Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Feidhmeannacht na Seirbhíse Sláinte
Rannán Gnóthaí Parlaiminte
Oifig an Ard-Stiúrthóra
Bloc D, 2 urlár
Ionad Gnó Gheata na Páirce
Sráid Gheata na Páirce
Baile Átha Cliath 8
Teil. (01) 635 2505
Facs (01) 635 2508
Rphost: pad@hse.ie

Health Service Executive
Parliamentary Affairs Division
Office of the Director General
Block D, 2nd floor
Parkgate Business Centre
Parkgate Street
Dublin 8
Tel: (01) 635 2505
Fax: (01) 635 2508
Email: pad@hse.ie

1st July 2020

Ms. Aileen Fallon,
Clerk to the Committee,
Special Committee on COVID-19 Response,
Leinster House,
Dublin 2.

Re: Submission on non-Covid19 healthcare & healthcare capacity (SCC19R-I-0306)

Dear Ms. Fallon,

I refer to your invitation from the Special Committee to make a written submission on the topic of non-Covid19 healthcare and healthcare capacity.

Please find attached from the HSE submission papers on both matters for the attention of the Committee members.

If any further information is required please do not hesitate to contact me.

Yours sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary Affairs Division

Encl.

HSE Submission – Capacity in the Healthcare System to deal with COVID-19 Cases

HSE
July 2020

HSE Submission – Capacity in the Healthcare System to deal with COVID-19 Cases

1. Introduction:

The Special Committee on COVID-19 Response has sought information in relation to the capacity of the Irish Healthcare system in the context of COVID-19.

This submission provides the following information:

- A high-level overview of pre-COVID capacity in hospital and community settings.
- The additional short-term bed capacity measures that have been taken in preparation for and in response to the COVID-19 crisis.
- Proposals for expansion of existing capacity.

2. Overview of Pre-COVID-19 Capacity

The Department of Health "*Health Services Capacity Review 2018*" provided an outline of the capacity of the health services and forecasted future capacity requirements in acute, primary care and residential/homecare services to meet population needs to 2031. Capacity was modelled to address unmet need and for a bed occupancy level, where appropriate, of 85%. When the impact of health service reforms as set out in Slaintecare was modelled, the number of additional acute hospital beds needed was forecast at 2,590 inpatient, adult critical care and day case beds. The Capacity Review also indicated a requirement for a 48% increase in the primary care workforce, 43% increase in residential care beds and a 120% increase in homecare provision over the period 2017 to 2031. Another key priority identified for the community was the enhancement of social care provision to provide timely step down and home care support to allow patients to be discharged from hospital as soon as clinically appropriate with the right supports (See Appendix 1 for details).

The original baseline figure for Acute beds in the Capacity Review was 12,728. Since then a further 510 acute beds (363 in-patient and 147 day case) have been added to the base to give an available acute bed count pre-COVID-19 of 13,238 (as of December 2019). Acute bed capacity remains significantly below that required to ensure appropriate levels of bed occupancy.

In relation to Community beds, the baseline position pre-COVID-19 was in the region of 7,000 public community beds available across the country.

3. Additional Capacity introduced in the context of COVID-19

As part of the response to the COVID-19 pandemic, 324 additional acute beds and 42 additional critical care beds were commissioned in order to increase available capacity in the short-term. Additional capacity was also contracted from the private hospital sector to deal with anticipated demand, particularly in relation to critical care, and to help maintain key elements of urgent scheduled care services during the crisis period.

In terms of community services, an additional 374 community beds and approximately 4,300 transitional care beds were introduced as part of the response to COVID-19. Community Hubs were also established across

the country for clinical assessment purposes and Community Isolation facilities contracted from private provides e.g. City West.

4. Further Priorities for Capacity Expansion

We are currently finalising a range of proposals to further expand community services and acute hospital capacity, both in preparation for the forthcoming winter and beyond. These proposals take account of the need to reduce hospital footfall by expanding significantly capacity in primary and community settings, while in parallel increasing acute capacity. Details are set out in the paragraphs below.

I. Building our Community Services Capacity

Plans and specific proposals for the expansion of community services are being accelerated in line with Slaintecare, the Capacity Review and learning from our experience of COVID -19, providing to a much greater extent health care services in the home or close to home rather than in hospitals. Specific priorities for community capacity enhancement include:

- The development of a national network of community specialist teams for older people and for chronic disease, co-located where possible, linked to General Practice and aligned to the rollout of Community Health Networks.
- The expansion of telehealth and other digital solutions.
- Providing direct access to diagnostics for General Practice.
- A substantial increase in home support hours in order to fully support patients at home with high to moderate levels of frailty.
- Expansion of intermediate care and short-stay bed capacity.

II. Building our Acute Services Capacity

In relation to further expanding acute services capacity, specific priorities include the following:

- The permanent resourcing of the acute and critical care beds which were temporarily commissioned as part of the COVID-19 response.
- The commissioning of further acute beds and critical care beds in key settings.
- Further capacity enhancements also being considered include:
  - The appointment of Specialist Frailty Intervention Teams in hospitals linked to the Community Network Strategy - dedicated to identifying frail patients presenting to EDs and providing early comprehensive multidisciplinary assessment (Frailty at the Front Door).
  - The appointment of Specialist Teams for Ambulatory Care Sensitive Conditions e.g. Diabetes, COPD and Chronic Heart Failure at Hub Acute Hospitals to support the governance and delivery of integrated ambulatory care.
- The development of dedicated Ambulatory Elective Facilities, focussing initially on Dublin, Cork and Galway.
- The development of a range of initiatives to deliver elective care services closer to home, such as:

- Physiotherapy led Musculoskeletal (MSK) clinics for patients to be seen directly by MSK physiotherapists, with a long term aim of integrating these MSK physiotherapists in the community.

- Audiology Service pathways involving direct referral to an integrated community-based Audiology service, thereby avoiding patient attendance at an acute hospital setting.

- Reconfigured haematuria services to avoid the need for multiple hospital attendances for this patient cohort.

5. Conclusion

COVID-19 has meant that health services will need to be delivered in new ways and in an environment that provides for new standards of infection control, including the physical spacing of beds and for unprecedented levels of essential PPE for the months and years ahead. The current preparations for winter planning are examining the short term options to accommodate anticipated demand while the planning for longer term capacity expansion is underway.

Finally, in relation to PPE, a multi-agency approach is being adopted to develop a more resilient and sustainable model to ensure a secure supply of PPE in the future, less reliant on international supply chains, involving indigenous suppliers, working within EU procurement rules. We are also developing more secure arrangements for ensuring continued access to other essential supplies such as medical devices, test kits, reagents, ICU gases and medicines.

Appendix 1 – Capacity Review - Demand Forecasts

Sector	POD	Current Capacity 2016	Forecast of Capacity in 2031	
			without reforms and showing % change from 2016	with reforms and showing % change from 2016
Primary Care	GP WTEs	3,570	4,970 (+39%)	4,600 (+29%)
	Practice Nurse WTEs	1,400	1,900 (+40%)	2,600 (+89%)
	Public Health Nurse WTEs	1,500	2,200 (+46%)	2,600 (+67%)
	PHYSIO WTEs	540	740 (+38%)	840 (+58%)
	S&LT WTE	470	440 (-6%)	420 (-11%)
	OT WTE	500	660 (+32%)	760 (+50%)
Social Care (Older Persons)	Residential Care – long term Beds	26,200	36,300 (+39%)	36,700 (+39%)
	Residential Care – short term Beds	3,800	5,600 (+46%)	6,300 (+62%)
	Home Care Packages	15,600	26,600 (+70%)	34,600 (+122%)
	Intensive homecare	200	330 (+70%)	660 (+230%)
	Home help hours (millions)	10.6	17.8 (+69%)	23.1 (+118%)
Acute Care (Public Hospitals)	AMU Beds	430	590 (+37%)	430 (+0%)
	Day Case Beds	2,140	3,140 (+47%)	2,440 (+14%)
	In-Patient Beds (95%)	10,500	14,600 (+39%)	*
	In-Patient Beds (85%)	10,500	16,300 (+56%)	12,600 (+20%)
	Adult Critical Care Beds (100%)	240**	340 (+43%)	*
	Adult Critical Care Beds (80%)	240**	430 (+79%)	430 (+79%)
	Bed Totals	13,310	18,670 (95% occupancy) 20,460 (planned occupancy)	15,900

** These scenarios were only run on Planned Utilisation (lower occupancy rate) basis.*
*** Rounded from 237 (actual 2016 figure). Source: Critical Care Programme*

Service Continuity in a COVID Environment

HSE Submission to the Special Committee on COVID-19 Response

July 2020

Contents

1 Executive Summary

1.1 Purpose

The COVID-19 pandemic has led to unprecedented interruption to normal healthcare activity, with both community and acute settings affected. The anticipated high-volume surge in COVID patients was flattened by close adherence to Public Health advice and levels of capacity within the health system are becoming available for services.

The purpose of this submission on service continuity is to describe the reintroduction of services that were suspended or reduced as a result of COVID-19. In doing so, this document outlines:

- Restarting non-COVID care
- Impact of COVID-19 on services and waiting lists
- Catch-up programmes for missed care and services
- Community Services
- Impact of COVID-19 on care provision
- Additional capacity in the health service
- Implementation of Sláintecare
- Testing strategy in a COVID environment
- Immunisation programmes in a COVID environment
- Organ Donation and transplant in a COVID environment

The HSE has developed a Strategic Framework to provide leadership to provide leadership and direction to a phased reinduction of services. The progress and implementation of the framework is dependent on:

1. The transmission of the virus in the community remains low
2. Public health measures continue to be reduced

1.2 Key Points

- If there is a second wave of COVID-19 during this period, the system will not have the capacity to meet unscheduled care demand unless specific actions are taken
- Community service activity has decreased as part of general COVID mitigation measures but also, in part, due to the redeployment of staff to support COVID services
- Across acute hospital settings, that were receiving hospitals, scheduled services were postponed or severely curtailed to provide capacity for COVID inpatients, for staff to be redeployed for training in the use of Personal Protective Equipment (PPE), COVID ward care and to support Critical Care surge delivery
- Some higher-priority services, such as the four screening programmes, will have a developing backlog of cases as a result of services having been reduced or suspended due to the pandemic. This backlog will now have to be cleared in a COVID environment, which represents an additional challenge as physical distancing measures and IPC requirements will have material impact on overall capacity and operational activity levels
- There is an urgent need to reconceptualise how we deliver care, to both address the present health needs of our population in a COVID environment and protect the future viability of health services by progressing the implementation of the Sláintecare vision

- Under the testing strategy for the reintroduction of services, appropriate testing will be key to maintaining staff health and wellbeing and sustaining service continuity. The primary components of an effective response, for which there is an evidence base, include appropriate IPC and prompt identification and exclusion of symptomatic HCWs from the workplace

2 Restarting Non-COVID Care

The COVID-19 pandemic has led to unprecedented interruption to normal healthcare activity, with both community and acute settings affected.

As a result of public compliance with mitigation measures, the acute healthcare service was able to match demand and maintain essential and time-dependent services. With surge control and the NPHET direction that service delivery can return based on clinical and organisational decision making, community and acute services can resume in a manner that:

- Maintains health service capacity at 80% in the acute system to allow us to rapidly respond to any potential COVID surge, ensure patient flow and avoid trolley waits
- Continues to rigorously comply with public health measures and Infection Prevention and Control requirements to protect staff and patients
- Reintroduces services in a phased, clinically aligned and integrated way across community and acute settings
- Continues to adapt new ways of working to allow us to maximise the activity that can safely be provided in a COVID environment, including digital technology adaptation
- Increasingly shifts care closer to home by delivering care in the community
- Increases services that support hospital avoidance and timely hospital discharge in order to maintain sufficient capacity for Winter 2020/21
- Applies evolving international experience and collective knowledge to ensure the safety of the public, our healthcare workers and the wider healthcare system as we deliver services in a new and pervasive COVID environment

2.1 What actions are being taken to resume or reopen services?

The HSE have developed and published a strategic framework for the delivery of services in a COVID environment. The purpose of this framework is to guide the reintroduction of services that were suspended or reduced as a result of COVID-19 and it outlines:

- The impact of COVID-19 on services across community and acute settings and the challenges and risks to service continuity in a COVID environment
- A common set of principles and guidelines, closely aligned to the national Public Health strategy and guidance, which will be used to guide the reintroduction of all services
- The need for continued adaptation to ways of working in service delivery, such as enhanced service integration across acute and community settings, and the increased use of digital technology
- The single national governance structure that has been established to promote a standardised approach to the reintroduction of services, reporting to the CEO and HSE Board

Given the challenges surrounding delivering services in a COVID environment and the associated capacity constraints, services are to be reintroduced in a phased manner. The framework provides an overview of this phased approach to reintroducing services, which is based on an analysis of demand, priorities, risks and benefits across services. The phases are set out in a Service Continuity Roadmap and are assumption and dependency based timelines.

2.2 Actions taken to date to deal with the COVID-19 emergency

The COVID-19 pandemic has led to unprecedented interruption to normal healthcare activity, with all services affected, across both the acute and community setting. During March 2020, increasing public health measures were implemented in a phased approach. On 27 March 2020, a decision was taken by the National Public Health Emergency Team (NPHET) to postpone all "*non-essential surgery, health procedures and other non-essential health services*".

The health service response to the emergency posed by COVID-19, was guided by advice from Public Health, and was unprecedented in terms of its scale, impact and response times. The need to secure acute capacity, particularly ICU capacity was addressed by obtaining private hospital capacity for a number of months, purchasing additional ventilators and upskilling and redeploying staff to convert existing clinical areas to ICU beds. A significant number of new staff were also recruited as part of a national campaign.

The requirement for additional hospital step down capacity and isolation facilities was addressed by the rapid conversion of existing infrastructures into field hospitals. Community Assessment Hubs were created as a hospital avoidance measure to allow patients with COVID-19 to be assessed in the community and General Practitioners played a crucial role in the referrals for testing and management of COVID-19 patients in the community. Across health and social services all staff received Infection Prevention Control training including the use of PPE, to protect and prevent against the spread of COVID-19. The forecast requirement for PPE was modelled (at a level over 10 times pre-COVID PPE levels), a supply chain established, and sourced in an extremely competitive global market.

Area Crisis Management teams established a number of Residential care and home support COVID-19 Response Teams (CRT) to address community outbreaks. A COVID-19 testing and contact tracing service was created through the development of pathways, staff redeployment and training, the creation of testing centres, the procurement of testing kits, the development of laboratory capacity and the continued expansion of capacity to reach testing and contact tracing targets.

The Public Health function continues to be a leadership role in the national response to COVID-19, including the management of health surveillance activities, such as contact tracing, complex case and outbreak management and surveillance. The continued role of Public Health will be essential in guiding the reintroduction and delivery of services in a COVID environment, particularly in the event of a potential COVID surge and / or the expected increase in acute care demand during the winter season.

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

There is no experience in any healthcare system globally in reintroducing services following a pandemic of this nature. In this 'naive' global healthcare system, the dearth of evidence based, or even experiential based, knowledge means we must proceed in its absence.

Other jurisdictions have begun or are in the planning stages of resuming clinical activity that was postponed or cancelled due to mitigation measures implemented in the context of the COVID-19 pandemic. Evidence is primarily emerging from Ministries of Health and various professional societies. Although the level of detail and breadth of guidance varies considerably by source, there is consistency on the need for a gradual increase in activities with a requirement for adequate capacity, infection control and Personal Protective Equipment supplies. As such, to date there is a dearth of international evidence to guide policies, procedures or guidance around the reintroduction of clinical activity. However, key concepts such as (1) Organisation measures (2)

Physical space measures and (3) Patient flow measures are emerging from international literature. As more regions continue to ease restrictions related to COVID-19, it is anticipated that further guidance will be published however there is likely to be a time lag before evidence on the effectiveness of measures specific to COVID-19 are available.

The overall approach to the reintroduction of services in a COVID environment must be iterative, informed by shared learning and solutions developed locally and internationally during the response to the pandemic.

2.4 What further actions may be necessary (including those needed to prepare for a potential second wave of infection and further pandemics in the future)?

The reintroduction of services in a COVID environment poses a number of challenges with regard to capacity and efficiency in the system. Key social distancing measures and IPC requirements, such as the current two-metre distancing, will have material impact on the available infrastructure and physical space to deliver services, significantly impacting on the overall capacity and operational activity levels on the acute inpatient / outpatient and community residential settings. Ongoing IPC and PPE requirements are also changing the way tasks are being performed, such as creating additional steps associated with safely using and disposing of PPE.

To provide flexibility for a COVID surge, Acute Operations have advised that an 80-85% capacity level should be maintained. The acute hospital system has an average occupancy of 94% (OECD) and surges above 100% during the winter season leading to delays in patient flow, overcrowding in Emergency Department waiting rooms and patients having to wait on trolleys in overcrowded EDs pending the availability of a ward bed. If there is a second wave of COVID-19 during this period, the system will not have the capacity to meet unscheduled care demand unless specific actions are taken, such as:

- The expansion and improvement of influenza vaccination programme uptake to reduce influenza related admissions
- Ongoing leveraging of private capacity to enable the delivery of specific services / procedures to facilitate service reintroduction
- The rapid development of hospital avoidance and timely hospital discharge services for older people in the community, through initiatives such as Intermediate Care facilities and Specialist Older Person services teams
- Enhanced support for General Practice in direct access to community diagnostic services and specialist consultation and enhanced multidisciplinary team delivery of Chronic Disease Management services to enable the delivery of care in the community and reduce unscheduled acute presentations.

Capacity also needs to be maintained for testing and contact tracing, COVID pathways for known and suspected cases, and required self-isolation facilities. A scale of COVID surge may present that means that capacity is again needed for COVID services. In planning for the reintroduction of prioritised services across phases, the HSE will:

- Identify which services' reintroduction would be impacted under COVID surge scenarios.
- Develop continuity plans for reintroduced services under surge scenarios, recognising that some organisations in the system have progressed these plans.
- Ensure that future response initiatives to a COVID surge encompass the lessons learned to date. Specific responses (e.g. with a geographic focus or service focus) would enable the maintenance of reintroduced services where possible and appropriate.
- The HSE will build up GP capability

- The HSE will work with the training bodies to establish additional training posts for doctors
- The HSE will continue to drive the implementation of CroweHowarth in the delivery of a new service delivery model for public health, including pandemic management, capacity and capability

This, combined with a legacy of capacity issues as recognised under the Sláintecare strategy and the Capacity Review, highlights the need for alternatives to expand capacity including the option of private hospital capacity and the delivery of community hospital avoidance pathways and supports. The continued role of Public Health will be essential in guiding the response to a potential COVID surge and the reintroduction and delivery of services in a COVID environment.

3 Impact of COVID-19 on Services and Waiting Lists

3.1 Impact on Community Services in a COVID Environment

Community service activity has decreased as part of general COVID mitigation measures but also, in part, due to the redeployment of staff to support COVID services. Primary Care and Social Inclusion, Mental Health, Older Person, Palliative Care and Disability Services continue to deliver essential services (e.g. residential services), but other services have been reduced (e.g. home support for lower level priority users) or suspended (e.g. clinic-based therapies), as shown in Table 1 below.

Table 1. Breakdown in percentage of community services continued, reduced or suspended due to the COVID pandemic

	Primary Care and Social Inclusion	*Mental Health*	*Disabilities Services*	*Older Persons Services*
Service Continued	43.4%	43.2%	42.9%	30%
Reduced Service	32.3%	51.4%	35.7%	40%
Service Suspended	24.2%	5.4%	21.4%	30%

Source: Community Business Continuity By Care Group, 20 May 2020

The constraints around delivering service in a COVID environment has had an impact across a range of community services, causing a significant reduction in the obtainment of national targets, as shown in Table 2 below.

Table 2: National targets for discrete community services April 2020

Service	*Metric*	*Percentage reduction against national target for April 2020*
Audiology	No. of patients seen	43%
Occupational Therapy	No. of patients seen	30%
Ophthalmology	No. of patients seen	37%
Physiotherapy	No. of patients seen	28%
Podiatry	No. of patients seen	28%
Psychology	No. of patients seen	29%
Public Health Nursing	No. of patients seen	29%
Speech and Language Therapy	No. of patients seen	46%
General Adult Community Mental Health Teams	No. of new cases seen	19%
Intensive Home Care Packages	No. of home support hours provided	15%

Source: Management Data Report, April 2020

3.2 Impact on Acute Services in a COVID Environment

3.2.1 Scheduled Care

Across acute hospital settings, that were receiving hospitals, scheduled survives were postponed or severely curtailed to provide capacity for COVID inpatients, for staff to be redeployed for training in the use of Personal Protective Equipment (PPE), COVID ward care and to support

Critical Care surge delivery. Services that were postponed included daycase services, elective surgeries and outpatient appointments. Where services could not be safely postponed, they were delivered after case by case assessment either in the base hospital or relocated to another appropriate environment. Essential outpatient appointments were delivered, where possible, using a digital health solution. The overall impact has been an increase in patients awaiting inpatient and daycase admissions as well as outpatient appointments.

Table 3. Increase in Numbers on Waiting Lists Pre and Post-COVID Measures

Waiting List	*January 2020*	*April 2020*	*Difference*
Public In Patient (> 15 months)	2,613	3,115	19.2%
Public Day Case (> 15 months)	3,206	4,058	26.6%
Public Outpatient (> 52 weeks)	173,256	194,190	12.1%

Source: Management Data Report, April 2020

In addition and as outlined later in this document, key social distancing measures will have a material impact on the available capacity in the system. This in turn will make it impossible to return to previous ways of working and waiting lists will continue to increase based on limited capacity and reduced access, as services are delivered in a COVID environment.

3.2.2 Unscheduled Care

Unscheduled care is the predominant driver of activity in acute hospitals. COVID-19 required a major reorganisation of patient management with screening on arrival and division into COVID and non-COVID pathways. Productivity was impacted by the increased demands associated with Infection Prevention and Control (IPC) requirements associated with COVID care and the requirement for separate pathways both from an infrastructurally and a workforce point of view. This was mitigated by the unanticipated reduction in presentations both to general practice and to the Emergency Department, which has now reversed.

Fall in referrals to rapid access cancer clinics especially, together with a protracted suspension of cancer screening services, leading to delayed presentations, more advanced disease and poorer outcomes placing additional demand on cancer services.

Table 4. Decrease in Unscheduled Care Activity

KPI	*January 2020*	*April 2020*	*Difference*
New ED attendances	98,190	65,672	(33.1%)

Source: Management Data Report, April 2020

4 Catch-up Programmes for Missed Care and Services

The reintroduction of services will be on a phased and incremental basis, addressing those with the most critical requirements initially. Service prioritisation is a key first step in planning for and operationalising the reintroduction of healthcare services in a COVID environment and allows for the allocation of appropriate resources and staffing, in the appropriate setting, to meet demand and deliver those services.

Some higher-priority services, such as the four screening programmes (CervicalCheck, BreastCheck, BowelScreen and Diabetic Retina Screen), will have a developing backlog of cases as a result of services having been reduced or suspended due to the pandemic. This backlog will now have to be cleared in a COVID environment.

While reintroducing services, the ability of the organisation to "catch-up" is impaired by the challenges referenced throughout this document, most notably:

- Reduced capacity in the system
- Reduced operational productivity in the system
- Physical distancing measures and IPC requirements which have impacts on existing processes and lead times with some services operating at less than 50% capacity
- Delay in detection increases the percentage of patient referrals for treatment which has downstream impacts (e.g. on endoscopy and colonoscopy capacity)
- Overarching challenge of staff availability in a COVID environment (e.g. Staff redeployment, requirement to self isolate)
- The ability of acute hospitals to deliver inpatient services is heavily dependent on patient flow from the acute setting into the community
- Need to maintain COVID services for the foreseeable future and the associated costs
- Potential winter of a surge
- Staff training and education
- Ongoing capacity constraints in the Irish healthcare system (e.g. requirement for an additional 2,590 acute beds - *2018 Department of Health Capacity Report*)

Taking the National Screening Service as an example, each programme has developed a dynamic and detailed plan for the reintroduction of services. However, it will take time for screening programmes to both build up to pre-COVID productivity levels and to clear the backlogs arising from the pause.

5 Community Services in a COVID Environment

5.1 Older Persons

A main focus area for community services in a COVID environment is older persons (age 75+). In terms of this population, activity is increasing week on week. This is particularly important when planning capacity across hospitals and community services, where the goal is to reduce the need for attendance at Emergency Departments and provide other types of interventions. Attendances and admissions have currently passed last year's numbers and patient experience times for older persons remains at a high level.

5.2 Disability

In the disabilities and the disability sector, there are currently over 18,000 adults attending disability day services supported by 91 service providers across 1,000 service locations. Urgent and critical services have been maintained in a COVID environment, however day services were reduced. This is due to the limited capacity to see people in group settings, the ability to transport people to day services and staff being able to work safely in these services. There is also an effort to scale up services across mental health and social inclusion including addiction services and services for the homeless.

5.3 Mental Health

Within Mental Health services, it is clear that the psychosocial impact and mental health burden as a result of the COVID-19 pandemic is unprecedented. Compounded by the economic impact of the pandemic, COVID-19 is likely to cause a long-term increased demand for mental health services, and in particular specialist services. Specific population cohorts have been identified as particularly vulnerable and likely having increased requirements for mental health supports.

5.4 Health and Wellbeing

Given the impact that COVID-19 has had on the most vulnerable in our communities the requirement to deliver a strong and focused health and wellbeing accessible programme of support, whilst addressing health inequalities, is imperative. The fight against COVID-19 has identified issues in our response to emerging gaps among subgroups of our population affected disproportionately by health inequalities. The Health and Wellbeing agenda is required now more than ever by not only this vulnerable cohort but also our staff, our communities and the population as a whole. We need to ensure when ramping back up services and adopting new ways of working that we are led by a population-based needs analysis and health intelligence approach and build on our collaborative approach with Public Health in this regard.

6 Impact of COVID-19 on Care Provision

6.1 Need to Maintain COVID Services for the Foreseeable Future

Capacity to manage COVID cases is essential to limit the spread of the virus. Maintaining health service capacity at 80% in the acute system allows us to rapidly respond to any potential COVID surge, ensure patient flow and avoid trolley waits. In addition, capacity also needs to be maintained for testing and contact tracing, COVID pathways for known and suspected cases, and required self-isolation facilities.

6.2 Reduced Capacity in the System

The reintroduction of services in a COVID environment poses a number of challenges with regard to capacity and efficiency in the system. Key social distancing measures and IPC requirements, such as the current two-metre distancing, will have material impact on the available physical space to deliver services, significantly impacting on the overall capacity and operational activity levels on the acute inpatient / outpatient and community residential settings.

Acute Operations estimate that the potential impact of the two-metre rule could result in approximately a 25% reduction in acute inpatient beds. The implementation of the *Health Service Capacity Review 2018* must be prioritised to ensure that all patients requiring hospital admission have access to a hospital bed immediately.

Table 5 below identifies the expected activity per the National Service Plan which assumed current high occupancy levels. This assessment can be further assessed at a hospital level.

Table 5. Targeted Acute Activity in 2020 and Total Available at 80%

Targeted Acute Activity	
Targeted Inpatient Cases in 2020	**645,038**
Targeted Emergency Cases	444,606
Targeted Elective Cases	91,635
Targeted Maternity Cases	108,796
Acute Activity Impact	
Total Available at 80%	516,030
Total Available at 80%, Excluding Maternity	428,993

Source: National Service Plan

6.3 Reduced Operational Productivity in the System

Patient pathway to allow for physical distancing in emergency departments, theatre and treatment rooms, examination room layouts, diagnostics and x-ray and all waiting areas. will lead to a significant reduction in activity due to delays associated with appointment-based systems, patient screening, use of PPE, environmental cleaning, and news methods of delivering care. This will reduce productivity but is likely to improve the patient experience and reduce non-value adding activities.

6.4 Staffing Challenges in a COVID Environment

Significant staff redeployment has taken place in order to generate capacity for COVID services. Returning these staff to their previous roles presents a challenge as COVID services, particularly testing and contact-tracing, need to continue for the foreseeable future. Overcoming these challenges may require the roles and responsibilities of different staff members to be reviewed, alternative workforce strategies to be deployed or staff to be reassigned to other care settings which will require employee relations engagement. In addition, staff will continue to be at risk of contracting COVID-19 and, with regular testing, will be required to self-isolate. This will also be a challenge in maintaining the necessary staffing levels. In addition, ongoing IPC and PPE requirements are changing the way tasks are being performed, such as creating additional steps associated with safely using and disposing of PPE.

6.5 Cost Implications of a COVID Environment

The measures to respond to this challenge will have significant cost implications for the organisation. The key drivers of cost to date in managing COVID-19 include PPE requirements, Private hospitals capacity (including consultant contract), Testing and Contract Tracing (including laboratory costs and staffing), Intermediate care capacity (including field hospitals and City West), Medical equipment (including ventilators), Healthcare workforce capacity (including On Call for Ireland, retired and overseas staff returning, locum and absenteeism cover).

Additional costs will now be incurred to facilitate the reintroduction of services in a COVID environment. These include but are not limited to the adaptation of new ways of working such as digital technology such as ePrescribing and telemedicine, enhanced integration across community and acute settings such as the development of hospital avoidance services and investment in enabling supports including facilities and staffing.

6.6 Communicating Impact to the Public

Services will not be reintroduced to the same scale or scope as pre-COVID levels and may have to be reduced or suspended again in the event of a COVID surge. Public expectations surrounding service reintroduction need to be carefully managed as how services are delivered will change, particularly with the increased adaptation of technology. A national approach is required to ensure a clear and consistent message to inform the public of service continuity plans and increase confidence in the public to re-engage in positive health seeking behaviours.

7 Additional Capacity in the Health Service

As set out previously, health service capacity needs to be maintained at 80% in the acute system to allow us to rapidly respond to any potential COVID surge, ensure patient flow and avoid trolley waits. Combined with physical distancing measures, IPC requirements, likely increased unscheduled care activity during the winter season and a legacy of capacity issues as recognised under the Sláintecare strategy and the Capacity Review, highlights the need for alternatives to expand capacity including the option of private hospital capacity and the delivery of community hospital avoidance pathways and supports.

It is noted, the challenges with regard to the delivery of care in a COVID environment are exacerbated by the current and ongoing capacity constraints in the Irish healthcare system. The capacity in the Irish Health Service is widely recognised as a significant challenge, in regard to both a current constraint and a future challenge to meeting the ongoing health needs of the Irish population. The *2018 Department of Health Capacity Report*, outlined the requirement for additional capacity along with the requirement for significant reform regarding the model of care delivered in the Irish healthcare system, with a significant shift of service provision to the community setting. Under this scenario of reform, by 2031, the Capacity Report outlined a requirement for an additional 2,590 acute beds, along with significant capacity enhancements across long stay, intermediate care beds and community service provision. Under the Slaintecare strategy, the Capacity and Access Programme is delivering a programme of work to enable this additional system capacity.

Please refer to section 2.4 for examples of what actions need to be taken to meet unscheduled care capacity demands in the event of a second wave of COVID-19.

8 Implementation of Sláintecare

As the volume of both unscheduled and scheduled activity increases, we cannot return to previous ways of working. Overcrowded emergency and outpatient departments do not allow health services to comply with the physical distancing measures and IPC requirements necessary in a COVID environment. Delays in transfers of patients back to the community, either to their homes or to residential care facilities and prolonged length of stays due to delays in accessing necessary diagnostics, interventions, procedures or surgeries reduce vital acute hospital capacity necessary to rapidly respond to a COVID surge.

For the foreseeable future, health services will have to operate and develop pathways to treat both COVID and non-COVID patients simultaneously, in the context of an evolving pandemic where vital COVID capacity needs to be maintained and heightened safety measures need to be rigorously adhered to. As such, there is an urgent need to reconceptualise how we deliver care, to both address the present health needs of our population in a COVID environment and protect the future viability of health services by progressing the implementation of the Sláintecare vision.

The reintroduction of services will not be a return to status quo, but instead will build on the momentum that exists in the system and the realisation that traditional barriers to change can be overcome. Staff engagement and collaboration played a huge role in enabling service to rapidly adapt to the emergency and change the way services were delivered. Service reintroduction represents an opportunity to reform and deliver elements of Sláintecare and as such new ways of working need to be adopted. The following are five key new ways of working initiatives which are supportive of National Service Plan and Sláintecare priorities:

1. Enhanced integration of care pathways, i.e. the enhancement of community services that shift care away from acute settings is key to delivering the right care in the right place and at the right time. The response to the COVID pandemic has accelerated us on this journey and we must now continue to adapt and re-design our patient pathways to support this future model of care.
2. Enhancing and supporting General Practice is an essential component in achieving the necessary shift in delivery of care from acute to community settings. The supports which have been identified include timely access to diagnostic services in the community and the provision of Medical Assessment Units (MAUs) and Surgical Assessment Units (SAUs).
3. Enhancing Older Persons services, including Chronic Disease Management. Enhanced community services (such as home support hours, specialist Older Persons multidisciplinary teams, Community Intervention Teams and Frailty Intervention Teams) have a crucial role to play both in optimising health to avoid hospital admission and in facilitating timely discharge from hospital.
4. Digitally-enabled healthcare delivery, for example, retaining and maintaining some of the innovations which were implemented as part of the COVID response will be a key enabler of timely service provision as we deliver services in a constrained COVID environment while simultaneously working to meet the pre-existing unmet demand in the system.
5. Measures to reduce acute hospital admissions (such as increasing senior decision making in Emergency Departments) will be critical to maintain capacity in acute hospital settings.

9 Testing Strategy in a COVID Environment

Patient and staff safety remain of paramount importance when delivering services in a COVID environment. All centres must have access to rapid testing of patients and healthcare workers suspected of COVID-19 and for appropriate testing of contacts. Under the testing strategy for the reintroduction of services, appropriate testing will be key to maintaining staff health and wellbeing and sustaining service continuity.

Testing can be used to inform control measures. If there is an outbreak of COVID in a hospital or nursing home, testing can identify patients/residents who have the SARS-CoV-2 virus and appropriate infection prevention and control measures can be put in place to help prevent secondary transmission. Testing can also yield important information about chains of transmission and important surveillance data regarding trends in infection rates. This can help to identify high risk regions/ population groups and can facilitate assessment of the impact of control measures, e.g. social distancing.

There are several challenges surrounding testing in a COVID environment:

- Testing is not 100% accurate, international testing suggests the sensitivity of testing is between 80-90%.
- Testing yields information at a single point in time, therefore a test stating “not detected” is not an indicator of risk on an ongoing basis.
- A test reported as “not detected” may be a false positive.

Testing should be recognised as one component of a multi-faceted response to COVID in HCWs. Primary components of an effective response, for which there is an evidence base, include appropriate IPC and prompt identification and exclusion of symptomatic HCWs from the workplace. Addressing key knowledge gaps regarding the epidemiology of COVID-19 in HCWs in Ireland should be prioritised, and will provide the evidence base for future testing strategies. A detailed draft of recommendations for the testing of healthcare workers can be found in the *Public Health Recommendations on Strategic Approach* by Dr. Heather Burns and Dr. Lorraine Doherty.

10 Immunisation Programmes in a COVID Environment

Immunisations are one of the most cost-effective interventions available in healthcare and save many lives each year. The World Health Organisation recommended that immunisation programmes continued as far as possible during COVID-19.

10.1 Primary Childhood Immunisations

Primary childhood immunisations are provided in five visits at 2, 4, 6, 12 and 13 months and uptake is reported quarterly at the age of 12 and 24 months. Young children are most vulnerable to infections so on-time immunisation is particularly important. The HSE recommended that the primary childhood immunisations as well as immunisations for risk groups, including pertussis vaccine for pregnant women, continue throughout the COVID emergency. The National Immunisation Office provided information to parents on social and traditional media to reassure them that it was safe to bring their babies and young children for immunisations.

Due to the retrospective reporting of immunisation uptake data it is currently not possible to quantify whether the uptake of primary childhood immunisations was lower in the first half of this year than in previous years. The introduction of a National Immunisation Information System for Ireland, which is in the planning stages, is crucial for timelier uptake reporting.

10.2 School-Based Immunisations

Immunisations are also provided to school aged children: MMR and 4 in 1 for junior infants and HPV, Tdap and Men ACWY for first year of second level students. These immunisations are provided by Community Healthcare Organisations teams in schools.

Due to the sudden closure of schools in mid-March, these programmes were suspended. At this time approximately a third of students were still outstanding vaccines in junior infants and the visits to schools had only just commenced for the second dose of HPV and Men ACWY, therefore about 90% were outstanding.

As schools have not reopened, Community Healthcare Organisations have plans in place to provide these immunisations in catch-up clinics over the summer months. Some areas have already started these clinics and all areas plan to complete these immunisations before the start of the next academic year.

For the 2020-21 academic year, it is hoped that schools will reopen and therefore the model of school-based immunisation delivery can continue as before, because international literature shows that the highest uptake is obtained if immunisations are delivered in schools.

10.3 Influenza Immunisations

Importance of maximising influenza vaccine uptake in a COVID environment, to protect those at-risk of influenza and minimise the burden on health services is widely recognised. For the 2020/2021 influenza season two important extensions to the programme are planned:

- Introduction of influenza vaccine for children aged 2-12 years.
- Removal of administration fee for at risk groups who do not have a medical card to encourage high uptake of the vaccine.

The National Immunisation Office is working with groups across the HSE to implement these plans, promote the influenza vaccine and communicate its importance in a COVID environment.

11 Organ Donation and Transplant in a COVID Environment

As set out previously, the reintroduction of services will be on a phased and incremental basis, addressing those with the most critical requirements initially. Service prioritisation is a key first step in planning for and operationalising the reintroduction of healthcare services in a COVID environment and allows for the allocation of appropriate resources and staffing, in the appropriate setting, to meet demand and deliver those services. Time dependent surgeries, including transplant services, have been identified as a high priority for reintroduction.

12 Documents for Reference

The following documents will be provided as an attachment to this submission:

1. *COVID-19 RNA/PCR Testing in Acute Hospitals in Ireland: Public Health Recommendations on Strategic Approach*, Dr Heather Burns and Dr Lorraine Doherty, 10 June 2020

2. *Service Continuity in a COVID Environment: A Strategic Framework*, 8 June 2020

3. *Service Continuity Roadmap,* 30 June 2020