration and streamlining of trauma and orthopaedic surgical services around the country. Key developments as a result of this work include:

- Nearly all hospitals that have trauma and orthopaedic surgical services on site have developed innovative arrangements to use different facilities for trauma of a lesser severity
- The coordinated Covid-19 crisis trauma response has resulted in a critical mass of similar cases that can be treated on one operating list by a surgeon with a sub specialist interest in a particular injury, which is likely to lead to enhanced outcomes
- The use of the trauma assessment clinic, whereby patients with certain injuries can be managed without physically attending outpatient services, has increased significantly.
- Alternative rehabilitation facilities for many long stay orthopaedic patients were sourced, creating significant extra space in the acute hospital setting for Covid-19 positive patients.
- An increased focus on planned trauma care in hospitals such as Cappagh Hospital has helped to ensure sufficient capacity in larger acute hospitals for Covid-19 patients. Changes introduced as part of this practice align closely with the National Trauma Strategy objective to streamline the delivery of trauma services across the acute hospital system. It is expected that mainstreaming these changes will ultimately facilitate accelerated National Trauma Strategy implementation.

These changes to service delivery have ensured that every trauma patient that needs to be seen by a healthcare professional or needs an operation has had access to that treatment. More day of admission surgery and sourcing of alternative rehabilitation facilities for many long-stay orthopaedic patients supported creation of capacity within the acute system.

Cancer services

Cancer services are continuing, albeit at reduced capacity , following the consideration of the risk:benefit ratio of treatment for each individual patient. The prioritisation of time-sensitive treatment, particularly surgery, through national guidance, has been crucial to the continuation of services, ensuring the referral, diagnosis and treatment of current and new cancer patients.

There has been a recent recovery in GP e-referrals to Rapid Access Clinics, with the number of referrals to Symptomatic Breast Disease Clinics returning to pre-Covid-19 levels. Rapid Access Clinics and diagnostic services are continuing in line with NCCP guidance documents. Patients are being triaged in advance of their appointment, and virtual/telephone clinics are in operation where possible.

There is an ongoing review of the location of the delivery of cancer services. Medical oncology services continue with the relocation of day wards where necessary, radiation oncology services continue with provisions made for physical distancing and maintaining urgent surgical oncology services is a priority with most services relocating to private hospitals.

The main focus now is on facilitating cancer services to return to pre-Covid levels, as far as possible, and on how this can be done in a safe and effective way.

Transplant services
The ODTI and transplant centres have undertaken a number of measures to mitigate the impact of Covid-19 on the transplant service and protect those on the waiting list for a transplant. These include regular weekly multi-centre MDTs with Clinical Leads on Organ Donation (ICU), representatives from the three transplant centres (Beaumont, Mater and St. Vincent's) and the HSE. All potential donors are swabbed for Covid-19. Where the result is negative for Covid-19, a clinical decision is taken on whether to proceed with donation and transplantation, following a risk-benefit analysis.

Normal transplant activity ceased unless exceptional cases were highlighted. The ODTI advised that the standard risk/benefit ratios were challenging in a Covid-19 environment. Renal transplant services ceased activity as it was possible for patients on waiting to list to continue on dialysis. For liver and heart transplants, exceptional cases were highlighted to the ODTI and the Clinical Lead on Organ Donation/Organ Donation Nurse Manager network. Consideration was given to the demands for priority liver transplants and urgent and super urgent heart transplants relative to the clinical risk of infection in a potential recipient. Decisions were made to proceed with donation and transplant based on clinical risk-benefit assessments.

The renal transplant programme in Beaumont Hospital recommenced on 24 May. The Liver Transplant Programme, St Vincent's University Hospital, and, the Heart & Lung Transplant Programme, Mater Hospital remain active. However, as noted above decisions to proceed with donation and transplant are based on clinical risk-benefit assessments.

Blood supply
On 30 March 2020 the IBTS introduced changes to its blood donation clinics, including an appointment system for donors, cessation of collections from first time donors (due to length of time taken to interview first time donors etc), pre-screening of donors and maintenance of social distancing throughout the donation process. These changes allow for the maintenance of the blood supply to meet patient demand and ensure the safety of donors attending clinics. The changes have been positively received by donors.

The IBTS is a partner in a clinical trial, subject to securing funding, to introduce convalescent plasma ((i.e. plasma collected from patients that have recovered from an infectious disease) to the component range it offers. Convalescent plasma can be transfused to patients fighting an infection or can be used to manufacture immune globulin concentrates (medicinal products). This is in keeping with practice in many European countries and has been recommended by the European Commission.

Maternity services
All 19 maternity hospitals/units have maintained service delivery during the pandemic. It is recognised that women who are accompanied by a birthing partner have better outcomes than those who do not, and, as far as possible, such restrictions have been minimised. The use of remote technology has, in some instances, reduced the requirement for some hospital visits. In addition, some hospitals have developed online antenatal and postnatal classes, communication and meeting platforms. Some hospitals were in a position to scale up community service because community midwifery services were already established e.g. certain hospitals were able to extend the geographic catchment area for Early Transfer Home services, which reduced the time mother and baby spent in hospital.

Paediatric services
Given the burden of Covid care was expected to fall on adult services, and also a fall-off in ED presentations, CHI sought opportunities to support adult hospitals in Covid preparedness. This was in line with the response of paediatric services internationally. Provision of paediatric services at Tallaght Hospital was temporarily suspended, and staff were redeployed on a voluntary basis to adult services, including for example nursing staff deployed in Tallaght ICU. CHI further supported adult services in Connolly Hospital with an adult infusion lounge provided in the OPUCC centre. This allowed Connolly Hospital to deliver infusion services in a non-Covid environment to a patient cohort in a high-risk category.

4. Routine non-Covid care

The National Action Plan set out that elective and OPD activity should be restricted in order to maximise patient flow through hospitals and ensure most efficient use of existing resources. Consistent with this, NPHET's recommendations to the Minister on 27 March regarding further measures aimed at interrupting transmission of Covid-19 and related steps included that non-essential surgery, health procedures and other services should be postponed. The letter followed the publication on 25 March by ECDC of 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.

On 5 May, NPHET agreed that its recommendation of 27 March, in regard to the pausing of all non-essential health services should be replaced, from now on, in regard to acute care, with a recommendation that delivery of acute care be determined by appropriate clinical and operational decision making. Key factors for consideration in the provision of more non-Covid care will include capacity, infection control and mitigation of risk for both patients and healthcare workers through application of processes as outlined at a high level under the auspices of the EAG.

5. Mortuaries

The Department and the HSE participated in the National Oversight Group, established by the Department of Housing, to lead on the implementation of the Covid-19 mortality plan developed by the mass fatality expert group. The National Oversight Group meets weekly. An early decision of the Oversight Group/Mass Fatality Expert Group was to deploy two body storage facilities in Dublin and Limerick to provide for additional mortuary capacity should it be needed. Given the experience with mortality to date, the group recommended that the contract for the facilities should not be extended beyond the end of May. The facilities can be restored at 72 hours' notice should this be required.

6. Priority areas

The areas outlined above will require ongoing focus as part of day-to-day engagement and oversight on policy and operations in the "new normal". Also in that context, some particular areas of further focus, and some specific next steps, have emerged from the work of the Subgroup and these are outlined below.

Critical care capacity
The need to increase critical care capacity is a key learning of the pandemic response. Notwithstanding the effectiveness of public health measures in flattening the curve, ICU occupancy easily exceeded base capacity of 255[3] with 280 critical care beds occupied at the peak. The additional demand for critical care was easily met by surge ICU capacity, with clinical staff redeployed from other hospital services and locations and, at critical care capacity of 350, quality of care was sustained, and clinical

[3] NOCA ICU audit

risk was manageable. However, beyond total capacity of 350 (baseline of 255 and surge of 95), where redeployed critical care clinical staff and critical care facilities are unavailable, the National Clinical Lead for critical care has affirmed there would be major impacts on quality of care delivered, with unmanageable or overwhelmed clinical activity and consequently, in service planning terms, unacceptable clinical risk.

Accordingly, an urgent priority now is the finalisation of a submission on permanent strategic critical care capacity requirements, following receipt of a proposal in this regard from the HSE on 17 June. It is intended that the submission, underpinned by NOCA audit findings, by the Health Service Capacity Review and by wider strategic considerations, will be brought to NPHET on 25 June.

Use of additional private capacity
In line with Heads of Terms to the Agreement with the private hospitals to use their capacity, the Department's Governance and Performance Division oversaw the review of the arrangement at the end of May. The Government decided that the existing arrangement should not be extended to the end of August. It has mandated the HSE to negotiate a new arrangement with private hospitals which would provide the HSE with full access to private hospital capacity in the event of a surge of Covid-19 and separately with ongoing agreed access, to enable the HSE to meet essential and elective care needs.

The use of private hospital capacity provides potential for immediate additional capacity. However, private hospitals are designed to deliver a different model of care, which is largely high volume and low to medium complexity scheduled care. As confirmed by the Health Service Capacity Review, there is a need to invest in more sustainable solutions to meet requirements for the public health system into the future, in a Covid-19 environment.

Non-Covid care
As outlined by Scheduled and Unscheduled Care Unit, utilisation of available beds has to be balanced between the needs of Covid-19 patients, emergency admissions and elective procedures and the management of delayed transfers of care. Hospital occupancy will need to remain at a level that allows for surge capacity to respond to increased demand for Covid care periodically, and the current recommendation is for 80-85%, as opposed to the near 100% occupancy levels prior to the pandemic. Processes and protocols to mitigate risk for patients and healthcare workers will have operational implications including on patient flow and throughput. The strategic framework developed by the HSE, and the clinical prioritisation approach being taken in that context, will inform progress in this regard.

In regard to delivery of key services including cancer, time-critical surgery, trauma surgery, transplant services, and care for immune-suppressed patients, the role of NAS in testing and other key areas, engagement will continue as normal between the Department, the HSE and other stakeholders. This engagement will also be informed by the HSE's strategic framework.

Innovation and strategic change
The use of technology, service reorganisation and the role of clinical leadership in driving models of care, ED trends, approaches to dealing with delayed transfers of care, use of private hospital capacity, and collaboration from across the health workforce, were all key elements in the preparation for responding to Covid-19. All offer learnings that can and should support ongoing improvements in service delivery and may provide opportunity for longer-term strategic reform as the system responds to the enormous challenge presented by the delivery of Covid and non-Covid care in parallel. International learnings and comparisons also need to be identified.

It is important to say that while this paper emerges from the work of the Acute Preparedness Subgroup, the innovations noted below go across settings:

- The need for solutions to reduce ED attendance and hospital admission, including relocation of urgent care to community spaces

- The potential to refer directly from GPs to the acute setting

- Ensuring timely and appropriate discharge of patients in the context of winter planning, with a different model of care anticipated to be needed including increase in the provision of home supports

- The impact on infrastructural capacity of infection control and risk mitigation strategies to protect both patients and healthcare workers

Staffing
In the context of the significant levels of redeployment that took place, and staff return to core work, consideration should be given to identifying and training other non-clinical individuals to undertake roles that can be carried out by non-clinical staff, such as contact tracing. This may be part of continuity preparations for Covid surge planning. More widely, it is understood that strategic workforce planning is being undertaken to consider how resources are divided, including virtual clinics and alternatives to ED.

In the context of acknowledged capacity shortfalls in the public hospital system, investment in public health system capacity into the future will require consideration of staffing as well as infrastructural investment.

Communications
The Department and the HSE should continue to maintain a focus on necessary communications, as required on an ongoing basis in the context of side-by-side delivery of Covid and non-Covid care.

Data collection and monitoring
Continued work is being undertaken to determine time-critical and more routine care requirements, including through the RCSI at the request of the Department in regard to time-critical surgery, and through the Scheduled Care Data Group. The Department, the HSE including NCCP and HPO, the NTPF and the RCSI should continue to work together to maximise data gathering and reporting where needed to augment standard reporting as required during the coming months. This will be informed by the central framework / plan being developed by HSE. Data is also supporting the refinement and finalisation of the demand-capacity model developed under the auspices of IEMAG, and this should continue to enable the IEMAG subgroup finalise the model.

Outcome indicators
Consideration is required on whether additional outcome indicators are required that can ensure the impact of the pandemic on non-Covid care delivery is tracked and understood.

7. Conclusion

The work of the Acute Hospitals Preparedness Subgroup was commenced in the context of deep concern about acute hospital capacity and delivery of care for both Covid and non-Covid patients and potentially overwhelming demand.

While the approach to the Covid-19 pandemic still presents a significant challenge to the acute hospital system, the environment is very different to that of March 2020. Much more is known about the disease and the requirements of patients who are hospitalised because of it, while experience in other countries which are at different stages in the pandemic can also help to inform our approach.

In this somewhat more stable environment for the acute hospital system, it is timely now to move from reactive crisis management to a more strategic focus on the very significant challenges arising in both the short and long-term, within a wider integrated care context. These will require intensive and focused work between the Department and the HSE over time, and it is considered this should be part of normal, or "new normal", engagement.

Accordingly, it is proposed that the Acute Hospitals Preparedness Subgroup be stood down at this time, with the proviso that it be reconvened when and if required.

ENDS

Appendix 1 Terms of Reference and membership

Terms of Reference

The subgroup will provide oversight and assurance that preparedness plans are in place and are being implemented across the public hospital system. In particular, the subgroup will provide assurance to the NPHET that the HSE has:

1. 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.

2. 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.

3. Considered the role of private hospitals to support business as usual, as well as additional capacity for treatment of COVID-19 patients.

4. Reviewed the preparedness of mortuary facilities.

5. Assessed the capacity and responsiveness of the National Ambulance Service (NAS) and any issues that arise in relation to national ambulance services.

Membership

Ms. Tracey Conroy **(Chair)**	Acute Hospitals Policy Division, DOH
Ms Fiona Bonas	Interim Director, HSE National Cancer Control Programme
Ms. Sarah Cooney	Principal Officer, Social Care Division, DOH
Mr. Gordon Dunne	CEO, Hermitage Clinic
Mr. Martin Dunne	National Director, National Ambulance Service, HSE
Dr. Vida Hamilton	National Clinical Adviser and Group Lead, Acute Hospitals, HSE
Ms. Rachel Kenna	Deputy Chief Nursing Officer, DOH
Mr. David Noonan	Principal Officer, Primary Care Division, DOH
Ms Celeste O'Callaghan	Principal Officer, Acute Hospitals Policy Division, DOH
Dr Michael Power	Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital; National Clinical Lead, Critical Care Programme, HSE
Mr. Liam Sloyan	CEO, National Treatment Purchase Fund
Mr. David Smith	Director, Scheduled and Unscheduled Care Performance Unit, DOH
Mr. Liam Woods	National Director Acute Operations, HSE