Managing COVID-19 – hospital logistics/operations

- This webinar will start at 8.30pm IST / 4pm UK.
- You can watch the recording on the AHSN Network and SAHF YouTube channels afterwards.
- Please use the chat to submit your questions.

Panellists

- **Jonathan Brotherton** – Chief Operating Officer – University Hospital Birmingham

- **Professor Paul Cockwell,** Consultant Physician and Senior Responsible Consultant, University Hospital Birmingham

- **Dr Randeep Guleria,** Director, All India Institute Of Medical Sciences, New Delhi.

- **Professor Shailesh V. Shrikhande,** Deputy Director, Tata Memorial Centre, Mumbai

- **Professor Kiran Patel,** Chief Medical Officer, Deputy CEO & Consultant Cardiologist, University Hospitals Coventry and Warwickshire, Chair of Trustees (SAHF)

- **Dr Caroline O'Keeffe,** GP and Clinical Director CGH Partnership PCN, Clinical Lead for Urgent and Emergency Care – North Hants CCG

- **Professor Wasim Hanif,** Professor of Diabetes & Endocrinology, Consultant Physician, & Head of Service and SAHF Trustee

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Welcome

The webinar is about to begin.

Prof Wasim Hanif

Professor Diabetes & Endocrinology
Consultant Physician University Hospital Birmingham, UK
Board of Trustee Diabetes UK, Board of Trustee SAHF

Overview of webinar

- Triaging COVID-19 and setting up hubs
- Organising inpatient facilities, referrals
- Rational utilisation of resources (human, medication, etc)
- Running COVID and non-COVID facilities in parallel and efficiently
- Question and answer session

Dr Randeep Guleria

Director, All India Institute Of Medical Sciences, New Delhi

Running Covid and non-Covid facilities in parallel and efficiently

Professor Shailesh V. Shrikhande

Deputy Director, Tata Memorial Hospital
Chief, GI and HPB Surgery Professor & Head, Division of Cancer Surgery, Tata Memorial Centre, Mumbai, India

Outcomes of Elective Major Cancer Surgery During COVID 19 at Tata Memorial Centre

Implications for Cancer Care Policy

Shailesh V. Shrikhande, MS, MD, FRCS,✉ Prathmesh S. Pai, MS, DNB,* Manish S. Bhandare, MS, MCh,* Ganesh Bakshi, MS, MCh,* Devendra A. Chaukar, MS,* Pankaj Chaturvedi, MS,* Mahesh Goel, MS,* Ashish Gulia, MS, MCh,* Sajid S. Qureshi, MS,* Amita Maheshwari, MD,* Aliasgar Moiyadi, MS, MCh,* Sudhir Nair, MS, MCh,* Nita S. Nair, MS, MCh,* George Karimundackal, MS, MCh,* Avanish P. Saklani, MS, FRCS,* Vinay K. Shankhadhar, MS, MCh,* Vani Parmar, MS,* Jigeeshu V. Divatia, MD,† Pramesh CS, MS, FRCS,* Ajay Puri, MS,* and Rajendra A. Badwe, MS*, on behalf of all collaborators from Department of Surgical Oncology*

Ann Surg June 2020

Summary

Background

Overburdened systems and concerns of adverse outcomes have resulted in deferred cancer surgeries with devastating consequences. In this COVID pandemic, the decision to continue elective cancer surgeries, and their subsequent outcomes, are sparsely reported from hotspots.

Methods

Prospective data was analyzed from March 23rd to April 30th, 2020.

Findings

- 494 elective surgeries were performed (377 untested and 117 tested for Covid 19 prior to surgery). Median age was 48 years with 13% (n=64) above the age of 60 years. 68% patients were ASA (American Society of Anaesthesiology) grade I. As per surgical complexity grading, 71 (14·4%) cases were lower grade (I-III) and 423 (85·6%) were higher grade complex surgeries (IV – VI).
- Clavien - Dindo ≥ grade III complications were 5·6% (n=28) and there were no post-operative deaths. Patients >60 years documented 9·3% major complications compared to 5·2% in <60 years (p = 0·169). The median hospital stay was 1 – 9 days across specialties.
- Postoperatively, 26 patients were tested for COVID 19 and 6 tested positive. They all had higher grade surgeries but none required escalated or intensive care treatment related to COVID infection.

Shrikhande SV et al. Ann Surg June 2020

Cancer management at Tata Memorial

At Tata Memorial Centre (India's largest cancer center), despite having to scale back operations by about one third we made the decision to continue providing cancer care using a proactive and multipronged approach.

We have already learned a great deal from this pandemic. Being forced to quickly respond led to a radical overhauling of entrenched hospital systems and processes, which ultimately made our operations more efficient.

The decisions we had to make regarding triaging of patients for cancer treatment will undoubtedly be helpful when we establish a robust health technology assessment program, an essential tool in a country where public health care expenditures are low.

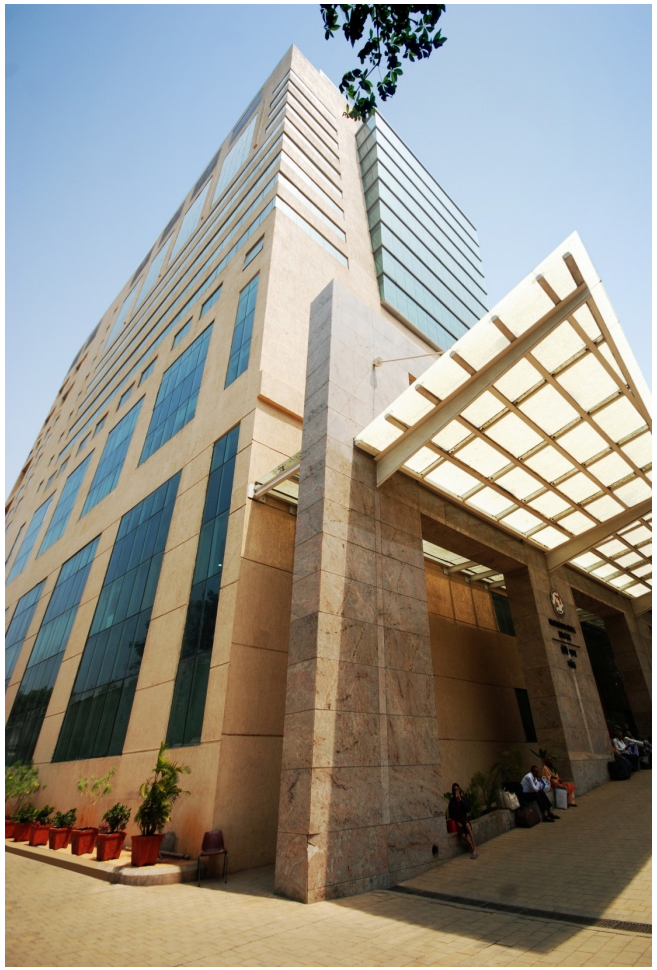
Countries that have not had high rates of death from Covid-19 could consider similar approaches that involve balancing pandemic control with providing continued cancer care.

Pramesh CS, Badwe RA. NEJM 2020 382:e61

Table 1. Summary of Covid-19 Measures Taken at Tata Memorial Centre.

Administration
Creation of a core Covid-19 action group
Daily debriefings and formulation of action plans
Cancer care
Avoidance of complex surgeries likely to require multiple blood transfusions and prolonged intensive care unit stays
Use of hypofractionated regimens whenever possible (e.g., for breast, prostate, and lung cancers); provision of palliative radiotherapy in a single fraction or weekly regimens
Reduced use of myelosuppressive systemic therapy; conversion to oral agents when feasible; deferral when magnitude of benefit is marginal
Patient-directed
Establishment of "screening camps" outside the hospital to reduce patient visits
Stringent restriction of relatives and friends in outpatient clinics and inpatient wards
Use of teleconsults as a substitute for routine follow-up visits
Hospital preparedness
Establishment of standard operating procedures for cases of suspected or confirmed Covid-19 infection; use of simulation drills
Establishment of a fever clinic and creation of isolation wards
Employee-directed
Provision of paid leave for high-risk staff members (elderly people, people with multiple comorbidities or who are taking immunosuppressive agents, and pregnant people)
Rotation of staff to ensure a fallback option in case of mass quarantine
Provision of hospital buses to transport staff unable to reach work because of the transportation lockdown

Thank you



Managing COVID-19: logistics and operations, University Hospitals Birmingham

Jonathan Brotherton

Chief Operating Officer, University Hospital Birmingham

Professor Paul Cockwell

Consultant Nephrologist, University Hospital Birmingham

Measure

- COVID-19 numbers: population, hospital admission and inpatient, ITU use, mortality
- Non-COVID emergency numbers: admission, bed need, LOS
- Emergency department capacity and flow
- Bed numbers and configuration (Hot and Cold)
- Staff numbers, configuration, **ITU redesignation**
- **ITU capacity**
- Local, regional, national

Maximise Capacity

- Senior review and early decision making
- Accurate early discharge
- Configure a 24/7 hospital
- Radical rota changes
- Enable and support agile leadership
- **Focus on ITU requirements**

Optimise Flow

- **Rapid testing**
- Configure the physical footprint (ITU, HOT care, COLD care, ED)
- Process mapping
- Surge planning
- **System working** (e.g. ambulance diverts, inter-hospital transfers)

Staffing

- **Communicate - virtual and written briefings**
- Clear leadership and line management structure
- **Keep staff safe: PPE, equity of workload (v difficult)**
- **Well being:** e.g. psychological support, buddy systems
- **Redesignate staff to areas of need:** ITU, acute pathways
- On the job training; training packages

System Configuration

- **Vaccination:** hubs, prioritisation, staff hesitancy
- Cross hospital and system working: ambulance diverts, inter-hospital transfers
- Integrated care system response
- **Regional emergency operational delivery networks**
- Ventilator, RRT, consumable procurement
- NICE COVID-19 guidelines
- Emergency Field Hospitals (Nightingale)

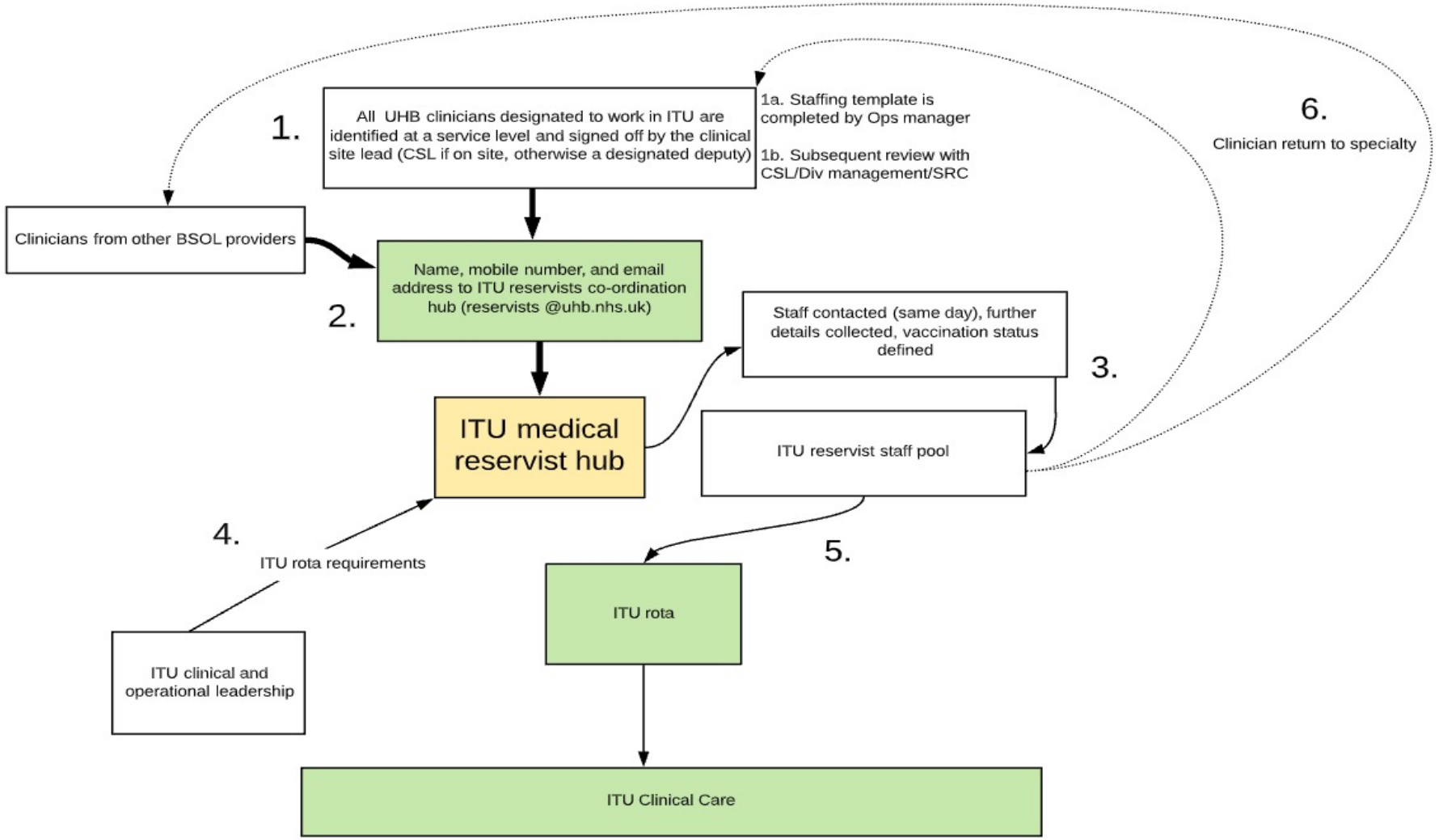
Elective Care

- Hot and Cold hospitals and units
- Prioritisation (national guidance)
- Capacity mapping
- Expanding cold level 2 (HDU)
- Ensuring cancer care

UHB clinical medical staff allocation: COVID-19 wave three

Intensive care	Acute care	Inpatient care	Specialty time-critical
All clinical staff not working in other areas	Staffing models agreed for each acute care area (ED/AMU/acute specialty care) SRC defined	**Minimum safe daytime staffing** 1 consultant/2 junior doctors/ward Delivered at QEHB as four days on/Four days off 12.5 hour shifts Site specific variation but consistent intensity and time commitments across sites Some specialty specific adjustment	**Minimum safe staffing** Speciality designated, Division/SRC agreed Time-critical = patient at risk of serious harm within 2 weeks without specialty care

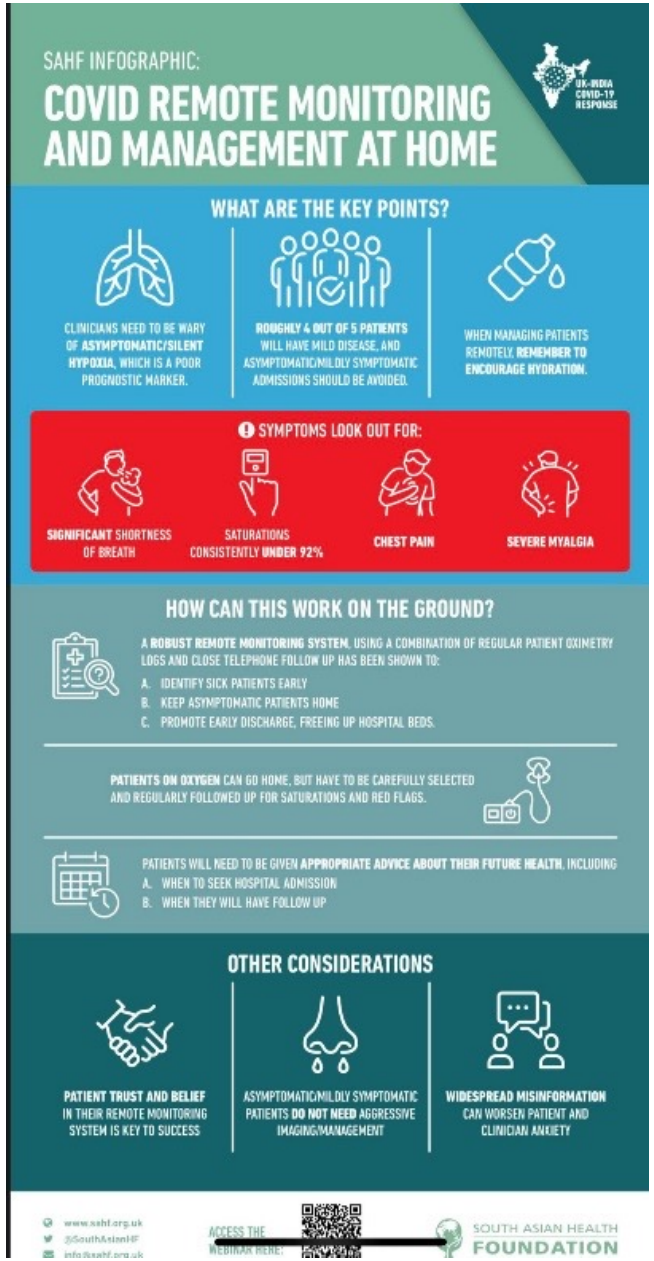
Process map – redesignation of clinical staff into ITU



COVID Oximetry @home (CO@h) – North Hampshire

Dr Caroline O'Keeffe

North Hampshire Clinical Commissioning Group Clinical Lead for Urgent and Emergency Care

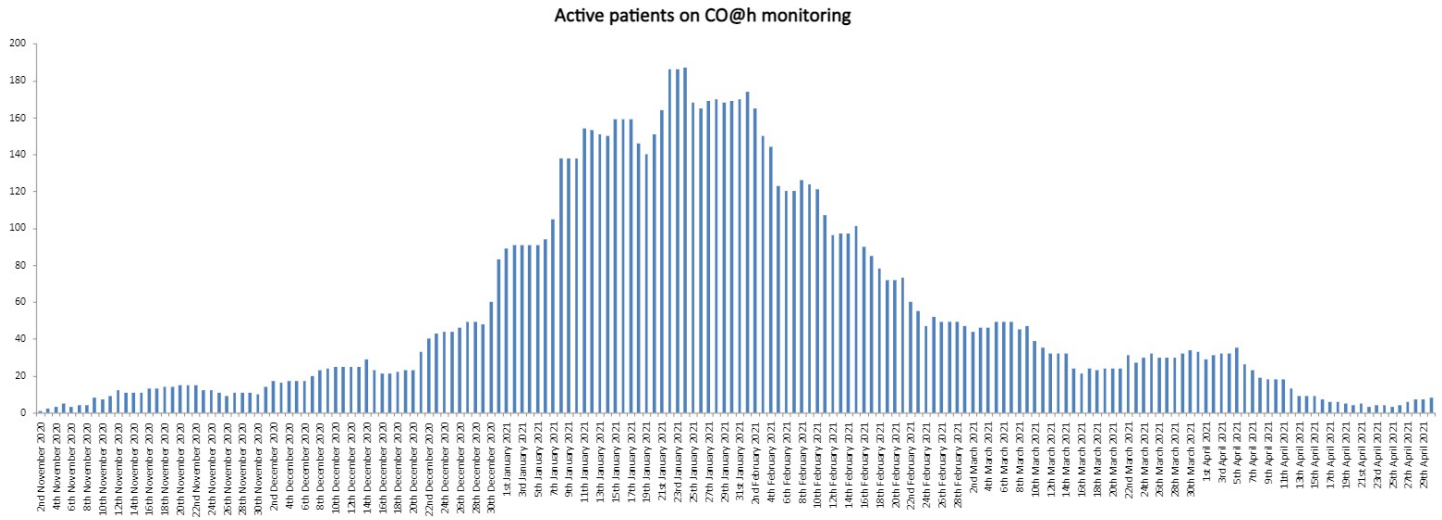


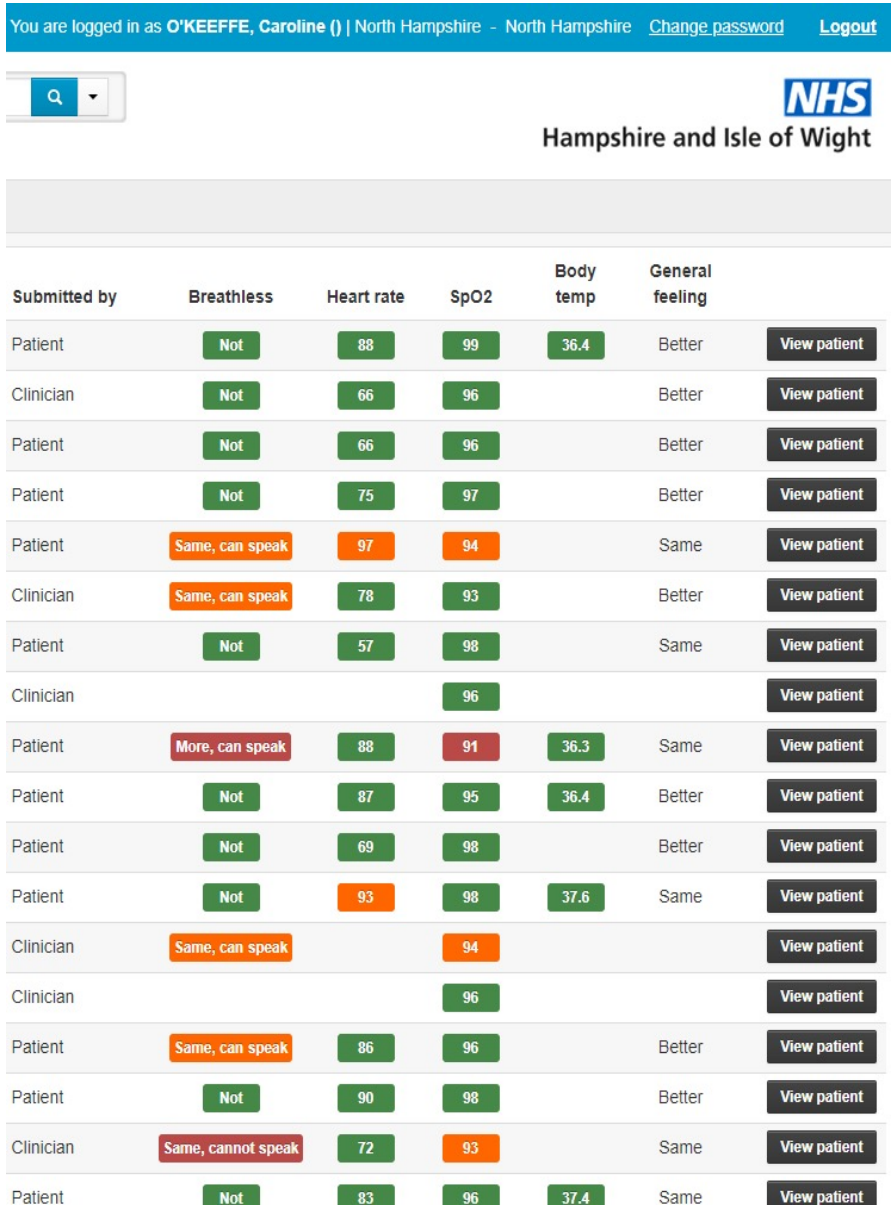
- 6 PCNs / 230,000 patients
- Co-located
  - Winter Assessment Centre – Hot Hub
  - Rapid POC testing – early identification
  - Opened 2.11.2020
- Single integrated platform 24/7
- Staffing
  - Lead ANPs – job share
  - Care Coordinators
- Pulse Oximeter pack
  - Instructions
  - Link to YouTube video
  - Paper diary – TDS readings
  - Return envelope
- Referral Pathway
  - Email
  - Phone Line in hours / 111 OOH
- IT Solution
  - Entered into ward on EMIS or by phone/email
  - AccuRx – COVID Monitoring Florey
  - Automated texts daily for 14d asking about symptoms and observations
  - Single CO@h spreadsheet – shared on Teams
  - InHealthcare
    - 12th January 2021 (10w)
- Monitoring
  - CO@h Lead ANP oversees
  - Checks data, identifies deterioration and acts
  - Digital exclusion – paper diary and phone

COVID in North Hampshire – current situation

- Started 2nd November 2020
- Operating 28 weeks
- Total seen at Winter Assessment Hub – 4620
  - RED admissions to hospital - 243
  - AMBER assessments in hospital - 110
  - GREEN – managed at home - 4270

- COVID Oximetry at Home
  - Onboarded – 841
  - Active – 8
  - Discharged – 833
  - Early detection silent hypoxia
    - 116 admissions
    - 2 deaths – 1.7%



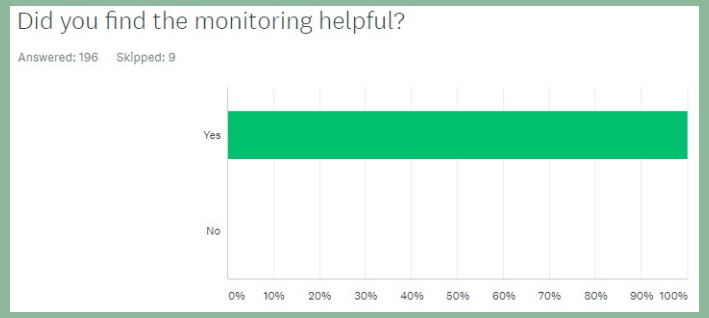


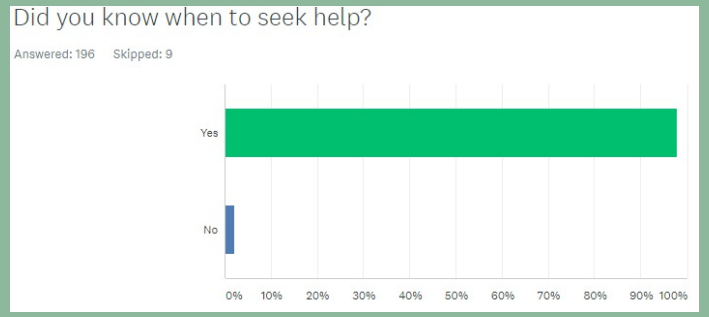
Lessons learned and next steps

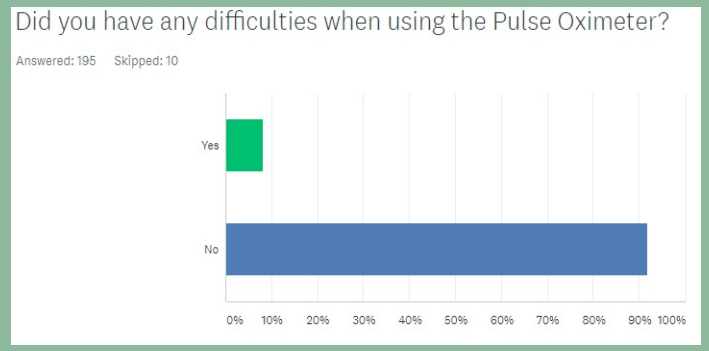
- InHealthcare Platform
- Care Home Outbreaks
  - ReSPECT forms for all Care Homes
- Cohort becoming younger – impact of vaccine
  - Discharges – first 100 – 18% >80
  - Discharges – last 100 – 4% >80
- MDT – PCN/OneTeam
  - Strengthen links with practices
  - Palliative Care/H@H input

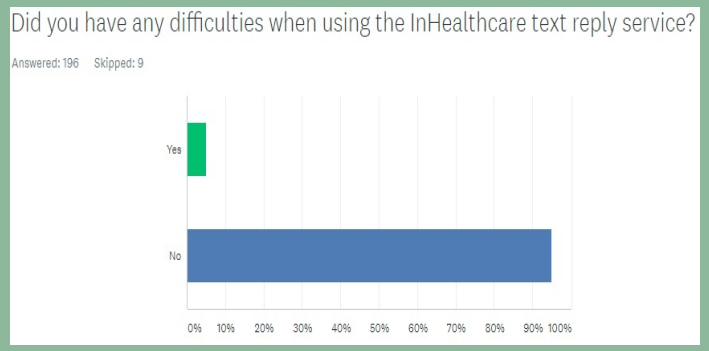
- Increased capacity
  - Care Coordinators / Health and Wellbeing coaches
  - Social Prescribers
- Active Case Finding
  - Review to identify all positives, safety net low risk
  - Refer high risk positive cases to CO@h
- Secondary Care Virtual Wards
  - SDEC/Telemedicine - Communication and clear responsibilities

Patient feedback – 205 respondents









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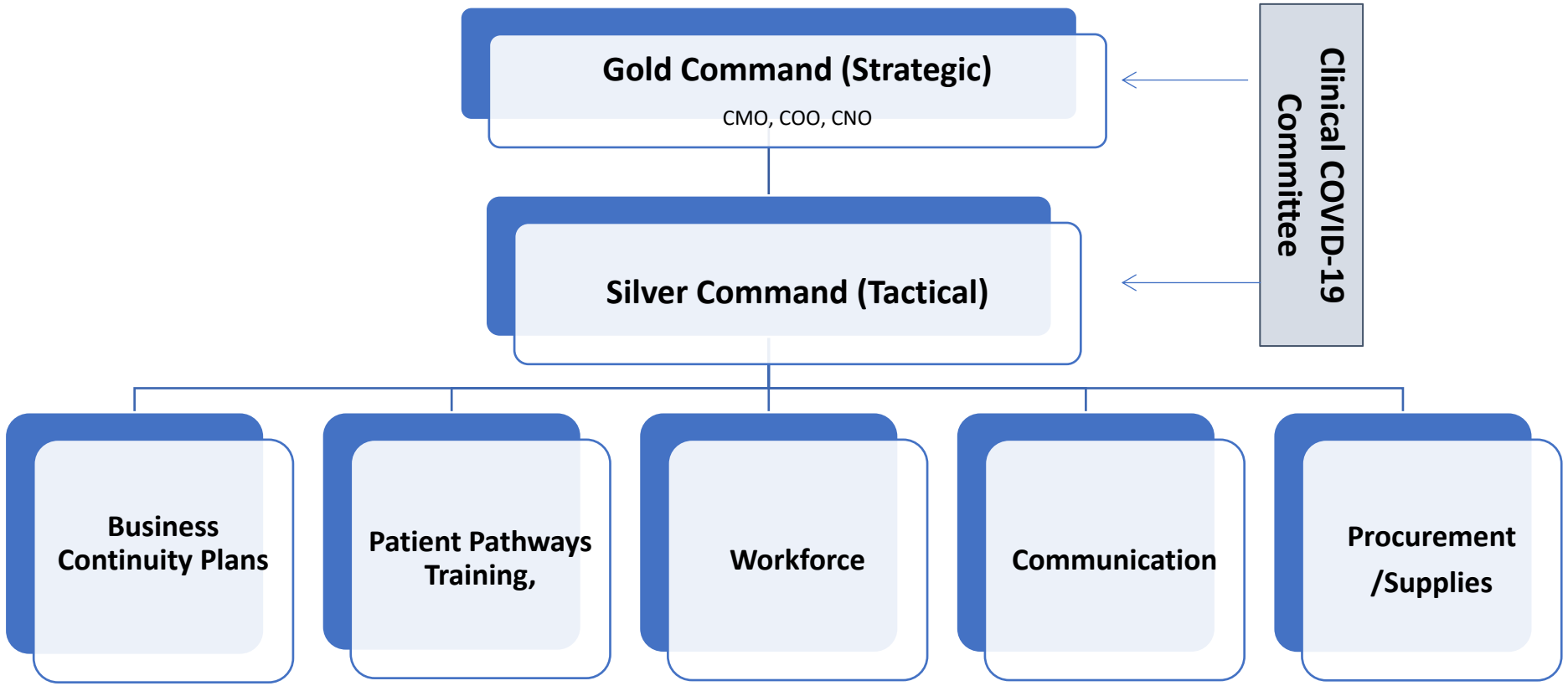
COVID-19: Strategic and operational reflection from UHCW

Prof Kiran Patel

Chief Medical Officer, Deputy CEO & Consultant Cardiologist, University Hospitals Coventry and Warwickshire, Chair of Trustees (SAHF)

COVID-19 governance



Clear strategy and leadership

1. COVID, non-COVID and post-COVID care
   - Open for business – communicate to staff and public
   - Standardisation and learning : QI
2. Maintain emergency services & surge plans
   - Clear and direct access pathways e.g. PPCI, stroke, O&G, SAU
   - Oxygen draw dashboard
3. Support others under pressure
   - Mutual aid
4. Infection prevention and control
   - Segregation, siderooms and testing
5. Workforce support and management
   - Deployment and redeployment
   - Innovation – Med students, RnD, Teaching