EUROPEAN ASSOCIATION
OF HOSPITAL MANAGERS

Fighting Strategy COVID-19
Northern Ireland

1. What is the COVID-19 fighting strategy of your government (National, local)?

In Northern Ireland we follow the strategy of the UK Government as interpreted by the government of the devolved administration – the Northern Ireland Executive. The strategy development is informed by international experience and data, local academics, scientists and public health professionals. The strategy has followed the course of detection with testing and contact tracing when the numbers of people infected was small, followed by containment – a policy of social distancing – schools closed, working from home where possible and not an 'essential worker'; complete re-organisation of the hospital estate and bed capacity, e.g., – large hospital emptied and kept for COVID-19 patients only**.** The next phase will be the introduction of much more intensive 'track and trace' with an app being tested this week in one part of England and recruitment of large numbers of staff to undertake contact tracing. In Northern Ireland there is also engagement with the Irish government, public health professionals, the two Chief Medical Officers signed a 'Memorandum of Understanding' on public health matters and there is significant political, media and public interest in comparing strategies north and south of the border. There has been a significant operation by both police forces on either side of the border at Easter and this week-end to ensure that people from Northern Ireland do not travel to their holiday homes in the north west of the island.

2. What is the strategy towards the population (Mask wearing, containment …)?

The UK Government has not supported the wearing of masks in the general population citing lack of evidence for their effectiveness, the risk of complacency in social distancing which their wearing might bring about and the risk to supplies of masks for healthcare workers (HCW).

3. Are there enough masks for the population in your country?

See answer to q2. This week however there has been some softening of the policy in briefings from the UK government and some leading public health commentators. The Scottish government has recommended that people use face coverings when in shops and on public transport although this is not compulsory and suggests that people use cloth coverings such as a scarf, rather than 'medical grade face masks' and no face coverings should be used for children under the age of two years. Advice for England, Wales and Northern Ireland has not changed and masks have not been recommended.

4. Are there enough masks and personal protective equipment for health professionals?

There have been challenges along the way however the UK Government agency – Public Health England has constantly updated guidance to ensure clarity on what PPE should be used by whom and in what context. In Northern Ireland we have effectively harnessed infection control expertise to work with frontline clinicians to help manage supplies. We also have effective procurement, logistics and supplies teams linked to the UK supply chains and a policy of pushing out supplies, constant monitoring of supplies against need, redistribution of supplies, 'mutual aid' between hospitals; collaboration with other sectors which use PPE, universities, manufacturing have all contributed to innovation including 3D printing of visors and other useful equipment to avoid serious problems.

5. What is the biological screening strategy (Polymerase Chain Reaction – *PCR*, serological tests,)?

The UK government published a testing plan on 4th April 'Coronavirus (COVID-19) Scaling up our testing programmes
https://www.gov.uk/government/publications/coronavirus-covid-19-scaling-up-testing-programmes
This sets out the 5 pillars:

Pillar 1: NHS swab testing for those with a medical need and the most critical workers (*this is PCR testing, developed and delivered in hospital laboratories, introduced mid-March*)

Pillar 2: Commercial swab testing for critical key workers in the NHS, social care and other sectors. (*This is a drive-through arrangement in local arenas, arrangement with 4 UK diagnostic companies – for N. Ireland this is Randox – an international company founded and HQ in N. Ireland*.)
Pillar 3: Antibody testing to help determine if people have immunity to the coronavirus (*under development*)
Pillar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments (*commenced in pilot phase in N. Ireland last week, app being tested in one part of England this week, large scale recruitment of contact tracers intended*).
Pillar 5: Diagnostics national effort to build a mass-testing capacity at a completely new **scale (*to meet the demands of the 'track and trace' strategy)***

6. **Do you have enough biological screening tests?**

   Tests were initially provided by the central virology lab, then testing capacity developed in other hospitals largely focused on testing symptomatic patients and healthcare workers. A UK wide consortium of four diagnostic testing companies has collaborated with the UK government to create additional capacity – see the 5 pillar strategy above. The testing capacity has therefore been prioritized and as it is expanded testing is provided to more people and strictly controlled.

7. **Do you have enough beds for inpatients? (intensive care and other).**

   Yes. A Northern Ireland wide Surge Plan was developed, much elective surgery was postponed, discharges expedited and one large hospital in Belfast converted to COVID-19 only and considerably increased intensive care capacity created. 'COVID-19' centres staffed by General Practitioners (GPs) were created to treat ambulatory patients with suspected COVID – 19 thus avoiding presentation to ED or hospital admission. All of these measures have resulted in sufficient capacity being available to admit where necessary and retain sufficient spare capacity for any surge.

8. Do you increase the number of intensive care beds in your country?

Yes. In N. Ireland by c. 60% by creating additional ITU capacity within existing hospitals. A 'Nightingale' Hospital (ref. Florence Nightingale[1]) was created in London in 9 days in early April, in an exhibition centre, with the help of the army (one of 17 'field' hospitals across the UK with locally relevant models of care). The intended capacity of the London Nightingale was 2,900 intensive care beds and 750 further beds. The combined, normal compliment of intensive care beds in London, that is, within hospitals, is approximately 770, this was doubled to 1,555. Newspapers to-day report that these are scaling down due to lack of admissions. Sir Simon Stevens, Chief Executive of the NHS is quoted as saying that it would "count as a huge success for the whole country if we never need to use (the Nightingales), but with further waves of coronavirus possible it is important that we have these extra facilities in place and treating patients"; "it makes sense to hope for the best but nevertheless to prepare for the worst".

9. Do you have enough human resources to manage the epidemic? '

Surge plans' including standing down a considerable amount of non-COVID-19 activity and staff were redeployed and upskilled where necessary to deal with COVID-19 patients. Where staff were unable to work due to having COVID-19 symptoms they were prioritized for testing so that they would be able to come back to work. There was a UK –wide call for volunteer staff including recently retired doctors, nurses etc. or lay people who could carry out non-clinical tasks. There has been some use of these people but they have not been required in the numbers anticipated. Recently there have been staffing pressures on care homes as staff have become ill or required to self-isolate. Hospitals have provided replacement staff and additional skills where necessary.

10. Do you have guidelines for good practices between healthcare teams and physicians in the context of the COVID-19 crisis?

Staff have been unstinting in their commitment to flexibility and working together during this team. In addition, in Northern Ireland we have combined health and social care staff and primary care teams all within the same governance – all public health and social care system, independent contractors

[1] https://en.wikipedia.org/wiki/Florence_Nightingale

are managed by the same regional authority etc. This has helped understand the plans and challenges through all stages of COVID-19 patient's experience and enable collaboration to support staff and facilities where necessary. Official guidelines are provided across the UK by 'Public Health England', considered locally and where necessary amendments are incorporated. Locally hospitals have guidelines and there is good sharing between organisations, for example, we have a Northern Ireland-wide 'Critical Care Network' which operates to ensure best practice and support between all of the critical care units. In addition all of the Royal Colleges (Surgeons, Physicians etc.) have published guidance for their members and these provide the detail to frontline clinicians.

11. What are the main challenges for hospital managers during the COVID-19 crisis?

Uncertainty – although planning has been strong, the path of disease and the amount of spread had been uncertain – national (UK) and local (N. Ireland) modelling by a group of experts has been useful but this has changed as data has developed and understanding of the disease pathway and spread has improved. Worry about: staff absence through the need to isolate due to a health condition or a family member with a health condition or covid symptoms; concern about supply of PPE, some medical supplies due to global demand, oxygen. However the strength has been anticipation or early identification of potential challenges and swift action to avoid difficulties.

12. Other important information?

The experience has been important in identifying the interdependencies and the value of working together – between disciplines within the hospital setting; the dependency on the care home sector to ensure that hospital bed capacity is kept free for potential surge in admissions. The value of other partners including, for example, in Northern Ireland with a strong agricultural industry, the expertise of veterinary scientists in epidemiology, virology and the wider scientific community including the universities and the community at large – in changing their behaviours to avoid illness and protect scarce hospital resources.