

University Hospitals of Morecambe Bay
NHS Foundation Trust
COVID-19 Emergency Response Plan





The purpose of this document is to clarify the planning assumptions and predicted increased pressure arising from the COVID-19 pandemic on the population of Morecambe Bay...

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A. Introduction:

1. This Emergency Response Plan is a plan detailing the response of University Hospitals of Morecambe Bay to the COVID-19 emergency. It details the objectives of the response together with the actions that UHMBT and partners will take forward.
2. The first goal is to reduce excess mortality across the hospital sites;
 - Excess mortality linked to COVID-19
 - Excess indirect mortality caused by disruption to other services (e.g. sepsis, cancers, cardiovascular disease)

The second goal is to protect staff and the higher risk subgroups within our staff.
3. The purpose of this document is to;
 - Clarify the planning assumptions and predicted increased pressure arising from the COVID-19 pandemic on the population of Morecambe Bay;
 - Detail the UHMBT and partners response;
 - Outline the streams of work required to deliver the response effectively.

B. Strategic Approach:

4. The overarching strategy to meet this increased COVID-19 demand is to;
 - Close down and/ or reduce non-essential activity in order to redirect and re-purpose workforce resources towards the expected higher demand of in-patient care;
 - Commission and mobilise additional critical care and acute respiratory in-patient bed and equipment resources on the FGH and RLI sites to support meeting this higher demand;
 - To work with partners to commission and mobilise additional out of hospital in-patient bed and equipment resources across the Morecambe Bay footprint to supplement the acute bed provision;
 - To commission and mobilise existing and additional workforce resources to support the delivery of the additional in-hospital and out of hospital critical care and acute/ non acute bed base;
 - To work with partners to optimise opportunities to avoid acute hospital admissions and to expedite earlier discharge in order to deliver effective patient flow and access to appropriate levels of care, and;
 - To support our staff throughout this unprecedented period



C. Planning Assumptions:

- 5. Our planning assumptions for the Morecambe Bay area encompassing South Cumbria and North Lancashire is based on the emergent national modelling. The actual numbers have been plotted to determine which of the scenarios is closest to our population and adjusted plans appropriately.
- 6. The work in the model has been based on the assumptions in the Imperial College (IC) paper which supported the national response (“Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand”, 16th March 2020). The key assumptions are:
 - IC estimates of severity by age band have been used and applied to the local population breakdown;
 - Bed demand has been calculated using the IC assumption on the duration of stay ie: 8 days if critical care not required and 16 days (with 10 of these days in ICU) if critical care is required;
 - The IC paper assumed that 30% of hospitalised care will require critical care. The older profile of our population means that 34.7% of our population are likely to require critical care (based on the estimates of severity by age band);
 - Most of the work used the IC assumption that we will hit peak rate in 3 months. However, we have made an adjustment in light of national evidence that the increase was greater than this and in light of local (albeit limited) actual figures. A peak in mid-April (12th April) is assumed.
 - It should be noted that this planning assumption ie 12 April may change in response to the social isolation measures currently in place. As this date shifts back and the curve is flattened this will benefit our emergency response.

- 7. Three scenarios have been worked up:
 - Assumed **80%** of the population will be symptomatic (i.e. the original IC assumption)
 - **50%** of population is symptomatic
 - **20%** is symptomatic



This gives the following bed numbers:

| Additional beds: | S1: 80% symptomatic | S2: 50% symptomatic | S3: 20% symptomatic |
|------------------|---------------------|---------------------|---------------------|
| General | 713 | 442 | 171 |
| ICU | 197 | 119 | 48 |

- 8. It is believed that Morecambe Bay is likely to be between the 20% and 50% scenario depending on the impact and timing of national suppression measures. It should be noted that NHSE/I have requested to plan for a seven fold increase in ICU beds which would give an increase from the current baseline of 14 to 98: ie within the 20% to 50% range: The general bed target will be for the 50% scenario: ie 442 additional beds across Bay and for 119 ICU beds – higher than the 7-fold increase.
- 9. The general flow of patients to our two acute sites is generally: 65% RLI; 35% FGH. When applied to the numbers above this gives the following bed planning numbers:

| Additional beds | Total | RLI | FGH |
|-----------------|-------|---------------------------------|------------------------|
| General* | 442 | 287 | 155 |
| ICU | 119 | 77 (higher than 7-fold request) | 42 (as 7-fold request) |

NB: General beds may mean additional beds created in non-acute settings around the Bay.

- 10. The plan is therefore based on the 50% attack rate predictions.
- 11. The 50% attack rate predicts a requirement across bay of an additional 442 general beds and 119 critical care beds.
- 12. These figures have been analysed by site against a predicted timeline with the peak brought forward to 13 April week and a gap analysis is in the process of being finalised. This illustrates that in the peak weeks each site has shortfalls – up to 125 and 50 acute and 35 and 15 critical care beds on the RLI and FGH sites respectively.
- 13. The plan is to cohort as many acute beds within the acute footprint as possible and work with external partners ie other independent providers and the Military to close the capacity gap as the following sections describe.



D. Management of non-essential Activity

OUT-PATIENT SERVICES:

- 14. Since mid-March 2020, all clinic attendances have been reviewed and replaced where possible with telephone conversations in order to reduce face to face contacts and observe social distancing. Urgent appointments including 2-week waits have continued.
- 15. With the lockdown commenced from 23 March and workforce resources now increasingly required for the in-patient front line, it is necessary now to cancel all routine face to face appointments from the week commencing 6 April 2020 and to cohort only the very urgent cases into smaller clinics. It should be noted that some services e.g. Ophthalmology, due to the close nature of the consultation have already cancelled all activity.

With effect from 6 April 2020 therefore all but the most urgent appointments will be cancelled until further notice.



- 16. Oncology at the RLI is based in Medical Unit 1 in prime front door space required to re-accommodate the Fracture Clinic in order to release space adjacent to ED. Demand for Oncology has reduced as patients are not starting new treatments at this time - the Lancaster service is therefore planning to move to the Kendal and consolidate provision on the WGH site.

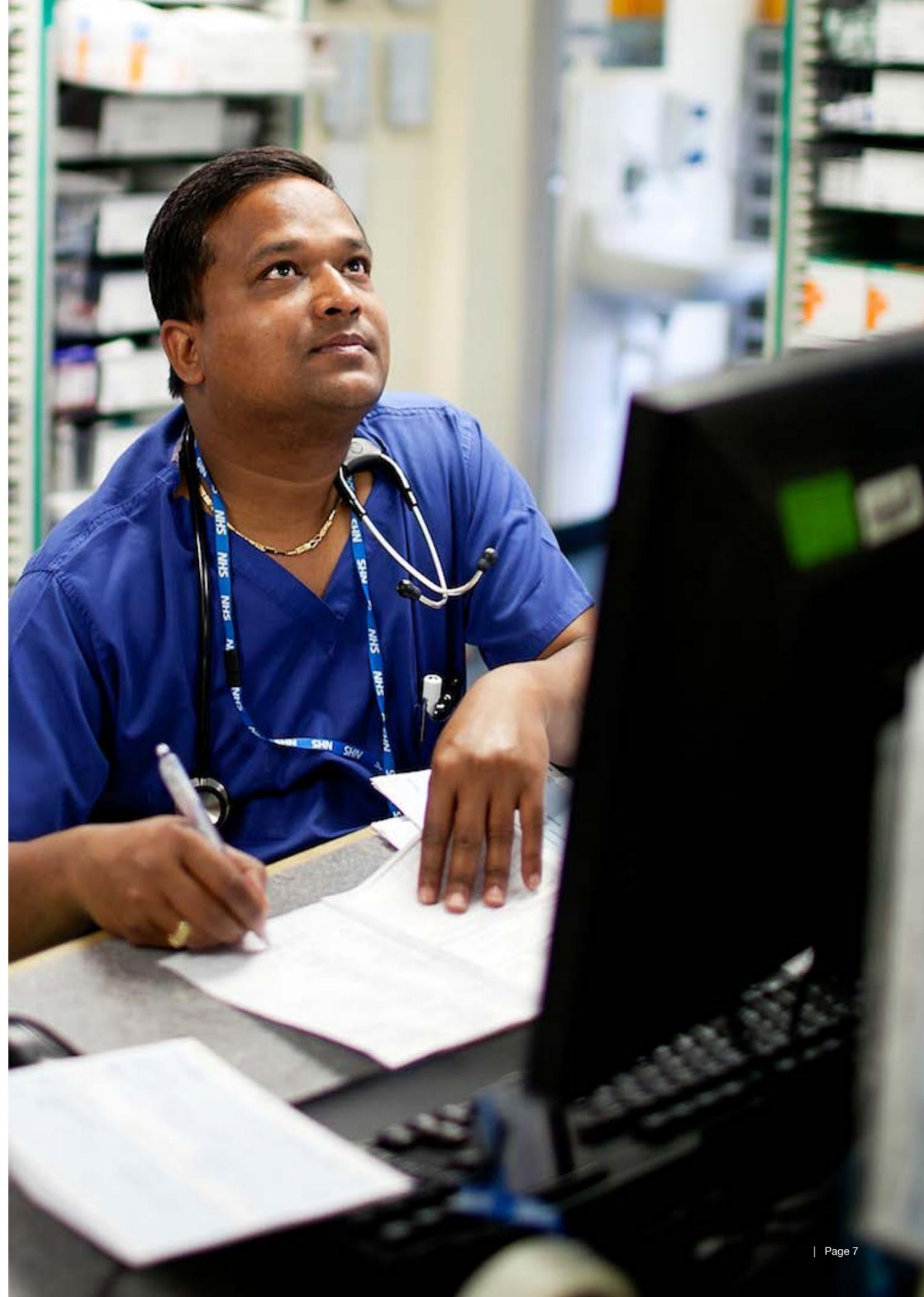
This move occurred on the weekend of 28/29 March 2020.

ELECTIVE ACTIVITY:

- 17. All routine elective inpatient activity on both the FGH and RLI sites was cancelled with effect from 23 March 2020. Urgent cases including cancer cases continue on each site at this time. All routine elective day case activity is cancelled with effect from 30 March 2020 on both the FGH and RLI sites.
- 18. It is recognised that the continued provision of urgent surgery on the acute sites may not be sustainable as the COVID-19 in-patient demand increases. The possibility of continuation of urgent elective activity on the WGH site and/ or the BMI site in Lancaster as the pressure deepens on the acute sites is being explored.

ROLE OF WGH:

It is planned that WGH will remain a non-COVID site with current services continuing plus a number that would be transferred from the acute sites e.g. minor trauma and more day case activity. Plans are continuing to be developed.

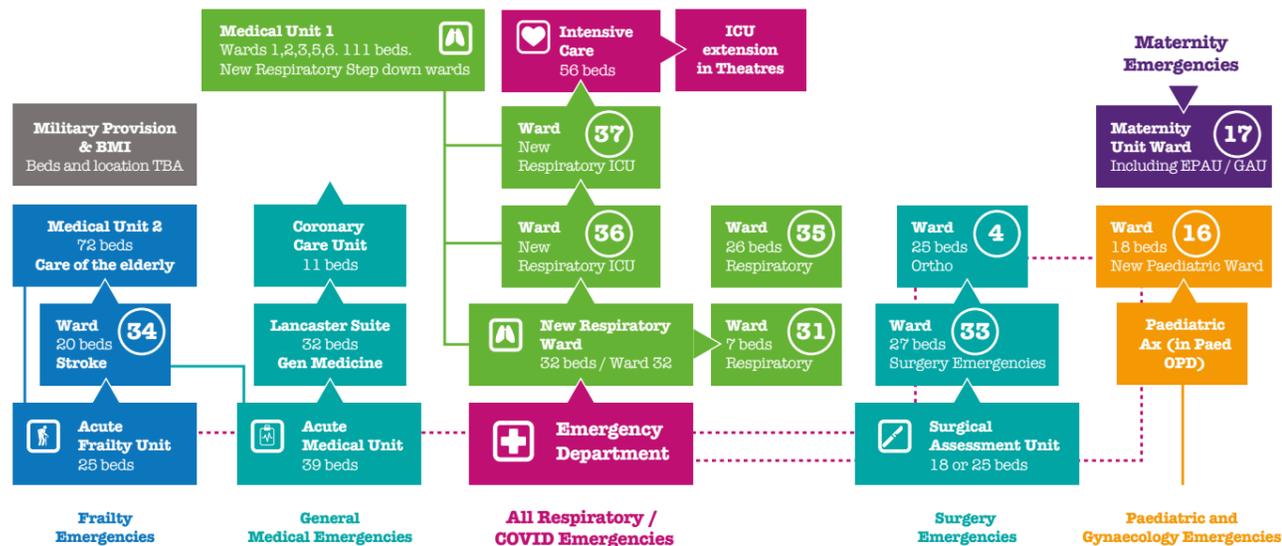




E. UHMBT Bed Expansion: RLI

19. The diagram below illustrates the reconfiguration and commissioning of additional bed capacity at the RLI.

RLI planned COVID-19 bed reconfiguration:



RLI Expansion of ICU Critical Care beds:

20. The ask from NHSE/I is to increase critical care capacity by 7-fold ie from 8 to 56 at the RLI. In addition to the existing 8 beds on ICU, this will be delivered through the conversion of –

- 9 beds on **ward 37** to provide a further 6 ICU beds;
- Utilisation of 3 main theatres to provide a further 9 ICU beds;
- Utilisation of main theatre recovery to provide a further 3 ICU beds;
- 18 general beds on **ward 37** to provide a further 12 ICU beds;
- 28 general beds on **ward 36** to provide a further 18 ICU beds.

(Note – this reduces G&A bed stock by 24 beds on **ward 37** and 28 beds on ward 36).

17. Provision of 56 ICU beds remains dependent upon a number of factors –

- Confirmation of sufficient oxygen flow on each of these ward areas;
- Provision on additional ventilator and other key equipment;
- Appropriate workforce resources and skills.

Confirmation of these issues is work in progress via the Tactical Planning Group.

RLI Expansion of acute G&A beds:

18. It is proposed that all non-respiratory patients access emergency assessment via the respective acute assessment area ie Acute Medical Assessment (AMU), Acute Frailty Assessment Unit (AFU), Gynaecology Assessment Unit (GAU), Surgical Assessment Unit (SAU). At this point it is proposed that the Medical Ambulatory Care Unit remains as is adjacent to the AMU however consideration is being given to a proposal to re-provide the Surgical Emergency Ambulatory Care Unit off site.

19. The majority of patients therefore accessing care through the ED will be COVID related although resus facilities for non COVID related patients will continue to be provided. The ED requires additional space to operate increased numbers of presentation and to support patients awaiting results. Thus the adjacent Fracture Clinic move to Medical Unit 1.

20. Additional acute in-patient bed capacity and specifically additional respiratory acute in-patient bed capacity will then be provided through a series of reconfigurations –

- **The Paediatric Ward – ward 32** – will move and be re-provided on the Gynaecology Ward – **ward 16**. The Early Pregnancy Assessment service together with the GAU will move temporarily onto **ward 17** – Maternity. Any in-patient gynaecology care will be provided on **ward 33**, reserved for surgical and gynaecology emergencies.
- **Ward 31** will be re-designated for respiratory patients – noting isolation facilities.
- **Ward 32** will then be re-designated a higher care Respiratory Ward offering CPAP as well as acute respiratory care.
- **Ward 33** will remain surgical for surgical and gynaecology emergency care.
- **Ward 34** will remain the Stroke ward.
- **Ward 35** will be re-designated for respiratory care.
- **Ward 36** will be re-designated as level 3 respiratory ICU care (as noted in critical care bed section).

- **Ward 37** will be re-designated as level 3 respiratory ICU care (27 beds).
- **Lancaster Suite** and CCU will remain as currently – designated for general medical and coronary care emergencies respectively.
- The **3 wards on Medical Unit 2** will remain designated for elderly non-COVID care but including contingency for delayed discharges of patients with complex needs, should that be required.
- Re-commissioning of 75 beds on the former nightingale wards on **Medical Unit 1**. This entails the re-provision of accommodation for a number of services currently occupying this space. This includes
 - o Clinical audit/I3 – moving to Moor Lane Mills/ Library;
 - o Bed store – relocated to old Physiotherapy empty space;
 - o Clinical Investigations – moving to Ophthalmology;
 - o Clinical skills – moved temporarily to Ripley 6th Form College adjacent to the RLI;
 - o Diabetes Centre – moved temporarily to Dermatology Department;

Wards 1, 2 and 3 will be re-purposed for step down respiratory care, **ward 4** will be repurposed for Orthopaedic rehabilitation care for the elderly.

- Re-purposing of 45 bed spaces on the Day Care Unit in **Medical Unit** – with the cancellation of elective day case activity this space will be re-purposed for step down respiratory care.
- As pressure mounts it may be necessary to then convert **Lancaster Suite** to respiratory in due course.

All subject at this time to workforce resource and appropriate equipment being available.

E. UHMBT Bed Expansion: RLI

RLI Timeline:

21. The timeline for the mobilisation is currently as follows:

| Week commencing | Ward area available | New additional beds | Respiratory beds | ICU beds | Note |
|-----------------|--------------------------|---------------------|------------------|-----------|---|
| 23 March 2020 | Theatres/ Recovery | - | - | +12 | ICU |
| | Ward 31 | - | +7 | - | Acute |
| 30 March 2020 | MU1 Ward 4 | +25 | - | - | Step down |
| 30 March | SEAC move | +7 | - | - | Provisional |
| 6 April | Paeds to ward 16 | - | - | - | Date |
| 10 April | Ward 35 | - | +26 | - | With new ventilation |
| | AMU / AFU to new ward 32 | | +54 | - | Transitioning from 6-13 April |
| | Ward 37 | - | -27 | +18 | ICU capacity |
| | MU1 Ward 6 | +30 | +30 | - | Step down |
| 13 April | Ward 36 | - | - | +18 | ICU capacity |
| 13 April | MU1 Ward 5 | +15 | +15 | - | Step down |
| | MU1 Ward 1 | +18 | +18 | - | Step down |
| 20 April | MU1 Ward 2 | +15 | +15 | - | Step down |
| 21 April | MU1 Ward 3 | +17 | +17 | - | Step down |
| | CCU | | +11 | - | |
| | Existing ICU | | | +8 | |
| Totals | | +127 | 189 | 56 | Normally 2 respiratory and 8 ICU |

22. All ward designations may be revisited as required.

23. Total additional net acute in-patient bed provision is 127 additional acute beds and 48 additional ICU beds. With re-designation of existing beds 160 acute respiratory beds will be available (normally 27 and therefore an increase of 133) for respiratory care together with 56 ICU beds (normally 8 and therefore an increase of 48 ICU).

24. A timeline of expected availability of beds v predicted demand/ requirement is currently being undertaken. Early indications are that if the disease follows the 20% attack

rate, the hospital will have sufficient beds to accommodate the increases in activity. If however the disease follows a 50% attack rate there will be a gap at the peak of approximately 125 general beds and up to 35 ICU beds. Further analysis is being undertaken and mitigations being considered which include further bed provision out of hospital including military support. This will be concluded by 3 April 2020.

25. It is noted that with a likely peak around mid-April, the mobilisation of wards 2 and 3 will need to be expedited.

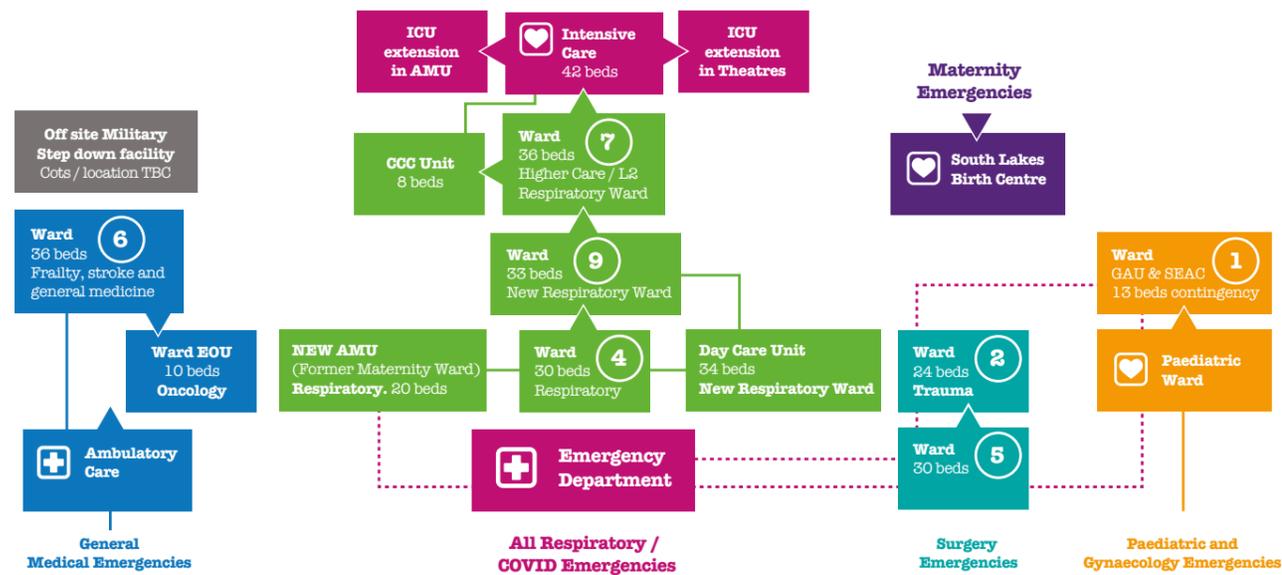




F. UHMBT Bed Expansion: FGH

26. The diagram below illustrates the reconfiguration and commissioning of additional bed capacity at the FGH.

FGH planned COVID-19 bed reconfiguration:



FGH Expansion of ICU Critical Care beds:

27. The 7-fold increase requires the existing 6 to increase to 42. In addition to the existing 6 beds on ICU, this will be delivered through –
- Provision of 1 additional bed on the current ICU;
 - Utilisation of 4 main theatres to provide a further 12 ICU beds;
 - Utilisation of 1 further main theatre (requires urgents to be stepped down) to provide a further 3 ICU beds;
 - Utilisation of main theatre recovery to provide a further 7 ICU beds;
 - 19 beds on the current AMU to provide a further 13 ICU beds.

(Note – this reduces G&A bed stock by 19 beds on the current AMU).

28. Provision of 42 ICU beds remains dependent upon a number of factors –
- Confirmation of sufficient oxygen flow on each of these ward areas;
 - Provision on additional ventilator and other key equipment;
 - Appropriate workforce resources and skills.

Confirmation of these issues is work in progress via the Tactical Planning Group.



FGH Expansion of acute G&A beds:

29. It is proposed that all non-respiratory patients access emergency assessment via the respective acute ward area e.g. general medicine to ward 6, surgery to ward 5.
30. The majority of patients therefore accessing care through the ED will be COVID related, although resus facilities for non COVID related patients will continue to be provided.
31. Additional acute in-patient bed capacity and specifically additional respiratory acute in-patient bed capacity will then be provided through a series of reconfigurations –
- With the AMU being re-designated for Intensive Care, the newly developed Hawcoat Ward (the former maternity ward and recently referred to as the D2A ward) will be temporarily designated as a **Respiratory Ward** with 20 beds;
 - **Ward 1** accommodates SEAC from Ward 5, retains GAU and serves as a contingency for delayed patients with complex needs with 13 beds;
 - **Ward 2** continues to provide trauma care;
 - **Ward 4** is re-designated as a 30 bedded respiratory ward;
 - **Ward 5** is expanded to 30 beds and will remain surgical for surgical and gynaecology emergency care;
 - **Ward 6** will remain as currently – designated for general medical, care of the elderly and stroke care emergencies;
 - **Ward 7** will continue as a 36 bedded respiratory ward;
 - **Ward 9** will be re-designated as 33 bedded respiratory ward;
 - **Day Care** is re-purposed as 34 bedded respiratory ward;
 - The **Elective Orthopaedic Unit (EOU)** will be re-designated for 10 Oncology beds;
 - **Paediatrics** and **Maternity** remain unchanged.



FGH Timeline:

32. The timeline for the mobilisation is currently as follows:

| Week commencing | Ward area available | New additional beds | Respiratory beds | ICU beds | Note |
|-----------------|-------------------------|---------------------|------------------|-----------|---|
| 30 March | Theatres | - | - | +12 | Using 4 theatres |
| | ICU & Recovery | - | - | +1+7 | |
| | Move of Oncology to EOU | | | - | Step down |
| | Ward 2 | - | -24 | - | |
| | Abbey View | - | -24 | - | Acute respiratory |
| 6 April | Ward 4 | +6 | -34 | - | Respiratory |
| | Ward 5 | +14 | - | +30 | Expansion and with SEAC move to ward 1 |
| | Ward 9 | - | +33 | - | |
| | Day Care | +34 | +34 | - | |
| | Hawcoat ward | +20 | +20 | - | Repurpose for AMU |
| | CCCU | - | +4 | - | |
| | Theatres – 5th theatre | - | - | +3 | Dependent upon stopping urgent elective surgery |
| 20 April | AMU | - | - | +13 | |
| Totals | | +74 | 132 | 42 | Normally 36 respiratory and 6 ICU |

33. All ward designations will be revisited as required.

34. Total additional net acute in-patient bed provision is 74 additional beds. With re-designation of existing beds 125 acute respiratory beds will be available (normally 36 and therefore an increase of 89) for respiratory care together with 42 ICU beds (normally 6 and therefore an increase of 36 ICU).

35. A timeline of expected availability of beds v predicted demand/ requirement is currently being undertaken. Early indications are that if the disease follows the 20% attack rate, the hospital will have sufficient beds to accommodate the increases in activity. If however the disease follows a 50% attack rate there will be a gap at the peak of approximately 50 general beds and 20 ICU beds. Further analysis is being undertaken and mitigations being considered which include further bed provision out of hospital including military support. This will be concluded by 3 April 2020.



G. Additional Military/ External Support

- 36. The Army are currently working in the Cumbria “cell” and helping to mobilise a number of “cot” beds in community buildings in the Barrow and Kendal area to support step down/ intermediate care requirements. At this time, they are scoping 250 cots to be available as soon as possible subject to equipment and workforce. (This volume scoped following discussion with UHMBT and CCG and the predicted demand).
- 37. Discussions are starting with the equivalent Lancashire “cell”.

H. Clinical Support Services Including Mortuary

- 38. Plans are in development to acquire additional mortuary facilities during the period. With demand dependent upon the predictions on modelling this is ongoing.

I. Workforce Requirements

- 39. A workforce cell has been established to pull all available resources – from staff currently at home, from the Care Groups non-essential activity, from volunteers and returning retirees to populate staffing rotas for the new ward areas. This is work in progress and requires staff to work outside of their usual roles and areas. It may also require a number of our staffing protocols and ratios and normal ways of working to be adjusted for the period e.g. nurse staffing ratios on ICU, pooling of junior medical staff across specialties.

J. Clinical Pathways

- 40. With agreement reached on the overall bed expansion plan, work is ongoing now to develop the Royal Liverpool pathway for infection prevention. This will identify different areas as COVID non suspected (white areas), query COVID areas (where patients will await results) (yellow areas) and COVID positive areas (red areas). The bed diagrams earlier in this document do not reflect this colour coding. These pathways will be developed by April 3 for each site and developed into a COVID bed management SOP for Clinical Site Management (and the colour coding reflected in the diagrams for clarity).

K. Avoiding Admission and Expediting Discharge

- 41. Colleagues within primary care have developed a COVID-19 Command Centre – a clinical triage centre working with agreed clinical guidelines for COVID-19 care. This will help direct patients to the appropriate support – in and out of hospital – and will include both health and social care support. The intention is to direct patients to the most appropriate place for the level of care they need, which may not be an acute hospital and will therefore include keeping many patients at home with additional support.

A proposal detailing the pathways will be submitted via the Strategic IMT.

- 42. With regard to discharge the aim of this stream of work is to implement the Hospital Discharge Service requirements outlined in the guidance on 19th March 2020. The initial areas of focus of the work programme is to secure timely discharge from acute and community hospitals as soon as clinically safe to do so; to ‘accelerate’ discharge for medically fit for discharge patients including removal of residual delay from current Discharge to Assess pathways.
- 43. The community emergency response plan which is being developed alongside this acute response plan incorporates the military response i.e. additional beds available within the community so support the acute hospitals with discharges including step down respiratory care where appropriate and also patients with more complex care needs that might be delayed within hospital as care homes and others struggle to keep up with the demand. It is planned that these beds would be managed within UHMBT and supported by primary care medical teams.



The Army are currently working in the Cumbria “cell” and helping to mobilise a number of “cot” beds in community buildings in the Barrow and Kendal area to support step down/ intermediate care requirements.



L. Governance & Assurance

44. The diagram below shows the governance and assurance process; with a brief outline of the roles and responsibilities of each part of the process



45. Day to day operational management, oversight and response is via the COVID-19 Operational Command Centre based at the Royal Lancaster Infirmary. Each Director has a deputy to ensure continuity and sustainability of oversight of COVID-19 is maintained.

46. The Command Centre is led by a (silver level) tactical manager, supported by a clinical manager and assisted by the following functions: medical doctor, senior nursing, infection control, occupational health, People and Organisational Development, communications, procurement and supplies; I3; Estates and facilities; patient liaison; volunteers and emergency preparedness and response.

47. The Command Centre is responsible for coordinating the response of the Trust to the incident and is accountable to the Chief Operating Officer as the Accountable Emergency Officer for the Trust. This responsibility sits alongside responsibility for business continuity plans, which is linked directly to the process outlined within this document.

48. Each Care Group has a cell that is responsible for ensuring that staff and patients receive care and support in line with latest government and professional guidance. The link to Local Authority is via the UHMBT community care group cell. The care group cells escalate and receive information via the Command Centre.

49. The Strategic Incident Management Team Meeting occurs on a daily basis and is chaired by the Chief Operating Officer, supported by the Executive Chief Nurse and Medical Director. Attendees include colleagues from Morecambe Bay CCG.

50. The Strategic Incident Management Team has delegated responsibility for strategic decision making in response to the Covid-19 Incident and is accountable to the Trust Board of Directors.

51. The Executive Management Team maintains visibility of the actions taken and provides advice and support as required to the Strategic Incident Management Team.

52. The Board of Directors are responsible for compliance with relevant principles, systems and standards of corporate governance; codes of conduct; accountability and openness.

53. The role of the Board in Coronavirus is to ensure that the Trust is compliant with the required level of preparedness and response to the COVID-19 Incident.

54. Notwithstanding National Guidance, the Trust will support Governors to ensure that they are able to fulfil their statutory obligations including seeking assurances from the Chair and the Non-Executive Directors regarding safe delivery of services.

Risks:

55. The response to COVID-19 presents a unique set of circumstances that we are operating in. There are emerging risks to this plan that need to be mitigated together with issues that need to be managed. Examples of some of the risks are summarised below and all risks will be managed through the assurance processes that have been in place.

Risks straddle several areas:

- Workforce: Insufficient staffing, skill mix issues – across both medical and nursing professions; use of volunteers and lack of training; COVID absence/self-isolation impacting upon substantive numbers; Changes in staffing ratios and change of normal roles; Increased service ask of support services workforce with higher volumes of patients in hospital.
 - Estates & Procurement: Work not completed on time/ in time; Contractors speed of working limited by social isolation requirements; procurement of equipment e.g. beds, ventilators, CPAP, syringe drivers, PPE.
 - Control of infection: Increased areas of infection are not managed in accordance with protocol.
 - Clinical Support services: with increase in number of clinical in-patient areas, insufficient kitchen trolleys, domestic equipment, mortuary facilities.
 - Bed modelling and activity modelling: Data not correct; curve trends shift.
56. A series of mitigations are being developed to minimise risks highlighted.

Mitigations to Offset Risk:

57. Throughout this process a number of mitigations have been put in place to offset risk and these are developing and changing as we work through each service change and associated operational requirements.
58. An example is for the critical care expansion the normal nurse to patient ratio is 1 nurse to 2 patients (1:2) and during the anticipated demand for this service in response to COVID this will change, in a stepped way to 1:3, 1:4 and up to 1:6 at the peak of this disease, reflecting the need for skilled staff to support the patient demand and in line with national guidance. To support this, additional staff will be skilled up to care for patients in critical care facilities, additional support staff will be put in place to enable the Registered Nurses to focus on the technical skills across a greater number of patients. To further support documentation in use will be simplified and pre-printed prescription sheets to include standard treatment for COVID-19 patients.
59. Through this Strategic Advisory Group a log of emerging risks, issues and mitigations are being developed which will describe responsible officers, how this will be undertaken and assurance around delivery and will complement existing governance arrangements.



Risks

Mitigations to Offset Risk

Decision Making

L. Governance & Assurance

Decision Making:

- 60. During the COVID-19 Pandemic rapid decisions will need to be made and therefore amendments to the way we operate have been agreed through the March Quality Assurance Committee Ward to Board COVID-19 paper and through the March Board.
- 61. The Constitution gives delegated authority to the Chief Executive in consultation with the Chair (or in his/her absence the Deputy Chair) and two other Non-Executive Directors powers to make emergency decisions on behalf of the Board. Any decisions taken using emergency powers will be shared with members of the Board of Directors and formally reported at the next Board of Directors meeting.
- 62. The Board have also delegated authority to the Director of Finance authority to vary Standing Financial instructions
- 63. The powers and duties of the Executive Directors are contained in the Scheme of Delegation and their Job Descriptions. (Note:-careful judgement is required before exercising an individual delegation during a major incident and it might be prudent to escalate issues to the Board).
- 64. If an urgent decision is required and there is not a planned meeting of the Council of Governors due to take place the there are two possible ways in which the Chairman can proceed:
 - Firstly, an emergency meeting of the Council of Governors can be called or;
 - Secondly, the Chairman, after consultation with the Head and Deputy Head Governor, is authorised to make urgent decisions and these decisions are reported to the next Council of Governors meeting.



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Please do not hesitate to contact us should you require this document in an alternative format.

The information in this report is correct to the best of our knowledge as of April 2020.

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