Submission to the Oireachtas Special Committee on COVID-19 Response on the Capacity Requirements to provide non-COVID-19 healthcare and deal with COVID-19 cases

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Executive Summary

The persistent underinvestment in hospital infrastructure, bed capacity and other facilities in the past decade and the failure of two successive governments to address the consultant recruitment and retention crisis have made it a challenging time to provide acute hospital and mental health services. The COVID-19 pandemic has highlighted the deficits in our system but also provides an opportunity for innovation and positive change.

Our public hospitals and the patients that depend on them for care face unprecedented challenges in the months and year ahead. Acute hospitals and mental health services were operating at full occupancy before COVID. Since the onset of COVID health professionals have reviewed every aspect of their work practises to provide a safe environment for their patients. The changes made necessary by COVID will unfortunately reduce the capacity of our hospital system further.

The capacity deficits in our acute hospitals have been evident long before the COVID-19 pandemic, as outlined in detail later in this submission. The postponement of procedures and treatments since the start of the COVID-19 outbreak, while a necessary response at the time, has amplified even further the unacceptable long waits patients now endure.

An ‘emergency’ response from the Government is needed and this will require significant investment and a clear focus in addressing public hospital and mental health capacity deficits. Investment in the health services will give us the breathing room to allow us to re-open our economy and keep it open.

The Government must prioritise urgently the funding, development and implementation of practical plans and workable solutions to expand our public hospital capacity and community step-down services to provide care to patients. To date, the pace of implementing the 2018 Capacity Review and the National Development Plan (NDP) has been far too slow. Now is the time to frontload the beds planned in the NDP and to finally address the consultant recruitment and retention crisis.

Hospital Consultants, as frontline healthcare workers, have been front and centre in providing care to our patients in an extremely challenging environment during the COVID-19 crisis. We all appreciate the gratitude which our patients and their families have expressed during those challenging months. This appreciation now needs to be built on with proper resourcing of our acute public hospital services and mental health services.

The Association strongly recommends the following priority actions to deliver care to patients with non-COVID-19 and COVID-19 illnesses.

1. Bed occupancy limits of 80% to 85% and other requirements if adhered to will negatively impact the capacity available to provide patient care. The rapid acceleration of the National Development Plan’s (NDP) expansion of acute hospital and community beds is critically important.
2. Fast track in the shortest possible timeframe the opening of the additional 2,600 acute hospital beds and 4,500 community step-down and rehab beds committed to in the 2018 Capacity Review and provided for in the NPD.
3. Urgently double the ICU capacity to 579 beds as recommended in an HSE commissioned report a decade ago, because the existing public hospital capacity of 250 ICU beds is far too low. The hundreds of improvised ICU beds opened in recent months must be fully equipped and staffed on a sustainable basis before the winter surge in demand, to not only provide the

required care for potential COVID patients and the annual increase in demand due to flu but also to facilitate complex operations for an increasing number of people on waiting lists.

4. Rapidly develop and implement plans for three or four new elective-only hospitals in Dublin, Cork, and Galway so they become operational without delay.
5. A full complement of psychiatric beds must be resourced and provided to deliver timely care to patients with mental illnesses and to ensure that children and adolescents are admitted to age-appropriate units. At a minimum, an increase of 300 acute adult psychiatric inpatient beds is required and an increase in child and adolescent beds.
6. It is essential to immediately fill the over 500 permanent consultant posts which are vacant. This is required to urgently increase critical frontline hospital capacity to assess and treat the record number of people awaiting outpatient appointments and inpatient and day case essential surgical and medical care. The numbers on waiting lists have increased by almost 40,000 since the start of the year but this is likely to be an underestimate of the actual increase as a lot have not presented because of COVID-19. The new Government has an opportunity to restore trust by ending the pay discrimination imposed on Hospital Consultants appointed on contracts since 2012, as recommended by the Public Service Pay Commission in September 2018. The discrimination has its origins in the unilateral salary cut imposed solely on hospital consultants by the then Minister for Health.
7. The physical distancing requirements of two metres, if implemented, will displace an estimated 25% of the existing inpatient acute hospital beds. Additional hospital space must be commissioned to accommodate those beds or essential capacity will be lost at a critical time.
8. Also due to the distancing, Outpatient Departments and Emergency Departments will also require hospitals to commission and equip additional space to hold outpatient clinics and assess emergency presentations.
9. The clinical prioritisation processes required to address the backlog of patients with urgent non-COVID-19 illnesses must have the appropriate clinical input from the responsible Consultants.
10. Increasing step-down, rehab and home care supports are required to reduce the number of clinically discharged patients in acute hospitals.
11. More effective Community Healthcare Networks could increase community care and reduce the number of clinically discharged patients in acute hospitals.
12. Government policy on older person services should promote and fund increased care in the home and the provision of safe nursing home care.
13. The demand and need for the provision of care to potential future waves of COVID-19 ill patients will be heavily dependent on the population's adherence to public health advice and the operation of highly effective programmes for rapid testing, contact tracing and isolation as required.
14. An effective end-to-end testing and contact tracing plan, with rapid turnaround times and clear KPIs, are required to ensure any future COVID-19 outbreaks are isolated and controlled. Regular and rapid testing of all healthcare staff should be adopted as non-COVID care restarts, to prevent the spread of the virus in hospitals. If antibody testing proves accurate and immunity can be confirmed, its use among HCWs and other targeted population groups should be prioritised.
15. There is a need to assess the risk of the potential impact on the Irish healthcare system of the combination of a range of viral infections including seasonal influenza A and B, the co-existence and continuance of COVID-19 pandemic in the population and the risk of the emergence of a novel Swine flu epidemic/pandemic.

16. Increased stocks of flu vaccine should be procured and offered without charge to wider population groups to reduce the number of influenza cases occurring during the next winter.
17. Fund and open the additional 1,350 intermediate transitional care and step-down beds immediately, which have already been identified by the HSE. These beds are required to provide for increased demand for care and to transfer clinically discharged patients to free up public hospital capacity which is required to treat patients on waiting lists.
18. Previously closed acute hospital beds, that were reopened since last winter need to remain open to provide care in the nest year. This includes the 220 inpatient beds funded under the 2019/2020 Winter Initiative and the 324 beds opened under the COVID-19 plan.
19. The need to retain the Citywest convention centre 300 bed capacity beyond October should be considered, as well as the additional step-down capacity in the UL Arena.
20. Any future arrangements with private hospitals and private practice consultants must ensure they can provide continuity of care to their patients in consultant outpatient clinics and in private hospitals and that they can operate at high levels of occupancy in line with their current usual effective operations.
21. Procure and stock advanced supplies of Personal Protective Equipment (PPE) to ensure ready availability over the next twelve months. Given the global demand for PPE, the Government should facilitate increased indigenous production of PPE.

Introduction

The Irish Hospital Consultants Association (IHCA) represents over 95% of hospital consultants working in Ireland's acute hospital and mental health services.

We welcome the opportunity to submit our views to the Committee on the capacity requirements to provide non-COVID-19 healthcare and deal with COVID-19 cases.

Providing acute hospital care to patients while living alongside COVID-19 presents significant challenges because of the overwhelming capacity deficits that have existed over the past decade due to the lack of investment despite sizeable population increases and other demographic changes. As a result, there is an urgent need for practical plans and workable solutions that will expand our capacity to provide timely care to acute hospital patients.

The Government needs to ensure that the population is protected from the coronavirus, and to allow the health service to resume the provision of timely non-COVID-19 care to patients.

The IHCA in seeking early engagement with the Minister for Health, Mr Stephen Donnelly, on these issues to agree practical solutions to the unprecedented challenges that lie ahead.

Overview of health system capacity for non-COVID-19 Healthcare

1. Acute Hospital Capacity needed for non-COVID care

1.1. Capacity Deficits before COVID-19

Even before the COVID-19 pandemic, the pace of implementing the recommendations of the 2018 Capacity Review and the provisions included in the National Development Plan (NDP) have been far too slow. They clearly need to be accelerated by the new Government to open the recommended additional 2,600 acute public hospital beds and the additional 4,500 community step-down and rehab beds in the shortest possible timeframe.

The NDP, when published in February 2018, provided for 260 additional acute public hospital beds on average per year.[1] It should be noted that this is at the lower end of the range of 2,500 to 7,000 additional beds recommended on a scenario basis in the Capacity Review. However, the HSE's Capital Plan published in September 2019 reduced the acute hospital bed target to 160 per year on average[2], a 40% reduction on the NDP provision which was at the lower end of the Capacity Review range.

The proposed drip feed approach of opening 160 acute hospital beds per year is clearly insufficient to ease the severe overcrowding being experienced year after year in public acute hospitals, even before the new COVID-19 requirements.

The consultant recruitment and retention crisis, with one in five permanent consultant posts unfilled, is a key workforce capacity deficit that is resulting in longer delays for patients on waiting lists. This must be addressed by Government immediately in view of the horrendous challenges our acute hospital services have endured and taking account of the greater challenges in the months and year

[1] National Development Plan 2018-2027, 16 February 2018.
[2] HSE Capital Plan 2019, 2 September 2019.

ahead. The Consultant salary inequity applying since 2012 is the root cause of Ireland's consultant recruitment and retention crisis and the unacceptable numbers of people on record waiting lists.

The consequence of the 2012 government induced consultant recruitment and retention crisis is that our public hospital and mental health services are simply unable to cope with the demands for patient care they face. The ongoing risk from COVID-19 cases adds further urgency for the Government to restore pay parity and end the discrimination urgently. Consultant vacancies must be filled before we rapidly approach the winter increases in demand for care on top of backlogs in patients awaiting urgent hospital care that have accumulated over the past four months in conjunction with the risk potential new waves of COVID-19 cases.

Ireland has 42% fewer medical specialists on a population basis than the EU average, and number of consultants in post is some 25% below that recommended in the Hanly Report in 2003.[3] When the unforeseen population growth and demographic changes are taken into account, the shortfall is significantly greater, particular in certain specialties.

HSE data confirms there are more than 500 permanent consultant posts (20% of the total) that are vacant or filled on a temporary basis.[4] The root cause for the vacancies is the lack of competitiveness due to pay disparity applied to consultants taking up contracts since the unilateral cut imposed by the then Minister for Health solely on hospital consultants in 2012.

The reduced New Entrant Consultant salary scales have resulted in:

- A disastrous decline in the number of applicants for posts, with the failure of the HSE to fill 38% of the Consultant posts advertised between 2015 and 2017.
- Almost three quarters (73.1%) of trainee specialists who plan to practise medicine abroad attribute their decision to the discriminatory salary terms imposed on new entrants.[5]
- More than 700 specialists either left Ireland to work abroad or ceased practice here between 2015 and 2017.[6]

Recommendation: Additional hospital space is needed to facilitate patient isolation and physical distancing while maintaining the existing bed capacity in our public hospitals. In addition, the opening of the 2,600 additional beds must be fast tracked in the shortest possible timeframe.

Also, the Government must restore pay parity for consultants appointed since October 2012 in order to end the medical brain drain and ensure that Ireland becomes an attractive place to pursue a medical career and fill over five hundred vacant permanent consultant posts.

1.2 Waiting Lists

One of the most important and egregious consequences of the consultant recruitment and retention crisis is the unacceptable delays in providing care to patients and growing waiting lists.

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[3] Report of the National Task Force on Medical Staffing, Department of Health, June 2003, p87.
[4] HSE figures confirm there were 3,354 approved consultant posts and 2,846 consultants employed as at 31 December 2019. Therefore 508 posts need to be filled on a permanent basis (Source: HSE Approved Consultant Establishment as at 31 December 2019).
[5] 'Your Training Counts', Irish Medical Council, 3 July 2019.
[6] Medical Workforce Intelligence Report for 2016/2017, Irish Medical Council, 11 April 2019.

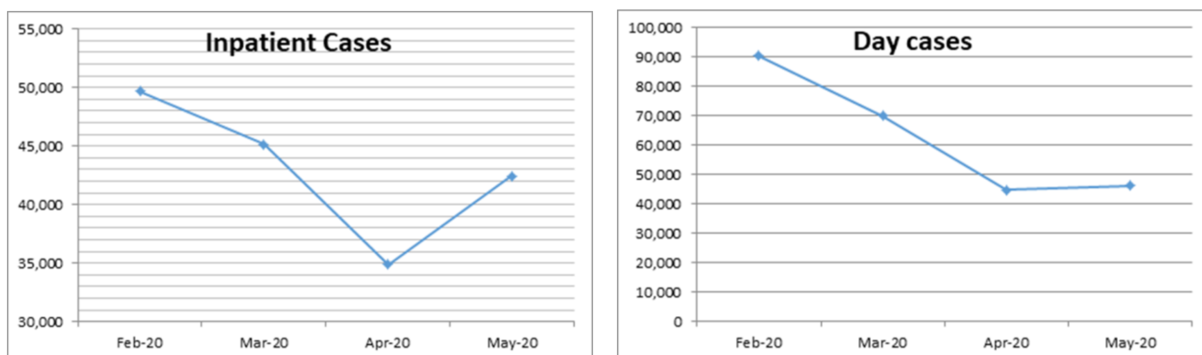
There could very soon be a million people on a National Treatment Purchase Fund (NTPF) waiting lists. A total of 39,683 have been added to the NTPF lists since the start of 2020.[7] It is also expected with the pause in non-emergency and non-COVID-19 care over the past four months has resulted in a hidden increase waiting list that are not fully reflection in the current waiting list figures reported for the end of May. In 2019, the public hospital consultants provided assessments 3.35m people in outpatient appointments and provided care to 1.74m inpatient and day cases.[8]

The latest waiting list figures for May 2020 confirm:

- 808,447 people are now waiting on some form of NTPF waiting list, an increase of 39,683 since the start of 2020;
- 575,863 outpatients nationally are waiting to be seen by a consultant, an increase of 22,429 since the start of the year; and
- 86,946 now wating for inpatient/day case treatment, an increase of an additional 20,241 (30.3%) patients since the start of the pandemic in March.

Dramatic falls were seen in the number of inpatients and day cases treated in public hospitals from February to May, although a portion of this day case activity was switched to the private hospitals. These falls are not reflected in the official NTPF waiting list figures.

Figures 1: Inpatient Cases and Day Cases Feb-May 2020



Source: HSE

The existing HSE outpatient waiting time target of 52 weeks is extremely high compared to countries such as Scotland, which see most outpatients within 12 weeks.[9]

The difference is that Scotland has invested in hospital capacity to ensure that patients can access timely hospital care. In addition, Scotland with a population of 5.5 million has 56% more public hospital consultants than Ireland.[10]

Recommendation: The 500-plus approved permanent Consultant posts must be filled to create the frontline capacity to treat the record number of people awaiting outpatient appointments and inpatient and day case elective procedures. This requires the Government to end the discrimination against all Consultants appointed since October 2012.

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[7] NTPF Waiting List figures for end of May 2020.

[8] HSE Annual Report and Financial Statements 2019.

[9] Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times: Monthly and quarterly data to 31 December 2019, ISD Scotland, 25 February 2020.

[10] NHS Scotland Workforce, ISD Scotland, 3 September 2019.

1.3 Physical Distancing Impact

The HSE in setting out how acute hospital services will adhere to the proposed two metre physical distancing rule has estimated a reduction of around 25% in acute inpatient beds if those existing beds are not accommodated elsewhere.[11] There were 10,919 inpatient public beds open in our acute hospitals in December 2019; so the reduction equates to 2,730 beds.[12]

Initial analysis by the South/Southwest Hospital Group has identified the following loss of bed capacity and throughput as a results of physical distancing measures:

- A reduction of Cork University Hospital's capacity by 144 inpatient beds (-23%);
- A reduction of University Hospital Kerry's capacity by approximately 70 inpatient beds (-29%);
- A reduction in capacity of up to 50% for some day surgical and endoscopy units.[13]

A recent IHCA member survey confirmed that:

- Bed capacity for acute medical patients at **Mallow General Hospital** has reduced from 57 to 26, but even with this reduction the hospital does not meet SARI guidelines for antimicrobial resistance. Renovation will increase capacity to 37, which is still a 35% reduction.
- Some Consultants at **Mercy University Hospital** are doing only a quarter the number of day case procedures pre-COVID and just over half the number of minor procedures due to physical distancing and infection control requirements.

Recommendation: It is imperative that the Government urgently decides on the physical distancing to apply, either two metres or less. Based on that decision the expansion of public hospital and community facilities will be required or the existing insufficient bed capacity will be reduced as we enter a critical period.

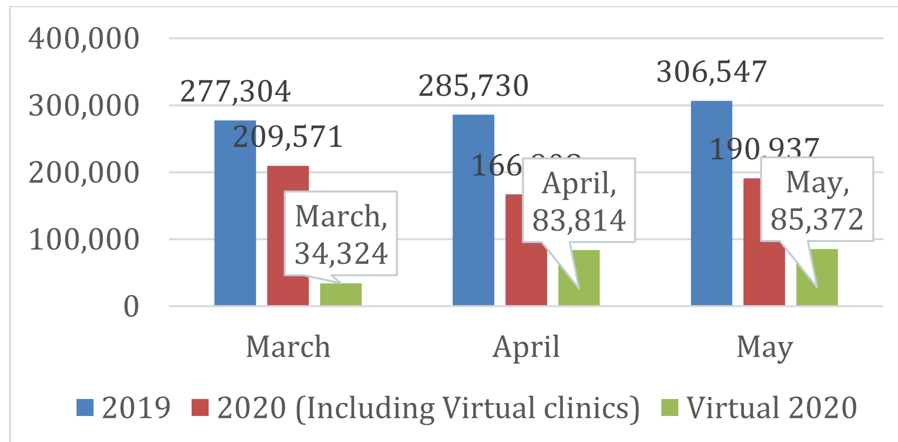
1.4. Outpatient Departments

Physical distancing will also create major problems for the arrangement of Consultant outpatient clinic appointments. Extra space for clinics must be funded by the HSE and arranged by management locally to ensure outpatient appointments can take place at required levels.

There were over 300,000 fewer outpatients appointments in March, April and May this year compared with 2019 (Figure 2).[14] This massive fall in activity has not been fully reflected in the NTPF waiting lists figures, which recorded an increase of just 17,309 in the outpatient waiting list (+3.1%) over the same period.[15]

[11] 'Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 8 June 2020 (published 24 June 2020).
[12] Open Beds Report December 2019, Department of Health, 3 March 2020.
[13] 'Service Continuity in a COVID Environment', HSE.
[14] There were 869,581 new and return outpatient attendances in March, April and May 2019. This feel to 567,416 outpatient attendances in the same three months in 2020. HSE Media Briefing Documentation, 24 June 2020.
[15] NTPF Waiting List Figures.

Figure 2: New and Return Outpatient Attendances (including 2020 virtual activity) 2019 -v- 2020 (March, April, May)



Source: HSE

Recommendation: All hospitals need to identify and commission more space for Consultants to see outpatients.

1.5. Emergency Departments

Despite a sharp fall in emergency department (ED) attendances at the onset of the COVID-19 outbreak,[16] ED demand is continuing to increase. Therefore, expanded space for EDs is needed because of the new physical distancing requirements. More older people are now presenting and being admitted to hospital, with levels having surpassed comparable levels in 2019. The total number of those aged over 75 who attended EDs in the week ending 21 June 2020 was 3,465, a 5.2% increase on the same week in 2019.[17]

The number of patients being treated on trolleys is also beginning to increase, with on average 100 people a day on trolleys awaiting admission to a bed across the country in the month of June.[18]

The risk of COVID-10 infection spreading means that overcrowding in EDs is unacceptable and cannot be allowed to recur. It is essential all hospital beds opened during the pandemic are retained and all beds currently under construction are prioritised for completion and a programme of new builds commissioned without delay. In parallel, the HSE must plan recruitment of the staff needed for that additional bed capacity when opened.

Recommendations: Practical workable solutions to address the inadequate bed capacity, poor infrastructure and Consultant staffing deficits are needed urgently or Emergency Departments will not be able to cope with the challenges of COVID-19. This will determine the length of time patients presenting at EDs will wait to be admitted to an inpatient bed if required, discharged home or transferred to a more appropriate service.

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[16] ESRI Special Article: COVID-19 and emergency department attendances in Irish public hospitals, 22 May 2020, https://doi.org/10.26504/qec2020may_SA_lyons.

[17] Anne O'Connor, Chief Operations Officer, HSE, speaking at the HSE weekly briefing, 24 June 2020.

[18] Trolley Watch; 'Fears hospitals will struggle in winter if COVID-19 resurges', *Irish Examiner*, 24 June 2020.

2. Restarting non-COVID-19 care

Acute hospital overwhelming capacity deficits must be addressed urgently to provide timely non-COVID care. This is needed to reduce waiting lists taking account of the new required infection control measures. In addition, COVID-19 testing and appropriate Personal Protective Equipment (PPE) supplies are required.

In recent years, Ireland's bed occupancy has been at 94%, well above the recommended maximum of 85% occupancy rate and 23% above the EU average of 77%.[19] Occupancy rates at this high level result in regular bed shortages, increased numbers of admitted patients being treated on trolleys and higher levels of healthcare acquired infections.

Ensuring that bed occupancy operates between 80%-85% for as long as we are living alongside COVID-19 will be extremely challenging. It will not be possible unless the existing total public hospital bed and other capacities are not expanded rapidly. It should be noted that the capacity in private hospitals is also in full demand by the patient cohorts relying on them and that arrangements with private hospitals do not add an additional capacity to the overall national hospital bed capacity which is one of the lowest in the EU.

The HSE has indicated that adhering to an 80% bed occupancy will lead to 108,000 fewer planned inpatient cases being treated a year.[20] This will have a dramatic impact on the provision of non-COVID care to patients as this figure exceeds the number of all elective discharges.[21]

Recommendation: It is imperative that the Government urgently expands public hospital capacity. This includes accelerating plans to open the 2,600 acute beds in the 2018 Capacity Review and NDP. Also the three or four new elective-only hospitals in Dublin, Cork and Galway need to be accelerated. All these need to be fast tracked and the facilities built without delay.

3. Catch-up programme for missed care and services

'Clinical prioritisation' is required to structure the resumption of services, including urgent non-COVID care. The backlog of those waiting to access all aspects of urgent care will present challenges.

The HSE's Strategic Framework for the resumption of services document outlines how a clinical prioritisation framework has been formulated by the National Clinical Advisors and Group Leads. It is understood that this needs to be strengthened to ensure that there is increased engagement with the treating responsible consultants in all cases.

The catch-up programme for colonoscopies prioritises the most urgent cases. This will now lead to longer waiting times for some patients who are placed on the waiting list, and for those routine and planned procedures in endoscopy units.

Consultants in respiratory medicine have indicated that the health service could be facing a 'lung health crisis' with greater waiting lists, an increase in patients presenting to EDs and increased

[19] Health at a Glance: Europe 2018.
[20] Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 8 June 2020 (24 June 2020).
[21] The projected outturn for elective inpatient discharges in 2019 was 91,635: Source: HSE National Service Plan 2020.

mortality.[22] Ireland has one respiratory physician per 80,000 people compared with one per 35,000 people as advised in international guidelines.[23] A further concern is that 85% of patients who are admitted to hospital with a respiratory illness at present are taken in as emergency cases.

The resumption of CervicalCheck from the second week in July is welcomed as are plans to resume other screening programmes.

Recommendation: The clinical prioritisation process must have the appropriate clinical input from treating Hospital Consultants and operate in a transparent way, especially as it is understood there may be significant variation in how the resumption of services is operating. Additional Consultants must also be appointed to clear the growing waiting lists for treatment.

4. Mental Health Services

The World Health Organization (WHO) has stated that mental health needs must be treated as a core element of our response to and recovery from the COVID-19 pandemic or it will lead to "long-term social and economic costs to society".[24]

A high priority is how to provide urgent care to patients with serious and potentially life-threating-mental illnesses. In a recent survey, 1 in 3 Consultant Psychiatrists have seen an increase in the number of emergency referrals compared with numbers prior to lockdown and 50% cited an increase in patients experiencing a relapse of mental illness.[25] Nearly 60% said the demand for inpatient beds had increased in the past month compared to March.

This will have significant implications on a service already overburdened and underdeveloped and having to now meet the additional requirements on physical distancing. Ireland has the third lowest number of inpatient psychiatric care beds in the EU (33.93 beds per 100,000 population[26]), which is less than half the European average (73.33).

While the previous mental health policy 'A Vision for Change' had planned for a marked reduction in acute psychiatric hospital beds, the promised alternative services have not been provided in the community. It is extremely disappointing that the new mental health policy 'Sharing a Vision' does not even attempt to quantify current bed capacity needs.[27]

Major capacity deficits exist in Child and Adolescent Mental Health Services (CAMHS), where only three quarters of the 74 available CAMHS beds are open at any one time.[28] This falls far short of the 108 CAMHS beds recommended in the previous mental health strategy and has resulted in the inappropriate admission of children and adolescents to adult mental health units, which increased by 24% over three years to 84 children in 2018. Last year 54 children were admitted to 15 units, the youngest of which was aged 15.[29] This constitutes a breach of Ireland's obligations under the UN Convention on the Rights of the Child.

[22] 'Coronavirus in Ireland: Lung disease crisis coming without investment, doctors warn', *The Times Ireland Edition*, 20 June 2020.
[23] *The Times*, 20 June 2020.
[24] WHO Statement, 14 May 2020.
[25] College of Psychiatrists of Ireland, Press Statement, 17 June 2020.
[26] Eurostat.
[27] 'Sharing the Vision – a Mental Health Policy for Everyone', Department of Health, 17 June 2020.
[28] HSE response to PQ 17381/19 to Deputy Pat Buckley, 7 May 2019.
[29] Mental Health Commission Annual Report 2019, 2 July 2020.

Plans to operate psychiatric inpatient bed occupancy levels of 80% to 85% will prove particularly difficult given that the overall acute mental health bed occupancy levels are 89.25%.[30] Only nine of the 28 acute units operating are within the less than 85% safe level of occupancy, with one quarter having true bed occupancy levels equal to or over 100%. Physical distancing requirements will result in major challenges unless increased space is provided in our mental health services.

The Mental Health Services must also recruit the number of Consultant Psychiatrists required to provide high quality, timely care and treatment to patients who need it. Ireland has 6.1 Consultant Psychiatrists per 100,000 population, just half the EU average number of specialists and one-third to a quarter the number in many EU countries.[31] Additional increases have been recommended, however there is major problem in that a high percentage of the 492 approved permanent Consultant Psychiatry posts remain vacant.[32]

These workforce deficits are contributing to persistent and damaging long waiting lists for treatment which are likely to worsen over the coming months. HSE data confirms that the number of patients waiting to be seen by a Consultant Child & Adolescent Psychiatrist nationally was 1,876 in September 2019, with 36% (668) waiting longer than 6 months and 11% (204) waiting longer than 1 year.[33]

These waiting lists will deteriorate due to the interruption of services over the past four months which has seen:

- A 57% reduction or suspension of community mental health services.
- The number of new cases seen by General Adult Community Mental Health Teams reduce by almost a fifth in April.[34]

Addressing the lack of Consultant Psychiatrists, inpatient beds and frontline resources would resolve most of the problems facing the mental health services.

While using telepsychiatry methods over the past four months has been of assistance during the lockdown,[35] two-thirds (67%) of Consultant Psychiatrists who answered the Information Technology questions felt they were ill equipped to conduct some/most or all duties from an IT perspective. They noted no availability or poor signal of Wi-Fi in offices, and that personal home Wi-Fi connections were also causing issues with the use of telepsychiatry assessment. The gold standard is in-person consultations and changes to this must be rigorously assessed to ensure the quality of the care is not compromised.

Increasing access to the mental health services via telepsychiatry is also unlikely to reduce the number of those entering the mental health services, as more assessments will be required. Therefore, the introduction of any 'tele-service' could significantly increase the demand for inpatient beds, which are already in short supply, as a bed is required to appropriately assess the risk of suicide and other conditions.

Developments such as 'web therapy' for moderate to severe mental illness will still require a sufficient number of Consultant Psychiatrists and other MDT members to deliver the service. It will not address the current shortage of Consultant Psychiatrists. Web therapy also needs to be properly resourced including staff, hardware, software, and ongoing technical and maintenance supports.

[30] 'Access to Acute Mental Health Beds in Ireland', Mental Health Commission, February 2020.
[31] WHO Mental Health Atlas 2011, published in 'Evidence Review to Inform the Parameters for a Refresh of AVFC.
[32] HSE Consultant Establishment as at 31 March 2020.
[33] HSE Performance Profile July – September 2019 Quarterly Report; HSE Management Data Report, September 2019.
[34] Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 24 June 2020.
[35] College of Psychiatrists of Ireland, Press Statement, 17 June 2020.

Recommendation: A full complement of psychiatric beds must be resourced to deliver timely, high quality care to patients and to ensure that children and adolescents are admitted to age-appropriate units. At a minimum, an immediate increase of 300 acute adult psychiatric inpatient beds is required in addition to required increase in child and adolescent beds.

The Government must also urgently address the recruitment and retention crisis in the Mental Health Services by increasing the number of Consultant Psychiatrists in post, in order to meet the increased demand for care from the population and to mitigate the risk of burnout among front-line mental health teams.

Increasing the use of web-therapy or 'tele-psychiatry' is not a solution to the significant workforce deficits.

5. Home help and Nursing Home care

Delays in the assessment and provision of nursing home and home care packages impacts the number of clinically discharged patients remaining in acute hospitals, which is turn delays urgent care to patients. Increased support for hospital discharges to either nursing homes or with suitable home care packages will be required to optimise the use of the existing acute hospital capacity.

The most significant population growth in recent years has been in the number of those aged 65 and over, which increased by 212,500 (44%) since 2008.[36] These demographic changes are driving the increase in demand for acute hospital care. Those aged over 65 represent 13% of our population but account for 54% of total hospital inpatient bed days, approximately 37% of day case and same day bed days, and 26% of ED attendances.[37]

Nursing home and residential care residents have accounted for approximately 60% of all deaths from COVID-19. Internationally, the figure for fatalities in residential care for older people is approximately 25%.[38] One of the key lessons from the COVID-19 pandemic to date must therefore be the need to enable our older population to remain at home for longer or be provided with safe nursing home care. This would significantly reduce the risk of transmission of the virus in this vulnerable population.

The provision of home care packages has also been hit by the COVID-19 pandemic, with the number of home support hours 15% below the target for April 2020.[39]

Recommendation: Government policy on older person services should promote and fund more care in the home and the provision of safe nursing home care.

6. Provision for people with disabilities, special needs and Section 39 agencies

[36] See Figure 9, Appendix 1. Health in Ireland: Key Trends 2017 and 2018, Department of Health; CSO Statistical release, 27 August 2019.
[37] HSE Planning for Health – Trends and Priorities to inform health service planning 2017.
[38] WHO Special Envoy Dr David Nabarro at the Special Committee on COVID-10 Responses, 11 June 2020.
[39] Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 24 June 2020.

Approximately 36% of disability services reduced their service due to COVID-19, with 21% of services suspended altogether.[40] This has had a significant impact on the lives of all those people living with a disability and on their families. Disability services should be among the areas of priority for the resumption of services.

Physical distancing is often not a practical option in disability services. PPE must be provided to persons with disabilities, their carers and support workers, including personal assistants and deafblind interpreters.[41]

It is understood that more than 1,000 applications for funding have been made to the €35m COVID-19 Stability Fund for Community and Voluntary Organisations, Charities and Social Enterprises. The first tranche of €10.5m was recently allocated to 179 organisations.[42] The allocation of the remaining €24.5m to organisations in need of emergency funding should be delivered as a priority.

Recommendation: PPE must be targeted at HCWs providing care to people with disabilities or special needs, where physical distancing is not feasible. Stability funding for the sector must be provided quickly in order to ensure continuity of care.

7. Impact guidelines will have on provision of care

Compliance with the current two metre physical distancing guideline is likely to significantly impact the capacity to provide care to patients unless the health service puts in place extra space to accommodate services. The appropriate physical distancing rules need to be kept under review based on public health evidence.

Specialty guidelines will also have a significant impact of the delivery of care and must be accommodated into the HSE's own guidelines. For example, recently updated intercollegiate guidelines for general surgery from the RCSI and the surgical colleges in England and Scotland advises that team changes will be needed in theatre for prolonged procedures in full PPE.[43] The guidelines also note that procedural tasks are much slower and more difficult when wearing full PPE.

Recommendation: The HSE must fully provide the additional space required to accommodate existing services. The appropriate physical distancing rules need to be kept under review based on public health evidence.

8. Implementation of Sláintecare

The Irish Fiscal Advisory Council and the Government expect very significant budget challenges in the years ahead due the impact of the COVID-19 crisis on the economy. The Council told the Oireachtas COVID-19 Committee on 16 June 2020 that an additional €3 billion a year would be needed to fund Sláintecare. In a 10-year period the cost if implemented in full would be equivalent to €30bn.[44]

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[40] 'Service Continuity in a COVID Environment: A Strategic Framework for Delivery', HSE, 24 June 2020.
[41] Joint Statement by European Disability Forum, European Network on Independent Living, and European Deafblind Union, 3 April 2020.
[42] Department of Rural and Community Development Press Release, 26 June 2020.
[43] Updated intercollegiate general surgery guidance on COVID-19, RCSI, 27 March 2020.
[44] Submission to Oireachtas Special Committee on COVID-19 Response, Irish Fiscal Advisory Council, 16 June 2020

There is a risk that relatively speaking public hospitals will be even more under-resourced in a post-COVID-19 environment, which would further delay the provision of patient care. What is required are practical plans and workable solutions that address the overwhelming public hospital capacity deficits, including the expansion of beds and ancillary facilities and the need to fill a large number of vacant hospital consultant posts, that are the root cause of the delays in providing timely, quality patient care in the public hospital system.

Recommendation: The Government must prioritise funding for practical plans and workable solutions to expand acute hospital beds and ancillary facilities and fill the large number of vacant hospital consultant posts.

9. Need for additional testing as non-COVID-19 care increases

Specialists in infectious diseases believe that control of COVID-19 can be achieved through a mixture of a highly effective programme of rapid testing, contact tracing, isolation as needed, and community actions. What is missing they say is a detailed end-to-end testing and contact tracing plan, embedded with rapid turnaround times and clear key performance indicators (KPIs).[45]

The HSE has confirmed that the design of this new model has commenced and is due to be implemented in August.[46] There is now a need for a more sustainable testing service that will deliver short turnaround times, maintain long-term capacity and effective contact tracing and be flexible for any future surges. This requires an effective contact tracing App to assist in in providing rapid notifications to all close contacts who are App users within three hours.

The accuracy of antibody testing still needs to be determined. If antibody testing with the required sensitivity to detect IgG antibodies to COVID-19 becomes available, and if immunity can be proven, healthcare workers and other targeted population groups should be prioritised for antibody testing.

Surveillance testing of patients in advance of admission to hospital to ensure the segregation of COVID and non-COVID streams is essential. The HSE has indicated that patients must, in so far as possible, minimise their risk of contracting COVID-19 in the two weeks prior to their scheduled admission. In addition, patients must attend for a COVID-19 test within 48 hours of scheduled admission.[47]

Recommendation: An effective end-to-end testing and contact tracing plan, with rapid turnaround times and clear KPIs, is required to ensure any future COVID-19 outbreaks are isolated and controlled. Regular and rapid testing of all healthcare staff should be adopted as non-COVID care restarts, to prevent the spread of the virus in hospitals. If antibody testing proves accurate and immunity can be confirmed, its use among HCWs and other targeted population groups should be prioritised.

[45] Opening statement by Prof Paddy Mallon, Professor of Microbial Diseases, UCD, to the Special Committee on COVID-19 Responses, 25 June 2020.
[46] Opening statement by Dr Colm Henry, Chief Clinical Officer, HSE, to the Special Committee on COVID-19 Responses, 25 June 2020.
[47] 'Service Continuity in a COVID Environment: A Strategic Framework for Delivery, HSE, 24 June 2020.

10. Vaccination programmes

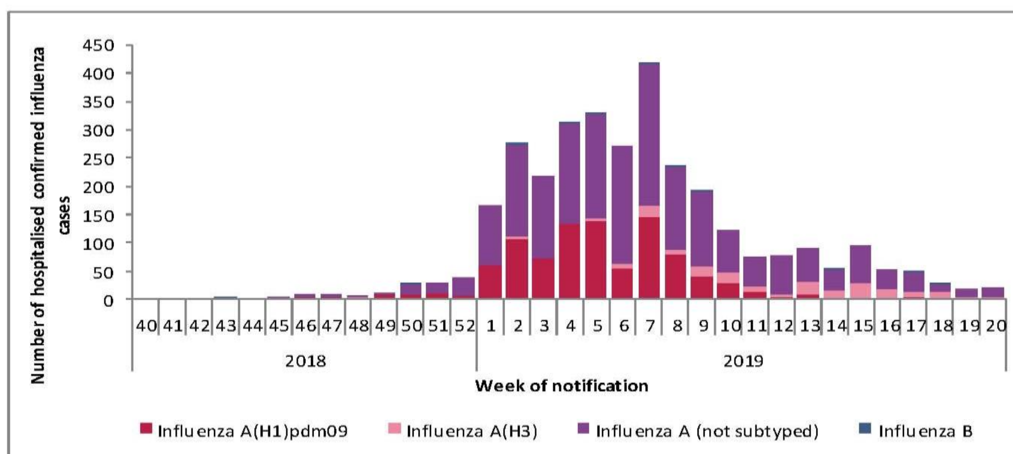
The current influenza season in Australia, which typically runs from April to October and peaks in August, has seen a dramatic drop in flu cases and deaths. This is being attributed to physical distancing associated with COVID-19 control measures and a higher uptake of the flu vaccine. The number of flu cases in 2020 has plummeted since the coronavirus emerged — from 20,032 cases of flu in the first three months of 2020 to just 504 in April and May.[48] Up to 14 June there had been only 36 confirmed influenza-associated deaths in Australia.[49] There are between 200-500 deaths each year in Ireland due to influenza and up to 1,000 could die during a particularly severe flu season.[50]

High uptake of the influenza vaccine in Australia is also a contributing factor. More than 7.3 million Australians are understood to have already received the vaccine, with the government making 18 million vaccinations available during the 2020 season.[51] That would be enough to vaccinate 70% of Australia's 25.6 million population.[52]

The vaccination uptake rate among Irish hospital workers is 53%, below the HSE target of 65%. However, uptake among medical and dental professionals is at 72%.[53] The HSE should intensify its multi-platform campaign outlining why the flu vaccine is strongly recommended for healthcare workers and the relevant sections of the population that are vulnerable to the flu.

The Irish Government recently decided to make the influenza vaccine available to all children aged from 2 to 12 years free of charge.[54] It is already available without charge to defined at-risk groups and to all persons aged over 70. The availability of the vaccine without charge to a larger portion of the population should be considered. The timing of the campaign should also be considered to ensure the best possible protection.

Figure 3: Number of Confirmed Influenza Cases Hospitalised, 2018/2019 season



***Cases where influenza type was not reported are excluded (n=4)**

Source: HPSC

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[48] 'Flu deaths prevented as cases plummet amid coronavirus lockdowns, AMA says', *ABC News*, 12 June 2020 https://www.abc.net.au/news/2020-06-13/flu-cases-drop-amid-coronavirus-restrictions-statistics-show/12332204.

[49] Australian Influenza Surveillance Report, Australian Department of Health, 1 to 14 June 2020, No 5, 2020.

[50] HPSC estimates.

[51] *ABC News*, 12 June 2020.

[52] The population of Australia is projected to be 25,620,392. Source: Australian Bureau of Statistics.

[53] Flu vaccine for healthcare workers, HSE, https://www.hse.ie/eng/health/immunisation/pubinfo/flu-vaccination/healthcare-workers/. Accessed 27 June 2020.

[54] Department of Health Press Statement, 18 May 2020.

Hospitalised cases of influenza peaked with more than 400 in hospital towards the end of February 2019 (week 7). ICU admissions totalled 159; 133 were adults and 26 were paediatric cases. Just 16% of those admitted to ICU were vaccinated.[55]

Fears of a second surge of COVID-19 cases has sparked a global scramble for supplies of the influenza vaccine from several countries already planning to vaccinate a wider cohort of their population.[56] The UK is reported to be considering extending flu vaccinations this winter to all those aged over 50, requiring 10 million additional doses.[57] However, vaccine manufacturers have warned that while production will increase, demand is likely to outpace supply.[58]

Recommendation: Consideration should be given to offering the flu vaccine without charge to a wider population group. A decision on this would have to be made quickly by Government to secure supplies as fears of a second wave of COVID-19 have sparked increased demand for the flu vaccine across the globe.

11. Organ transplantation

Performing organ transplantation during a pandemic is extremely challenging, with immunocompromised patients more likely to suffer severe complications from COVID-19. However, research suggest there may be a number of ways to continue a transplant programme.

During the 2003 SARS outbreak in Canada, physicians in Toronto devised a screening tool based on potential hospital SARS exposure, clinical symptoms, and epidemiological exposure to stratify donors as high, intermediate or low risk for SARS and defer more elective transplants.[59]

A more recent approach adopted in Singapore to cope with COVID-19 has involved both donor and recipient involved in a living donor transplant practising strict physical distancing and travel restriction.[60] This may include a 2-week 'stay home' period prior to the transplant, with a PCR test for both at the end of the period, prior to transplant.[61]

In NHS England, transplants are going ahead if it is safe and appropriate. Every potential organ donor is being tested for COVID-19 and if someone has the virus they will not be able to donate. New evidence is still emerging in this area, but currently there is no known transmission of COVID-19 through organ donation. However, as patients who need a transplant have to be immunosuppressed, any risks need to be minimised as much as possible.[62]

The international Transplantation Society suggests that in a country with widespread community transmission of COVID-19, temporary suspension of the deceased donor programme should be

[55] Annual Epidemiological Report, HSPC, 7 January 2020.
[56] 'Demand for flu vaccine soars as countries plan for second COVID-19 wave', *The Guardian*, 14 June 2020, https://www.theguardian.com/society/2020/jun/14/countries-scramble-for-flu-vaccines-to-ease-pressure-of-second-coronavirus-19-wave.
[57] 'Ministers consider flu vaccine for extra 10 million people', *HSJ*, 24 June 2020, https://www.hsj.co.uk/commissioning/ministers-consider-flu-vaccine-for-extra-10-million-people/7027893.article.
[58] 'GPs look set to face 'unprecedented' flu vaccine shortages', *Pulse*, 25 June 2020, http://www.pulsetoday.co.uk/news/gps-look-set-to-face-unprecedented-flu-vaccine-shortages/20041058.article.
[59] Kumar D, Tellier R, Draker R, Levy G, Humar A. Severe Acute Respiratory Syndrome (SARS) in a liver transplant recipient and guidelines for donor SARS screening. *Am J Transplant*. 2003;3(8):977-981. doi:10.1034/j.1600-6143.2003.00197.x.
[60] Ho QY, Chung SJ, Gan VHL, et al. High-immunological risk living donor renal transplant during the COVID-19 outbreak: Uncertainties and ethical dilemmas. *American Journal of Transplantation*: 2020 Apr. DOI: 10.1111/ajt.15949.
[61] Guidance on Coronavirus Disease 2019 (COVID-19) for Transplant Clinicians, The Transplantation Society, Updated 8 June 2020.
[62] NHS Blood and Transplant Coronavirus update, 24 June 2020.

considered. Consideration should also be given to the temporary suspension of the living-donor kidney and liver transplant programmes under the condition of widespread community transmission and when donation can safely be deferred to a later date.[63]

Recommendation: Ongoing monitoring is needed on the impact of COVID-19 on transplant programmes. International evidence on continuing organ transplantations safely during a pandemic should be examined.

Capacity in the healthcare system to deal with COVID-19 cases

12. Acute Hospital Capacity needed for COVID-19 surge

As outlined in the previous sections on providing non-COVID care, the capacity of our acute hospitals has been overstretched for at least a decade. Ireland has one of the lowest numbers of public hospital beds and hospital consultants in the EU, adjusted for population levels. The need to provide non-COVID care has to be provided for alongside the potential risk from a further COVID-19 wave or surge also needs to be provided for urgently.

Ireland has 2.77 acute hospital beds per 1,000 of population, almost a third (31%) below the EU average of 4.02.[64] These factors mean there is no capacity buffer in the system to absorb additional patients presenting for care during periods of peak demand such as a surge in COVID-19 cases.

What is urgently required is:

(i) Expand the Consultant staffing levels, which are one of the lowest in the EU, by ending the discrimination against new Consultants and filling the 500+ permanent consultant posts that are vacant.

(ii) Expand public bed capacity by providing:
  a) Additional permanent ICU and acute hospital beds
  b) Intermediate transition care beds and community step-down, nursing home and rehab beds.

(iii) Expand theatre and other facilities, including an additional three or four dedicated elective surgery facilities.

13. Scale of COVID-19 Infections

Up to 30th June there were 25,473 confirmed cases of COVID-19 in Ireland and 1,736 COVID-19 related deaths.[65] The peak of reported cases occurred around the middle of April, when 2,892 cases were reported in just three days (Figure 4). Transmission in the community has declined but could increase again as has been witnessed in other EU countries and elsewhere.

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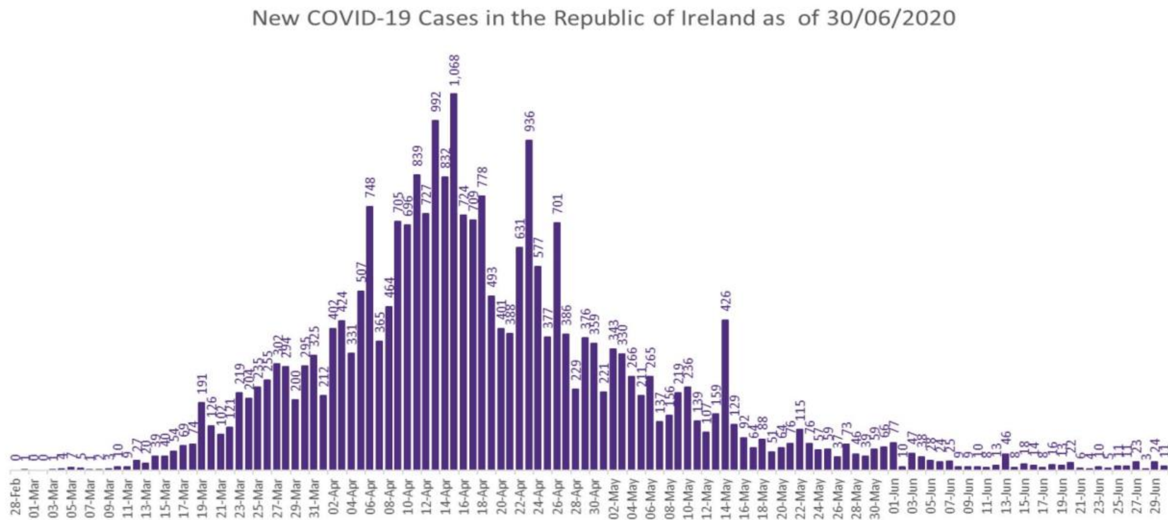
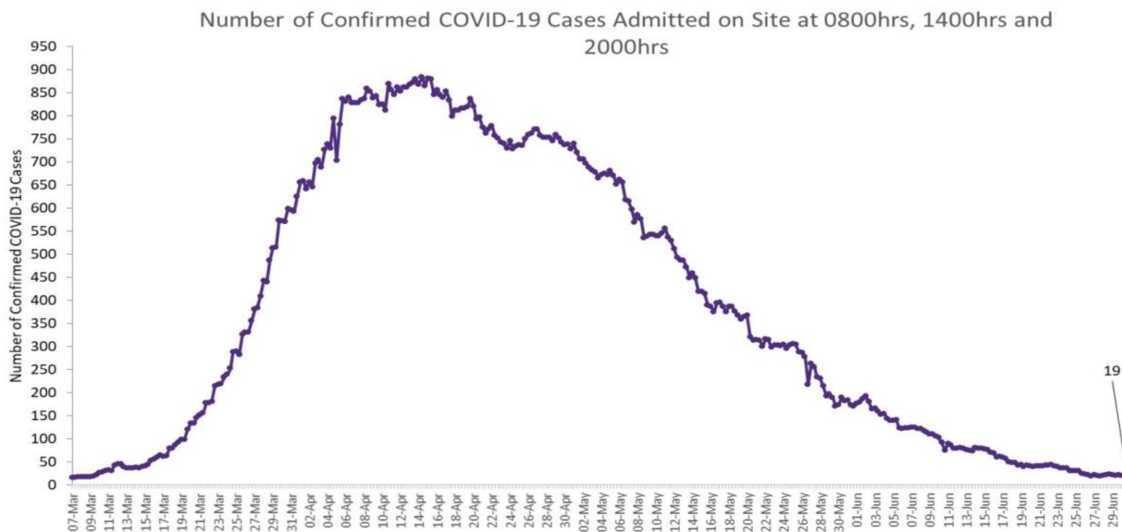
[63] The Transplantation Society, the leading international organisation on transplantation with headquarters in Montreal, Canada, 8 June 2020.
[64] OECD.Stat; Eurostat.
[65] Statement from the National Public Health Emergency Team, 30 June 2020.

Figure 4: New Confirmed COVID-19 Cases in the Republic of Ireland as of 30th June 2020



In Ireland, out of the 25,473 confirmed cases, 3,295 people were hospitalised with COVID-19, peaking on 15 April with 881 cases.[66] This declined to 19 patients at the end of June.

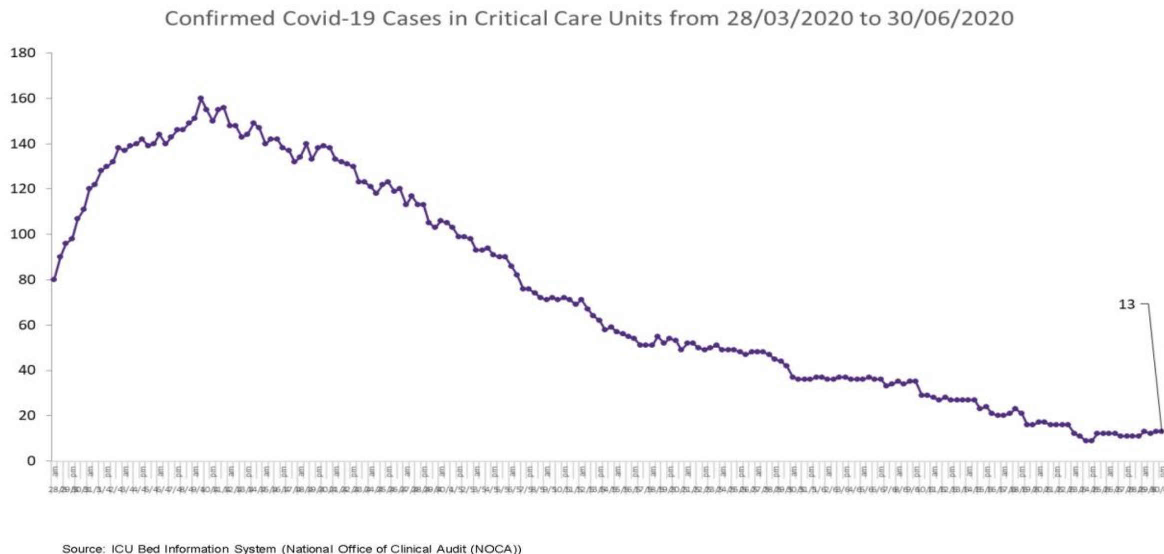
Figure 5: Number of Confirmed COVID-19 Cases Admitted in 29 Acute Sites (including CHI)



Patients with COVID-19 infections admitted to ICU peaked at 155 patients in critical care on both the 10th and 11th April.[67]

[66] COVID-19 Data Hub, https://COVID19ireland-geohive.hub.arcgis.com/.
[67] https://COVID19ireland-geohive.hub.arcgis.com/

Figure 6: Confirmed COVID-19 Cases in Critical Care Units



A relatively modest increase in the COVID-19 reproduction (Rt) rate above current levels would increase the need for critical care and acute hospital beds.

The existing public hospital capacity of 250 critical care beds and 11,000 inpatient beds needs to be expanded urgently. The public hospital response to the April COVID-19 surge was heavily dependent upon re-assigning 1,600 existing frontline staff and up-skilling them to support critical care teams in improvised ICU beds.[68] This will not be sustainable alongside a full resumption of non-COVID care.

As winter approaches, this year's flu season will add further challenges. A multi-pronged preparedness plan is required to limit the future infection through more effective flu vaccination schemes and other public health measures.

Recommendation: The public health service must therefore expand its capacity to provide non-COVID and COVID care.

14. Risks of Viral Infections in the months and year ahead

There is a risk that major challenges will impact the Irish healthcare sector in the Autumn/Winter 2021, due a combination of a range of viral infections. These include:

i) The emergence of seasonal Influenza A and B globally.

ii) The co-existence and continuance of COVD-19 pandemic in the population.

iii) The emergence of a novel Swine flu epidemic/pandemic.[69]

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[68] Liam Woods, Special Committee on COVID-19, 2 June 2020.
[69] https://www.sciencemag.org/news/2020/06/swine-flu-strain-human-pandemic-potential-increasingly-found-pigs-china.

These three viruses have individually and collectively the potential to cause significant morbidity and mortality in the Irish population.

The most recent of these viruses is influenza virus (dubbed G4).[70] The virus is a unique blend of three lineages: one similar to strains found in European and Asian birds, the H1N1 strain that caused the 2009 pandemic, and a North American H1N1 that has genes from avian, human, and pig influenza viruses. The G4 variant is especially concerning, because its core is an avian influenza virus - to which humans have no immunity - with fragments of mammalian strains mixed in.

The challenges are to ensure:

i. Adequate testing and tracing facilities are available for Influenza A and B, COVID-19 and Influenza G4.

ii. Proper molecular epidemiological tracing/tracking is available, including identification of the D614G substitution in the SARS-CoV-2 spike (S) protein of COVID-19. This mutant strain is associated with more invasive disease in the upper aero-digestive tract.[71]

iii. Targeted and potentially global population vaccination is available against Influenza A and/or B to the Irish population.

iv. Rapid access to novel COVID-19 vaccines (initially focussed at people with pre-existing co-morbid diseases, the elderly and front-line health workers).

v. Examination of the influence of a potential immunogenicity bridge between different vaccination events for seasonal influenza and a potential COVID-19 vaccine which may become available Q1, 2021.

Recommendation: There is a need to assess the risk of the potential impact on the Irish healthcare system of the combination of a range of viral infections including seasonal influenza A and B, the co-existence and continuance of COVD-19 pandemic in the population and the risk of the emergence of a novel Swine flu epidemic/pandemic.

15. How to add additional capacity to the system when needed

15.1. Temporary Acute Hospital Beds

The Government needs to provide funding to:

- Keep open the 220 beds funded under the 2019/2020 Winter Initiative, that have been effectively used as step-down facilities in the acute and community system.
- The further 324 beds opened under the COVID-19 plan or the equivalent also need to remain open on a permanent basis. Where these beds have been converted from day unit use, they will be required for non-COVID care.

[70] Prevalent Eurasian avian-like H1N1 swine influenza virus with 2009 pandemic viral genes facilitating human infection. Proceedings of the National Academy of Sciences (PNAS). First published June 29,2020: https://doi.org/10.1073/pnas.1921186117.

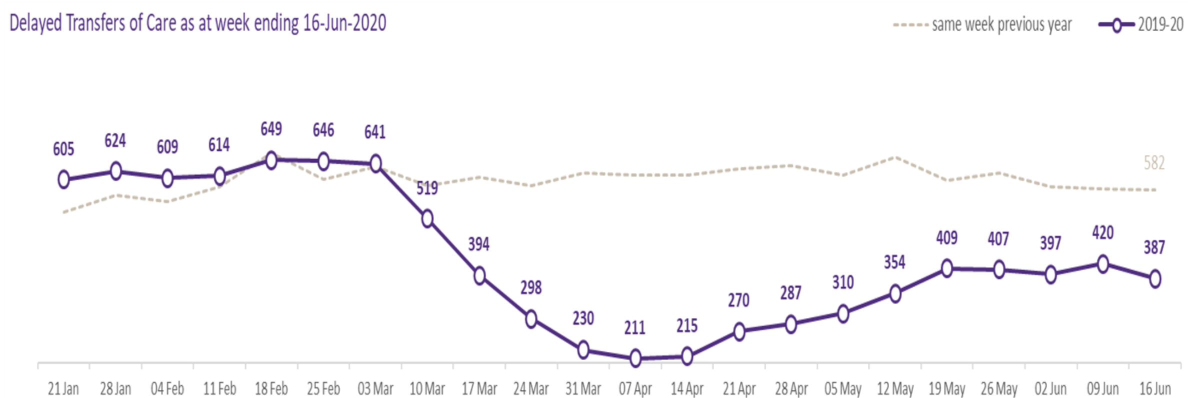
[71] https://www.cell.com/action/showPdf?pii=S0092-8674%2820%2930820-5.

15.2. Intermediate Care/Step-Down Beds

The equivalent of 1,351 potential intermediate care/step-down beds identified by the HSE to provide care during the crisis over the past few months should be opened.[72] The HSE proposal to scale down its plans in this regard to just 900 intermediate care/step-down beds needs to be reassessed. There is an opportunity to provide much needed additional capacity in the short to medium term to cater for non-COVID and COVID demand for care.

The number of clinically discharged patients in acute hospitals has started to increase, doubling from around 200 in March to approximately 400 in early June.[73] There were 724 Delayed Discharges in September 2019, according to the latest available performance report from the HSE,[74] and 641 in the first week in March.[75]

Figure 7: Delayed Discharges, January-June 2020



Source: HSE

An increased number of older patients are presenting to hospital, with levels having surpassed comparable levels in 2019. The total number of those aged over 75 who attended Emergency Departments in the week ending 21 June 2020 was 3,465 – a 5.2% increase on the same week in 2019.[76] ED admission for those 75+ years old were also up 5.8% on the previous week and 7.5% more than on the same week last year. This trend in attendances and admissions highlights the backlog of patients awaiting care. This increased demand will continue to lead to an increase in the number of delayed discharges from acute hospitals to community settings unless increased capacity is provided for step-down care.

Possible alternative uses of the Citywest convention centre beyond October as part of a winter plan for the Dublin area should be considered. In addition, the plans should be developed to ensure the fuller use of City West capacity over the next four months. The additional step-down capacity in the UL Arena is also vital given the Mid-West hospital capacity deficits. Every effort also needs to be made by the HSE to ensure the permanent additional capacity planed at University Hospital Limerick and Croom Orthopaedic Hospital, due to open by the end of the year, is not delayed. Similar increases in

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[72] COVID-19 ICF Capacity document, HSE.
[73] Liam Woods, HSE National Director, Acute Operations, at the Special Committee on COVID-19 Response, 2 Jun 2020; Figure of 387 delayed transfers of care was as at week ending 16 June 2020; HSE press briefing, 24 June 2020.
[74] HSE Performance Profile July – September 2019 Quarterly Report.
[75] HSE press briefing, 24 June 2020.
[76] Anne O'Connor, Chief Operations Officer, HSE, speaking at the HSE weekly briefing, 24 June 2020.

step down intermediate transition care beds should be assessed for other centres which traditional have capacity deficits and use of trolleys in previous years including Cork, Galway and other centres.

15.3. Private Hospital Arrangements

The Government's decision to end the agreement with Private Hospitals on 30th June will facilitate better utilisation of private hospital capacity and consultant outpatient clinic facilities to cater for the increased demand for urgent patient care which has been disrupted and prohibited over the past four months.

The contract with private hospitals represented poor value for money for patients and taxpayers. Despite costing an estimated €115 million per month, hospital utilisation continued to be low at around one third. It should be noted that the agreement with private hospitals did not result in any additional beds in the total health service. Overall, the contract resulted in increased waiting lists in private and heightened the risk of deterioration in patient clinical conditions and emergency admissions.

The HSE has confirmed it has commenced discussions with the Private Hospitals Association. The IHCA has sought discussions on behalf of private practice consultants.

Recommendation: The equivalent of 544 acute hospital beds that were opened in the past four months to cater for the COVID-19 crisis need to remain open on a permanent basis.

The Government needs to fund up to 2,000 additional intermediate transitional care and step-down beds without delay. These beds are required to urgently free up public hospital capacity to treat patients suffering from delayed care due to the pandemic and those on legacy waiting lists. Their capacity may also be required if there is another COVID-19 wave.

Any future arrangements with private hospitals and private practice consultants must ensure they can provide continuity of care to their patients in consultant outpatient clinics and in private hospitals and that they can operate at levels of occupancy in line with their usual effective operations.

16. Availability of acute hospital and ICU beds

16.1. Acute Hospital Bed Availability for COVID patients

In mid-April, during the peak of the COVID-19 crisis there were approximately 2,200 beds unoccupied in public hospitals, with non-urgent acute hospital care suspended.

It is important that this experience is reviewed to consider how similar arrangements may be used to manage a second wave if it occurs.

16.2. ICU Bed Capacity

Ireland has an average of 6 ICU beds per 100,000 population, about half the EU average of 11.5 per 100,000.[77] The HSE/DOH commissioned 2009 Prospectus Report recommended that the number of

[77] *Intensive Care Medicine* 38(10):1647-53 · July 2012, DOI: 10.1007/s00134-012-2627-8.

ICU beds should be increased from 289 to 579 beds. A 2019 HSE report found that there were then only 249 ICU beds – 40 fewer than 10 years ago.[78]

Our ICU beds normally operate at almost full capacity, which is not safe. Our ICU consultant staffing is less than half of the recommended 82 intensive care consultants needed to provide the standard of specialist care for critically ill patients across our hospitals.

In late June the HSE confirmed while there were 420 intensive care beds in the public hospital system, just 342 were open and staffed, of which 254 of these were occupied.[79] The number of available critical beds, which may differ from the above figures, was put at 80. Around the peak of the crisis, more than 500 critical care beds, some on an improvised basis, existed in our public hospitals.

We need to maintain all these ICU beds on a permanent basis to ensure capacity is available to provide urgent complex non-COVID-19 care and surge capacity for a potential second wave of COVID-19 admissions. It is clear public hospital system needs to expand ICU bed capacity on a permanent basis to the 579 recommended in the Prospectus Report a decade ago. The failure to implement the recommendation to double the number of public hospital ICU beds has over the years created significant problems in providing ICU care. This must be addressed on a sustainable basis before the winter.

In a recent survey, IHCA members highlighted an urgent need for new ICU infrastructure and increased capacity:

- In **Beaumont Hospital**, there are only six isolation rooms out of a total capacity of 30 critical care 'bed spaces'
- Non-ICU areas were used pre-COVID in **St James's Hospital** to resuscitate critically ill patients while waiting for an ICU bed. This is no longer acceptable practice and will require capacity expansion to address it.
- The ICU at **Sligo University Hospital** has just one isolation room.

The National Office of Clinical Audit has indicated that recommended occupancy rate for ICU across Europe should normally be 75%.[80] It noted that high levels of ICU bed occupancy are recognised as leading to delay in ICU admission, early discharge, cancellation of elective surgery, and increased incidence of hospital-acquired infection.[81]

Recommendation: It is essential that the number clinically discharged patients in hospitals are minimised so that more beds are available to treat non-COVID patients in the coming months and to care for COVID-19 cases if a second wave occurs.

The hundreds of improvised ICU beds opened in recent months must be fully equipped in appropriate settings and staffed on a permanent basis as recommended in 2009 so that the ICU capacity is doubled.

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[78] Multi-annual National Adult Critical Care Capacity Planning 2019, 2020 and subsequent years – Memorandum, HSE Critical Care Programme, 24 April 2019.
[79] COVID-19 Daily Operations Update Acute Hospitals, Performance Management and Improvement Unit, HSE, 30 June 2020.
[80] Irish National ICU Audit Annual Report 2018, National Office of Clinical Audit, 12 February 2020.
[81] ICU Audit, p6.

17. Community and residential care capacity for dealing with COVID-19 cases

17.1. Community Step-Down and Rehab Beds

The pace of implementing the 2018 Capacity Review and National Development Plan has been far too slow and needs to be accelerated by the new Government to open the recommended 4,500 community step-down and rehab beds in the shortest possible timeframe.

17.2. Nursing Homes

With 1,000 people every month normally transferring from acute hospitals into private and voluntary nursing homes,[82] the sector has a vital role in maintaining a flow of patients through the health system. Disruption in the ability to discharge patients into nursing homes increases the number of clinically discharged patients remaining in an acute hospital bed for longer than is necessary. The number of discharged patients in acute hospitals doubled from approximately 200 to 400 over an 8-week period between early April and June when many nursing homes were not accepting new residents.[83]

17.3. Hospital Avoidance

On the community side, there is also an opportunity for health service management to advance the development of Community Healthcare Networks (CHNs) – the geographically-based units delivering integrated primary healthcare services to an average population of 50,000. Effective CHN service provision could reduce demand for some hospital care.

Recommendation: The Government needs to provide significant investment to address the current bed capacity deficits in our step-down community and rehabilitation beds.

Appropriate ongoing testing of nursing home residents and staff must continue if coronavirus is to be kept out of these residential settings. Sufficient supplies of PPE also need to be available for frontline residential care staff to prevent future clusters of the virus emerging.

More effective care in Community Healthcare Networks could increase community care and reduce the number of clinically discharged patients in hospitals.

18. Impact on healthcare workers

18.1. Demands on Doctors

COVID-19 has resulted in extreme work demands on doctors especially throughout our acute hospitals and mental health services who have been struggling with capacity deficits. They have worked very long shifts during the height of the coronavirus crisis and have been redeployed to work in areas outside their speciality, such as in emergency departments, in order to both cope with the influx of COVID patients and to care for those hospitalised with non-COVID urgent conditions. It has been an extremely stressful period for the medical teams in our acute hospitals and mental health services.

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[82] Opening Statement by Tadhg Daly, CEO, Nursing Homes Ireland, for Oireachtas Special Committee on COVID-19 Response, 26 May 2020.
[83] HSE media briefing documentation, 24 June 2020.

Given the unprecedented challenges being faced by our frontline medical teams, it is extremely disappointing to learn that many NCHDs, often who worked additional nights and weekends during the pandemic, have been unable to secure placements in this year's July changeover. This has been a particular concern for those applying for Senior House Officer (SHO) posts.[84]

As the backlog of increased patients on waiting lists needs to be assessed and treated, more Consultants will be required in post. Therefore all impediments to the hiring of additional Consultants must be removed immediately.

18.2. COVID-19 cases among HCWs

The COVID-19 pandemic has had a significant impact on healthcare workers, with more than 8,200 positive cases among Irish HCWs up to 20 June 2020.[85] This represents approximately 32% of the total number of confirmed COVID-19 cases in the country (25,812).[86]

The current public health measures, together with adequate PPE, now appear to be protecting our medical workforce to a greater degree than in April. However, we cannot become complacent and must remain focused on ensuring the availability of appropriate PPE and implementing best practice infection and control measures to protect patients and all HCWs.

Recommendation: All qualified NCHDs should be given fixed-term contracts for one year to help alleviate the burden on existing overworked medical teams. The 500 plus permanent consultant posts which are vacant need to be filled to work through the significant backlog of treatment that has built up over the past four months.

19. Procurement and ongoing availability of PPE

There is a need to procure a stock of the required amount and quality of PPE well in advance to cover the next nine to twelve month period. The failure to secure adequate PPE for HCW teams increases the risk of avoidable deaths due to frontline staff falling sick and spread of the virus in healthcare settings. A depletion of capacity of medical staff to treat patients would also impact negatively on the provision of timely COVID and non-COVID care.

Recommendation: Procure and stock advanced supplies of Personal Protective Equipment (PPE) to ensure ready availability over the next twelve months. Given the global demand for PPE, the Government should facilitate increased indigenous production of PPE.

Additional Areas of Interest

20. Views on actions taken to date to deal with the COVID-19 emergency

The Association has been generally supportive of the public health measures taken by Government to control the spread of the coronavirus. However, there have been actions and inactions, that have been a cause for concern.

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[84] *Irish Examiner*, 22 June 2020.
[85] 'Report of the Profile of COVID-19 cases in healthcare workers in Ireland', HPSC, 22 June 2020.
[86] HPSC, 22 June 2020.

At the outset, the availability of PPE for front-line HCWs was a critical issue. Concerns around the availability, type and quality of PPE were widespread, with the HSE struggling to secure adequate supplies.

The agreement between the Sate and the private hospitals, which ended on 30th June, represented poor value for money for patients and taxpayers and disrupted continuity of patient care. Despite costing an estimated €115 million per month, hospital utilisation continued to be low at around one third. The private hospital contract prohibited the provision of urgent care required by patients with non-COVID illnesses. This led to the accumulation on waiting lists of patients who required urgent care.

21. Could anything have been done differently, and, if so, what?

COVID-19 has borne down hardest on our older people, with 63% of all deaths occurring in residential and care homes.

Tánaiste Leo Varadkar spoke in May when still Taoiseach of the need for nursing homes to have a "greater integration with the health service" and "clear clinical governance in order that there is no confusion about who is in charge of medical issues when they arise".[87] The COVID-19 Nursing Homes Expert Panel needs to ensure the necessary actions and procedures are put in place without delay to avoid a repetition of the problems in the future.

As indicated above, the agreement with the private hospitals should have been handled different so as to ensure the continuity of patient care and optimum use of facilities.

22. What actions are being taken to resume or reopen services?

The HSE has recently published it document 'Service Continuity in a COVID Environment: A Strategic Framework for Delivery', which aims to set out how best to reintroduce services suspended or reduced as a result of COVID-19. However, it provides no detail on exactly how and when this is to be achieved.

It outlines a number of practical actions in Section 13 of the document which it says are 'in progress' or due to be delivered later this year. The Association has not been consulted by the HSE or Department of Health officials on the Strategic Framework, which does not have the required details on many of these proposed actions.

23. What further actions may be necessary?

A major review of the additional capacity requirements for service provision is due to be submitted by the HSE to the Department of Health by the end of July, with a decision to be taken by the Department by the end of August. There is clearly an urgency about putting additional capacity in place. It is strongly recommended that they proceed immediately and not delayed until August as outlined in HSE briefing sessions.[88]

The new Government has yet to decide on whether to fund the request from the HSE for additional capacity. This is likely to include a request to keep open 220 beds temporarily funded under the Winter Initiative and a further 324 beds opened under the COVID-19 plan. This represents a minimal expansion in beds, given the challenges acute hospitals face. The HSE may look for up to a further 1,500 beds through a third and fourth tranche of beds earmarked in the Capital Plan. This would first

[87] Taoiseach Statements in the Dáil, 27 May 2020. https://www.oireachtas.ie/en/debates/debate/dail/2020-05-27/7/.
[88] HSE teleconference with unions, 24 June 2020.

include bringing forward those beds already beyond the planning and design phase and moving to the issuing of contracts. The fourth area of capacity would see funding allocated to bring the commissioning of beds ahead of schedule that have yet to reach planning and design stage.

A service prioritisation exercise has also yet to be completed by the HSE. This will determine the method of choosing what non-COVID services are restarted and when. This should be completed without delay in a transparent manner and with input from Hospital Consultants and the IHCA.

24. What measures may be necessary to prepare for a potential second wave of infection?

The WHO has produced a checklist of hospital governance, structures, plans and protocols to rapidly determine the current capacities of hospitals to respond to the COVID-19 pandemic and to identify gaps and major areas that require investment and action for the development of hospital readiness improvement plans.[89] The areas addressed by the checklist include:

- Leadership and incident management system
- Coordination and communication
- Surveillance and information management
- Risk communication and community engagement
- Administration, finance and business continuity
- Human resources
- Surge capacity
- Continuity of essential support services
- Patient management
- Occupational health, mental health and psychosocial support for HCWs
- Rapid identification and diagnosis
- Infection prevention and control.

The checklist takes into account a wide range of issues, however, it should be noted it does not address the situation in the Irish acute hospital service which has very significant capacity deficits in the number of Consultants in post and the number of hospital beds.

The University of Oxford's Blavatnik School of Government has developed a tool to track and compare policy responses of governments tackling coronavirus around the world.[90] The data, which can be used to inform a 'Lockdown rollback checklist', ranks Ireland 9th for its policy on controlling case transmission of the virus out of 27 EU countries; 16th for its capacity to test, trace and isolate new cases; and 18th for its plan to manage cases being imported and exported at airports.[91] Clearly improvements are required urgently in the latter two areas.

Recommendation: The HSE should adopt and adapt the WHO's 'Rapid Hospital Readiness Checklist for COVID-19' as a reference tool for assessing hospital readiness for a potential second wave. However, the Checklist does not address the clear need for urgent additional capacity. Testing, contract tracing and isolation procedures need to improve, specifically the management of imported cases.

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[89] Rapid hospital readiness checklist: Interim Guidance, WHO, 26 June 2020. The tool can be accessed at https://www.who.int/publications/i/item/WHO-2019-nCov-hospital-readiness-checklist-tool-2020.1.
[90] https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker.
[91] 'Ireland lagging behind in its response to COVID-19', Business Post, 28 June 2020.

25. What measures might be necessary to prepare for further pandemics in the future?

The top priorities for Government to ensure we are prepared for any further pandemic in the future include:

- Urgently increasing our public acute hospital bed capacity and other facilities;
- Significantly increasing the number of specialist consultants and other front-line medical staff;
- Increase stocks of PPE including the support of indigenous production; and
- Implement a more effective testing, contract tracing and isolation system.

3 July 2020.