Irish Nurses and Midwives Organisation
Working Together

Submission to the Special Committee on Covid-19 Response

Healthcare Capacity Non-COVID-19

1 July 2020

Introduction

The Irish Nurses and Midwives Organisation (INMO) wishes to thank the Oireachtas Special Committee on Covid-19 Response, for this opportunity to submit on the important matter of non-COVID healthcare capacity.

The main issues we will concentrate on are:

- Nurse and Midwifery Staffing
- Health service capacity
- Sláintecare
- Equitable healthcare

Background

As the number of infections has reduced, a return to non COVID care is now underway. The pandemic hit a health service with underlying capacity challenges and staffing shortages. These included overcrowded EDs, a shortage of acute hospital beds, high dependency on private for-profit delivery of care of the older person services, underdeveloped primary and community care and a shortage of nurses and midwives as well as other health care professionals. These issues have not gone away and must now be tackled in order to deliver a sustainable and equitable health service for the future.

However, the health system is now faced with a number of additional challenges including decreased capacity in the system, reduced staffing numbers, further increased waiting lists, funding issues and the requirement to prepare to deal with any new surges of the virus in the future. Addressing all of these issues will require real change within the health service and the development of new pathways and models of care.

Nurse and Midwifery Staffing

A shortage of nurses and midwives was a feature of the Irish health system before the COVID-19 crisis. The health service pre-COVID was experiencing increased activity and there were increased demands on the public health service. The reality over the last number of years has been a busier and more acute service with fewer staff to deliver it. The recruitment pause/freeze in place placed immense pressure on an already struggling workforce. The continued lack of clarity and the lack of a funded workforce plan to meet the needs of the health service and its patients continued to contribute to problems already evident due to the baseline shortage. This, combined with challenges associated with an ageing population, increasing incidences of co-morbidities and an ageing workforce, was undermining patient care and safety as well as creating intolerable working environments for nurses and midwives.

The Framework for Safe Nurse Staffing and Skill Mix must be rolled out across the health service. Phase 2 must be completed in the emergency departments, followed by phase 3 in the community and care of the older person settings. Simultaneously, the maternity strategy must be implemented in full and work must be progressed in developing staffing ratios for children’s health services.

Substantial evidence exists associating positive patient outcomes with a higher number of registered nurses (Aiken et al. 2014, Ball and Catton 2011). Research shows that an increase in nurse staffing is associated with increased patient safety and crucially that a lower staffing ratio is directly associated with higher mortality rates (Griffiths et al. 2018; Aiken et al. 2002). Research has also provided evidence that midwifery-led care can lead to benefits for mothers including less use of analgesia and fewer episiotomies or instrumental births and that lower staffing levels are associated with adverse outcomes in terms of safety and maternal experience (Sandall et al. 2013; Begley et al. 2011; Gerova et al. 2010).

To move forward in delivering non-COVID care in a sustainable way there must be an end to any further recruitment embargoes on nurses and midwives. A funded workforce plan is now essential, and we must commit to immediately growing the nursing and midwifery workforce by a minimum of 2,000 whole time equivalents (WTEs) each year for the next three years and this must include:

- Development of robust recruitment and retention strategies to make nursing and midwifery careers more attractive;
- a commitment to multi-annual funding to ensure the safe staffing framework is fully implemented. This has a direct staffing impact in reducing burnout and improving retention, while also reducing mortality, improving patient outcomes, reducing bed occupancy, and generating cost savings;
- a commitment to increasing nursing and midwifery undergraduate places**.** We currently have under 1,800 undergraduate places, but over 5,000 Leaving Cert students put nursing or midwifery as their first preference in the 2019 CAO. We have both a need and demand for these courses, which would guard against future shortages; and
- increase the allocation of places for health care workers who wish to train as nurses on each course.

Capacity

Another key challenge within the Irish health service pre-COVID has been the insufficient capacity to meet demand in the acute, community care and nursing home sectors. This inadequate capacity has placed extreme pressure on the emergency departments and acute hospital services throughout the country.

Ireland's experience of unmet need has been identified as a serious challenge to equity of access to health care in Ireland. There is a strong correlation between unmet need and the socio-economic status of certain cohorts in our society. Ireland has been identified as having the second highest share of persons reporting unmet health needs for health care at 40.6%, while the European average is 26.5%. Funding and waiting lists have been identified as the main reasons for unmet need. (Goldrick-Kelly 2018, pp.47).

Despite the significant level of spending, waiting lists in the past have added considerably to unmet need in the health service. However, the pandemic has meant that these wating lists have now reached unprecedented levels with 11,844 people added in May alone (IHCA, 2020). Reports published by the NTPF on 28th May identify that the total number of people on Inpatient/Day case waiting lists in Ireland was 86,946, of which 6,528 were waiting 18+ months.

According to the OECD, the occupancy rate for Irish acute beds is considerably above average at 95% (OECD, 2019). This must now be reduced to 80-84% of capacity as an imperative to ensure that overcrowding no longer exists and that safety can be maintained generally, and specifically in the context of the presence of the pathogen causing Covid-19. The HSE estimate this roughly equates to 108,000 cases per annum which exceeds all of the elective capacity within the acute hospital system. This is turn will further impact on waiting list issues which are deteriorating daily.

With strict social distancing and infection prevention and control measures the HSE also estimates a further reduction of 25% in acute inpatient beds. There is also an urgent requirement for transitional beds to allow timely discharge from the acute hospital sector.

To date the implementation of the Capacity Review (Department of Health, 2018) has been slow and this must change in order to meet the demands on the health service. The foregoing reflections should make clear that these recommendations will now need to be urgently exceeded, and real alternatives will now be required to increase bed capacity.

That these are immediate safety issues is reflected in the INMO's trolley figures, which are a standard measure of overcrowding and capacity across the acute hospital service, and which have identified a worrying trend in recent weeks. The initial onset of the pandemic saw a dramatic reduction in trolley numbers in the week beginning 9 March, with numbers on average 65% lower than the same week in 2019. As non-COVID hospital attendances decreased and remained minimal between 18 March and 16 April, trolley figures were on average 96% lower than the same period in 2019, with an average of approximately 14 people on trolleys across the country per day. However, this daily figure has been climbing significantly, with the monthly total more than doubling month on month since April (see table), and daily figures in June regularly exceeding 100 patients on trolleys across the country.

Month	2019	2020
Mar	9714	3152
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Table 1 INMO Trolley Watch Comparison

Sláintecare

The implementation of Sláintecare is now an urgent requirement and there must be a renewed commitment to this by the incoming Government. The COVID-19 response provided evidence that the public health system must be the delivery mode for all health services.

The implementation of Sláintecare has to date been very slow and no meaningful advances have been achieved. Funding has been a major concern and allocations to date have been insufficient to meet the key transitional requirements as set out in that report. To deliver this model of healthcare, progress must now be made in real terms including multi- annual funding.

In order to deliver care in a COVID environment, there is now an urgent requirement to develop our primary and community care services and deliver new pathways of care. A strong primary healthcare system is key to improving the health and wellbeing of people, particularly in the older population. As we face an increase in chronic diseases, co-morbidities and an ageing population, this development is now more important than ever.

There must also be an expansion of diagnostic services within the primary health care services and the development of nurse led care to deal with chronic disease management. In addition, care of the older person services outsourced to the private for-profit sector must be insourced and provided by the state. The role of nurses in this sector can and must be utilised to the fullest extent possible (e.g. include nurse prescribing, and administration of fluids etc)

Nurse staffing in this sector must be determined by a dependency model of assessment and not based on the current model of cost of care.

Post-acute care services have been identified as playing an important role at this stage of the pandemic. Treat-in-place protocols for non-COVID admissions must be developed. These are particularly important for vulnerable groups. Post-acute care COVID designations and transfer protocols for various designations must also be created (Tumlinson, et al., 2020).

Integrated care is a key requirement in building a sustainable health service in a COVID environment. Services need to be joined up across acute, primary and social care, so that the individual needs of patients are managed in a more integrated manner. The key objective must be to develop, deliver and maintain highly integrated care pathways for every user of the service. This requires a simplified organisational structure which clearly indicates responsibility for service delivery. This can only be done by devolving responsibility, for the provision of all care, to the frontline.

The privatisation of care of the older person services should be reversed. 82% of this service is now provided by private, for-profit organisations. The 2020 HSE Service Plan in December 2019 proposed to worsen this problem, by cutting 220 care of the older person public service beds. The public/private system must become a singular system, re-modelled in line with Sláintecare to deliver the standard of excellence available in the public health sector to all members of our community.

Equitable Healthcare

Equity of access to health care must be a central focus in delivering health services in both COVID and non-COVID care. Our health service is the only health service in Europe which does not offer universal health care.

During the crisis, many services including surgeries, diagnostics and screenings were suspended. The HSE is now seeking to reintroduce services on a phased basis. Decisions on what services are to be re-introduced must occur without disadvantaging any group in our society.

Unfortunately, many of the most vulnerable in our society were adversely affected by the COVID-19 crisis. Our older population in nursing homes were exposed to the vulnerabilities of the system in particular around governance, privatisation and understaffing. These must now be addressed in a meaningful way. New models of care delivery must be developed which include community clinical and financial supports to provide those who want care in their own home with a real option and alternative to residential care.

The reduction of disability services during the crisis has had a profound effect on people with a disability. Almost 60% of services in the community were either suspended or reduced (HSE 2020). Many of the services delivered are essential to daily living and as a result many people experienced loneliness, anxiety, loss of learning and development. A snapshot study across

Europe revealed a number of challenges in disability services during the pandemic including funding, a lack of PPE and lack of staffing (EASPD, 2020). Planning for health services must be inclusive of disability services.

Actions

1. There must be a renewed commitment to a single public health service.
2. The funding of our public health services must now be multi–annual and focused on investment in retention of nurses and midwives.
3. The provision of optimum care must be based on scientific models rather than accountancy models geared solely towards annual budgets.
4. An immediate acceleration of the provision of – additional acute hospital bed capacity, additional public capacity in intermediate and care of the older person settings, enhanced community and primary care capacity, and the delivery of truly integrated care through the prism of Sláintecare which utilises professional nursing capacity to its full extent to deliver care closest to the patient.
5. A funded annual plan for nursing and midwifery staffing.

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Introduction

The Irish Nurses and Midwives Organisation (INMO) wishes to thank the Oireachtas Special Committee on Covid-19 Response, for this opportunity to submit on the important matter of COVID-19 related health care capacity.

The main issues we will concentrate on are:

- Nurse and midwifery staffing.
- Bed capacity.
- Testing and tracing.
- New work practices and policies.

Background

Preparing for and responding to any future surges of COVID-19 must be achieved in a way that is equitable and accessible and protects patients and staff. Appropriate surveillance, testing, response planning and resource planning is essential across the entire health service to ensure COVID capacity in terms of staffing, beds and services can be maintained.

Our health care system has experienced significant strain. This pandemic has shown that the public health care system is the optimum delivery model, which can and does provide care to match and exceed the highest international standards. Many of the challenges encountered concerning capacity and staffing were legacy issues which now need to be addressed in order to prepare a COVID health capacity in the context of ongoing healthcare demands.

Nurse and Midwifery Staffing

Pre-COVID Nurse/Midwife Shortages

Staffing pressures and the resulting overcrowding and long waiting lists were a feature of our health service before this pandemic. The long-standing understaffing problems were exacerbated by the recent moratorium/pause on recruitment. According to the OECD (2020), one of the key lessons to be learned from the pandemic is that countries which experience a shortage of nurses and midwives before the outbreak of an epidemic struggle to cope as additional pressure on the healthcare system becomes unmanageable. It is essential in the current context that workforce planning include preparing for scenarios beyond the peak demand.

We need to rapidly plan to retain those nurses and midwives who are working in our health services and who have met the pandemic head on and saved many lives in doing so. Over the course of the life of this government, this must extend to delivering pay equality for nurses and midwives to others in the health service with comparable qualifications, such as allied health professionals to ensure not only equity but also incentives to retain vital professionals.

Health Care Infection Rates and Occupational Health

From the HPSC report dated the 22nd June 2020, the total number of infections was 25,812. Of these infections, 8,219 (32%) were HCWs and 2,690 (32%) were nurses (HPSC, 2020). This has meant absence from work due to self-isolation as well as some longer term effects of the virus such as chronic fatigue and respiratory and cardiac complications. It is expected that this will continue for a significant portion of the workforce.

The inability to replace nurses and midwives absent on leave has never been satisfactory and now we are facing an even bigger problem. This is a matter that cannot wait for HSE and Department of Health annual pay and numbers strategies but is a real and growing crisis and must be examined immediately by the incoming government.

Overseas Recruitment

The health service has had a long-standing dependence on overseas recruitment, which is currently at a standstill due to travel restrictions and is likely to remain difficult in the next 6-8 month period as restrictions on travel remain a feature of dealing with the pandemic. In 2019, 49% (1,819) of nurses who joined the register in Ireland were trained outside of the EU. We will not now be able to recruit these nurses and midwives and this is a major concern. When restrictions ease the highly competitive global recruitment market for nurses and midwives will have intensified as all countries now struggle to come to terms with the increased nurse staffing requirements. This will result in outward migration pressures, as before, where Irish trained nurses and midwives seek employment in comparably higher salary jurisdictions.

A funded workforce plan is now essential for nursing and midwifery in order to ensure that present bed capacity can be retained and additional capacity opened in the coming months. Public health guidelines will result in the imminent reduction of bed capacity in acute and non-acute settings which will have serious implications for the health service with regard to service provision and maintaining COVID and non-COVID services. Additional capital works have been completed over the last 3 months, which will make available additional bed capacity. However, the revenue funding must be provided to staff these beds to ensure staff are recruited immediately. The staffing requirements for all beds should comply with the principles of the Framework for Safe Nurse Staffing and Skill Mix. The Government must act immediately or face the prospect of overcrowded and unsafe hospitals which will create unprecedented risk for patients and staff alike.

Staff Well Being

Although research is still emerging there is evidence to suggest that the mental and physical health of nurses, midwives and other HCWs has been adversely affected during the pandemic. The International Council of Nurses (ICN) has identified the need for increased mental health supports for nurses globally as they work during the pandemic (ICN, 2020). The demands placed on HCWs, including nurses and midwives, are described by one author as “extraordinary and long lasting” (Gavin et al., 2020). Some of the concerns of nurses and midwives include risk of exposure, risk to family members, as well as increased workloads and inadequate staffing levels (McMullan, et al., 2016).

It has recently emerged that another worrying development of the global pandemic has been a social stigma associated with nurses and midwives working with COVID-19 patients. Globally, social stigma has been experienced in a number of different ways. In the UK, nurses have been experiencing physical attacks and online trolling (Hackett, 2020). In Japan, reports have emerged of HCWs being refused childcare or having their children removed from childcare facilities. Nurses and midwives are under extreme pressure and the added dimension of social stigma can only have a further detrimental effect on their mental health. The ICN has called on all governments to take action on this issue.

Specific Measures for Protection of Healthcare Workers in Ireland

There must be a central legislative role for the Health and Safety Authority (HSA), in areas of inspections and reporting of infections among health care workers which they have acquired at work.

Role of Occupational Health

A national occupational health policy which strengthens worker protection, infection control advice and protocols, provides necessary supports, must be agreed. These policies must have equal weight and application across all of the health service HSE, section 39, private and voluntary sectors. Occupational Health and Human Resource departments must work together to ensure maximum protections are provided to health care workers with particular emphasis on the following:

- Regular schedule of risk assessment for healthcare workers.
- Protective protocols for self-isolation of healthcare workers combined with human resource staff replacement policies.
- Widespread availability of appropriate, accessible personal hygiene facilities for nursing/midwifery staff in all workplaces.
- Provision of scrubs in all work environments to be laundered by the employer.
- Strict implementation of the return to work protocol and appointment of worker representatives in accordance with this protocol in all areas of healthcare.
- Health Surveillance protocols for healthcare workers.
- Strict adherence to the Return to Work Protocol requirement for Lead Worker Representative.
- Amendment of health and safety regulations to ensure COVID-19 classified as an occupational injury/personal injury when acquired at work.
- Adequate and frequently reviewed PPE protocols based on the best available evidence, and the application of the precautionary principle.
- Protocols for the routine monitoring and recording of infectious illnesses, including recovery or death of healthcare workers.
- All infections occurring at work must be reported to the HSA and any resulting deaths must also be notified.
- Protocols to monitor stress, burnout or mental health issues arising in healthcare workers.
- Practical onsite psychological supports for health care workers.
- Policy to combat social discrimination of healthcare workers providing care to COVID-19 patients.
- Adequate rest periods for healthcare workers.
- Provision of adequate childcare for healthcare workers.

Bed Capacity

There is an urgent requirement to ensure adequate levels of beds are accessible if any new surge of COVID-19 develops. This is key to reducing the spread of the virus. However, the aim must also be to ensure an 80% occupancy level within the public hospital system, to prevent overcrowding, and that the recommendations of the capacity review are implemented.

In recent weeks there have been reports of reduced capacity in many of our hospitals as non-COVID care resumes. On 28 May 2020, there were 113 critical care beds and 866 general

beds available throughout the country. As of 28 June, there were only 87 critical care beds and 563 general beds available (HSE, 2020). These figures are reducing daily. The HSE states that critical care beds will be available for any new surges of the virus, however, there needs to be a clear plan around how this will now be achieved.

According to the HSE, the winter surge can increase demand on the health service by up to 20% in area of unscheduled care. At current occupancy levels, if a second wave of the virus hits, the HSE states that it will not be able to cope with this increase without changes to how the current system is operating including the expansion of influenza vaccination, timely discharge for older people, hospital avoidance, and the expansion of diagnostics in the community.

Emergency Departments and hospital wards must not become reservoirs of healthcare-acquired infection for patients and must therefore not be allowed to return to pre-COVID overcrowded levels. The INMO's trolley figures, which are a standard measure of overcrowding and capacity across the acute hospital service reflect a worrying trend in recent weeks. The initial onset of the pandemic saw a dramatic reduction in trolley numbers in the week beginning 9 March, with numbers on average 65% lower than the same week in 2019. As non-COVID hospital attendances decreased and remained minimal between 18 March and 16 April, trolley figures were on average 96% lower than the same period in 2019, with an average of approximately 14 people on trolleys across the country per day. However, this daily figure has been climbing significantly, with the monthly total more than doubling month on month since April (see table 1), and daily figures in June regularly exceeding 100 patients on trolleys across the country.

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Table 1 INMO Trolley Watch Comparison

Key planning around IPC must be continued to ensure appropriate management of any new cases of COVID-19 that emerge. The establishment of cohorted areas, including areas within emergency departments, wards and ICUs, dedicated to the treatment of COVID-19 patients will be vital while maintaining clinical care of non COVID patients (Carenzo, et al., 2020).

There are 11,907 beds in the acute hospital system, excluding critical care beds (Department of Health, 2020). It is vital that any new beds opened during the pandemic remain open and the priority must be on ensuring access to beds can be facilitated as quickly as possible. Access to private hospital beds must also be prioritised to meet this demand if required.

Testing and Tracing

Developing a long-term solution for testing in Ireland is now required and must be a priority for government. Ireland is now entering a recovery phase therefore the testing strategy should now be reviewed to ensure testing capacity is maximised in an appropriate manner until such a time as a treatment/vaccine becomes available. Increased surveillance with key early warning indicators identified and leveraging of digital tools to inform surge planning and care is essential.

As the number of daily contacts increases, this increases the possibility of new surges in the virus. Extra vigilance too will be required as we enter the winter season. Testing and tracing should be completed in a targeted way with a focus on timely results. This will be a key factor in maintaining a timely flow of (COVID positive) patients from the ED area to the appropriate cohorted ward in the acute hospital setting. Clear protocols will be required to ascertain the most effective mechanism to ensure such timely testing and results in this regard.

The strategy for Ireland must be informed by key evidence as it becomes available. Research is still required into characteristics of the pathogen and the population such as immunity, vaccine development and the extent of asymptomatic transmission. Antibody testing has the potential to allow increased insight into the spread of the virus in the community. The INMO welcomes the recent launch of the HSE's antibody testing project. However, it has not been established if the presence of antibodies actually confers immunity, or if so for how long, in the context of subsequent exposure to the virus. Therefore, the results of antibody testing must be used cautiously and must not undermine the overall public health response to the pandemic.

There should be a multipronged approach to testing and tracing, and this must be facilitated through appropriate capacity within the health service in terms of resources to provide a responsive and effective testing and tracing infrastructure to address any future outbreaks of the virus in a timely fashion. Testing and tracing must also be prioritised in a way that provides clear protection for healthcare workers as an essential resource to combat any resurgence, and in addition other high-risk and vulnerable groups as those most at risk. Strong consideration of healthcare worker antibody testing must be a priority.

New Work Practices and Policies

There have seen several new work practices and polices developed which are working well during the pandemic.

The development of telehealth clinics for outpatient appointments and community care have been implemented and engagement is currently taking place with the Health Sector Trade Unions on the expansion of these practices. In May, 85,000 outpatient appointments were completed using telehealth. This has the potential to alleviate pressure on the acute hospital system as well as reduce hospital acquired infection. Clear guidance on telehealth is required to ensure that it is equitably deployed and available for patients.

A review of changes to work practices, as well as health care policies, must be completed in order to identify the practices that should be further established and continued in a COVID and non COVID healthcare environment, for example, clinical leadership teams, care delivery based on clinical need on presentation, removal of the recruitment embargo, care triage and stepdown care in the community in the post-acute phase.

Actions

1. There must be a central role for worker protection for Health and Safety Authority (HSA).
2. There must be a commitment to a funded workforce plan for nursing and midwifery employment, to allow for the opening of the required additional bed capacity. The

additional staffing requirements should be based on the principles contained within the Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings. Bespoke recruitment campaigns should commence immediately to recruit specialist nurses into the relevant specialty.

3. Early engagement with the INMO on winter planning for the public health service.
4. Strict adherence to 85% occupancy of acute hospitals and zero tolerance of hospital overcrowding.
5. Supports for healthcare workers in area of childcare and mental and physical side effects of COVID 19 as a feature of working life.

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