Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

COVID-19 Committee

Meeting

Tuesday 2nd June 2020

Opening Statement

by

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Good Afternoon Chairman and members of the Committee. Thank you for the invitation to attend the Committee meeting. I am joined by my colleagues:

- Ms. Angela Fitzgerald,
- Dr. Vida Hamilton,
- Mr. Ray Mitchell,

Chairman and members I would like to update you on the following issues relating to the partnership arrangement with the Private Hospitals:

Decision to partner with Private Hospitals

In March, 2020, Government approved a proposal from the Department of Health to allow for a formal partnership with private hospitals which would make their facilities and capacity available to meet the challenges of the COVID-19 pandemic. This put over 2,200 beds, approximately 8,000 staff, and a range of clinical facilities at the disposal of the public health service. A number of other countries have made similar arrangements (for example UK, Australia and Spain). By decision of Government the arrangement is now ending with a view to negotiating a new one going forward. We look forward to working with the Private Hospitals to negotiate a new arrangement based upon the Government decision.

In seeking to identify the preferred mechanism for securing private hospital capacity, we looked for a model that:

- would deliver the **necessary capacity requirements** for both patient cohorts (ie urgent COVID-19 cases plus urgent general work ongoing,) **working to a common clinical plan;**
- would support **safe and quality-assured** care;
- delivered **cost effective services** for both patient cohorts;
- used **established mechanisms and expertise** (legal, contractual etc) as far as practicable;
- made **best use of the skills** available across sectors to treat both patient cohorts;
- **protected or added to the national bed capacity** in the future;
- could **adapt and flex** to address evolving needs of the pandemic response.

The Government's ultimate decision to acquire access to the total resources of the private hospital sector included a number of key principles:

- **The private hospitals would operate on the basis of public-only work** for the duration of the arrangement. They are precluded from generating income from private patients and the public statutory charges apply to patients treated in private hospitals;

- Specific arrangements to ensure the provision of **continuity of care** for existing public and private patients would be established and put in place;
- **The basis for funding the hospitals** was to be through a **Cost Recovery model,** as opposed to a rate per case and on a non-profit basis;
- **Private hospitals would focus, initially at least, on delivering time-dependent care** in a non-COVID-19 environment for the greater protection of patients and staff.
- Private-only consultants associated with the 18 private hospitals to be offered **temporary consultant contracts for exclusively public work**
- **Public hospital system would continue to operate under existing eligibility rules** i.e. consultants who have private practice rights may continue to see and treat private patients and receive private income for such work.

The decision to proceed with a partnership was reflected in a set of Heads of Terms (HoT) negotiated by HSE collectively with 18 private hospitals through the Private Hospitals Association (PHA) and signed on 3 April, 2020. The HoT has legal effect and was placed before the Oireachtas**.** The HoT provides the basis upon which services are provided and overseen, with specific provisions for verification of activity level and cost. The duration of the agreement is three months minimum, effective from 30 March to 30 June, with an option to extend for up to five months.

Clinical Context

The overall response to COVID-19 is based on the twin objectives of reducing transmission and saving lives. You will recall that, as the COVID pandemic developed across neighbouring European countries earlier this year, there was clear evidence of catastrophic levels of demand on other countries' health systems. Ireland, with significant capacity limitations in critical care, and in overall acute hospital bed stock needed to prepare to meet similar extreme pressures. To put this into context Ireland has a low number of ICU beds per head of population and the high acute hospital occupancy rates per OECD data.

Clinical modelling exercises undertaken within the HSE in March, 2020, regarding the expected demand for acute care and critical arising from the pandemic indicated that by mid-April, we might possibly require up to 1,000 critical care beds and 2,000 additional inpatient beds to match peak demand. Existing public sector capacity was 250 critical care beds and 11,000 inpatient beds operating at close to 100% occupancy with 650 unavailable due to Delayed Transfers of Care (DTOC). The timeline was pressing and the options available to ramp up short-term capability were limited. As a consequence we secured the Government decision and agreement outlined above.

On 27 March 2020, NPHET directed that *"All non – essential surgery, health procedures and other non –essential services be postponed";*

As a result, all public and private hospitals curtailed their elective activity during April in the interest of patient safety and protecting capacity for surge requirements. Many patients chose not to attend for appointments and procedures. These curtailments remained in place for the following five weeks. Fortunately, the actions taken by the wider population served to flatten the curve. It is important to recognise that there was significant and sustained pressure on the hospital system in terms of access to critical care. The numbers requiring admission to critical care remained high throughout April and into May. At its peak two-thirds of critical care base capacity was used for COVID patients requiring ventilation. The combined measures taken to protect capacity meant that the public hospital system was able to cope with the sustained demand during this time. A decision of 5th May by NPHET recommended the re-establishment of elective work based on clinical and operational prioritisation.

Approaches to boosting Acute Capacity

At the onset of the pandemic the HSE sought to do a number of things in relation to overall acute capacity:

Stop all non- urgent elective work

This was NPHET-directed from 27, March 2020. As a result over 2,000 beds were freed up at the end of March;

Grow critical care surge capacity

We provided for a maximum surge of up to 800 critical care patients from the baseline capacity of 250 critical care beds. This was heavily dependent upon re-assigning existing staff and up-skilling them to support critical care teams. Over 1,600 staff were trained to do this;

Acquire private hospital capability (including 'private-only' Consultants and 100 critical care/high dependency beds)

The private hospital arrangement brought four separate benefits:

- It provided much needed capacity against expected surge pressures;
- The capacity to maintain essential service to non-COVID but time-dependent surgery and treatments (expl cancer, transplant, cardio-thoracic services etc.) for all patients;
- It has allowed for safer environments for patients and staff. This is very significant; clinical guidance is that hospitals need to cap their occupancy rates at 80% to allow for safe working practices;
- Finally, it has provided the opportunity to begin to address the extensive build-up of displaced work which has been added to already substantial waiting lists in many areas.

Experience to date

The partnership arrangement with the private hospitals was devised and executed quickly, starting in mid-March. Despite the unique nature of the initiative and its relatively short existence we can point to very substantive benefits in line with the objectives I have just described. A total of 7,605 in-patients have been seen to date and 26,007 Day Cases. In addition, the private hospitals have delivered 24,407 out-patient consultations and 35,073 diagnostic tests. Inpatient occupancy rates have grown to an overall level of 51% for the week ending 22 May, 2020, daycases are at 150% occupancy

The private hospitals do not, generally speaking, employ the consultant specialists who work with them. They are served by either public appointment holders with private practice rights or by a group of 'private-only' consultants who do not have public appointments. The number of private-only consultants is in the region of 550. Of these, 291 have taken up the offer of a public-patient only contract from HSE (Type "A" contract) and are treating public patients on the private sites. A key concern identified was the imperative to ensure continuity of care for private patients. The HSE fully acknowledges this requirement and where there is a justifiable case based on continuity of care needs, we have agreed that private-only consultant rooms can be included in the initiative as a recoverable cost. The HSE agreed a range of measures to ensure continuity of care including;

- Private patients who were in a course of treatment at the date of the arrangement commencing would continue in care;
- Patients who were booked for procedures based upon clinical priority were to be admitted as public patients without charge;
- Some consultants offered to provide care pro bono to ensure continuity of care where they did not take the contract offered;
- Both the HSE and individual consultants have a duty to ensure care continuity and this occurred;
- Consultants from public hospitals provided care in the private hospital setting.
- Indemnity was provided to all consultants to support practice

As with any whole-system change operational and logistical issues are to be expected. It needs to be borne in mind that the public and private hospital providers are simultaneously facing massive disruption in working with the constraints imposed by COVID. Our task is to support the total delivery system to respond to the need for COVID and non-COVID patients. For this reason, each private provider has an assigned lead Hospital Group partner to provide accountability and governance oversight.

Future considerations

Until such time as there is a vaccine or cure for COVID-19, healthcare delivery will occur in a higher risk environment where outbreak and surge could occur at any time.

The underlying capacity issue remains in the acute system. This is amplified by the need to manage in a Covid environment. The private hospital system is not the sole solution for the safe delivery of care in the COVID environment, but it is the only immediate acute option that can help provide an occupancy of 80% delivering on the twin requirements of matching non-COVID demand and providing surge capacity for COVID-19. This will have to be complemented by a range of other capacity measures in both acute and non-acute settings across the public system.

The sharp reduction in numbers presenting to our EDs over the past two months because of concerns on the part of the public about disease transmission has allowed the system to cope with the significant numbers of patients that required admission for COVID over the past eight weeks. Over the past two weeks we have seen a steady increase in the number of patients presenting to our EDs and a sharp increase in the number of DTOCs. As winter approaches and with it all of its annual challenges, this year there will be the additional challenge of COVID-19. Patients on trolleys in ED awaiting admission to hospital wards, COVID or non-COVID, cannot be a part of how an optimal service is delivered.

HSE and NPHET modelling looks continuously at the implications for critical care and acute general care of increases in the Rt value and the associated timelines for such an impact. A relatively modest spike of the Rt rate above 1 (1.2 – 1.3) would have very significant impact on both specialist critical care beds and the wider hospital system. Uncertainty about the impact on transmission rate of the phased unwinding of lockdown is just one of the many unknowns we are grappling with as we attempt to provide safe care. As I speak to you today the situation remains a work in progress.

Against this backdrop, our objectives remain as set out earlier; to provide a capacity reserve against surge pressures, to maintain essential service to non-COVID but time-dependent surgery and treatments, to ensure safe environments for both patients and staff and to address the extensive build-up of displaced work as soon as possible.

On the latter point, there is now specific evidence of the latent and displaced non-COVID-19 activity which will need to be provided for by the acute hospital sector and of a build-up of waiting lists. Areas of immediate priority include Endoscopy, Cardiology, Cardiovascular, Urology, Orthopaedics. The numbers waiting for more than three months for Endoscopy at end February have gone from 11,801 to 17,664 at end April. Equivalent waiting list figures for Orthopaedic procedures go from 6,134 waiting more than 3 months in February to 8,672 by end April, 2020.

Similarly, all four national screening programmes have been suspended under clinical advice since March and can only re-commence when certain safety conditions can be met.

Some of the innovation undertaken in the last two months will need to stay in place. Virtual clinics can support the delivery of up to 50% of out-patient appointments in some specialties, reducing the requirement for face to face appointments and facilitating social distancing and fixed scheduled appointments. Risks in unscheduled care provision can be mitigated by providing alternatives to the Emergency Departments in terms of resources to facilitate the completion of an episode of acute care in the Community such as access to diagnostics, CIT, OPAT, Virtual Specialist Opinion and Home care packages. Alternate routes into the acute hospital system such as rapid access virtual specialist consultations, appointment based AMAU and ASAU review can all be further developed.

Summary

I will summarise as follows:

- All indications are that the pandemic will remain a significant shaper of all healthcare well into the medium term;
- Our existing infrastructure in many of our public hospitals is not fit for purpose in terms of meeting the emerging requirements in terms of safe distancing;
- The basic shortfall in acute hospital capacity identified by the Department of Health Capacity Review in 2018 has now been exacerbated by the impact of COVID-19.
- There will be similar effects in other areas, such as Intermediate Care and Long-term Residential Care, which will in turn impact on the hospitals;
- Our ability to provide a safe and equitable acute hospital response over time is going to need an ongoing strategic relationship with all acute providers;
- The current partnership initiative has provided capacity and addressed a key point of surge. We will continue to require enhanced acute capacity.

What has been achieved in hospitals over the last weeks is based entirely upon the dedication of staff and the care provided to Covid and other patients in this time of national challenge is a testament to their commitment to delivering care for all patients.

Conclusion

This concludes my opening statement and together with my colleagues we will endeavour to answer any questions you may have.

Thank you.