IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Submission to the Special Oireachtas Committee on Covid-19 on Health System Capacity for Covid and Non-Covid Care

July 2020

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel (01) 676 72 73
Email : vhetherington@imo.ie
Website www.imo.ie

IMO Submission to the Special Oireachtas Committee on Covid 19 on Health System Capacity for Covid and Non-Covid care

Covid 19 has had a significant impact on our already overstretched healthcare system, requiring all-non-urgent care to be effectively shut down. Decades of under investment has left us with overwhelming capacity issues across the entire system including Public Health services, acute hospital capacity (bed capacity and medical manpower), diagnostics, General Practice, Public health, Long-term care, EHealth and IT infrastructure and Community Health. The capacity deficits which have left us with excessive over-crowding in our Emergency Departments and long-waiting lists for specialist care are now exacerbated by Covid 19 requirements for social distancing and infection control and the need to guard sufficient spare capacity for a future surge.

Covid 19 is likely to be with us for some time - urgent planning and investment is immediately required across our health services to ensure that we are prepared for future surges and that care for non-covid patients (urgent and elective) not only continues but is enhanced and provided in a timely manner.

In order to address our key capacity issues the IMO recommends:

1. **<u>Strengthen Public Health Capacity</u>**
   - **Immediate awarding of consultant contracts to Specialists in Public Health Medicine (SPHMs) in line with their specialist training and experience, allowing them to work to the top of their licence as per the recommendations of the Crowe Horwath report and the Scally Report in 2018;**
   - **It is important also that the requirements of Senior Medical Officers in Public Health are supported to include clerical support and adequate rota cover;**

2. **<u>Immediately invest in the expansion of acute bed capacity</u>**
   - **Immediate expansion of physical capacity through investment in temporary builds;**
   - **Immediate financing of a programme of Investment in 5,000 additional public acute bed capacity including investment in stand-alone public hospitals for elective care;**
   - **Urgently increase critical care capacity by at least 300 intensive care beds;**
   - **Examine options to ensure that NTPF funding is used to the maximum benefit of patients and the taxpayer;**

3. **<u>Address the shortage of Hospital Consultants</u>**
   - **Urgently implement targeted measures to recruit and retain hospital consultants – The HSE is not an employer of choice and the Report of the Public Sector Pay Reform Commission, the HSE and the Government recognise that the two-tier consultant pay issue is a major barrier to recruitment;**
   - **In the meantime to retain their essential skills, all SpRs who have finished training should be offered a temporary consultant locum post;**
   - **In light of current manpower shortages no NCHDs should be left without a post -Both Consultants and NCHDs have stepped up, working long hours and weeks at the frontline of Covid care;**

4. **Pro-actively support General Practice in the shift of care to the community setting**

- **Appropriately resource diagnostic, radiology and laboratory departments to allow extended and timely access to investigations and the results of same for both hospital doctors and GPs in the community;**
- **Immediate reopening of AMUs and ASUs with clear referral pathways so that GPs and hospital consultants can prioritize those with most urgent need for services;**
- **Support GPs to employ additional GPs, practice nurses and other support staff;**
- **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**
- **Develop and resource a triage /telemedicine system in General Practice;**

5. **Invest in Care for Older Persons**
   - **Urgently increase the number of rehabilitative care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**
   - **Where nursing home care is required**
     - **ensure that nursing homes are appropriately staffed and there are sufficient isolation facilities in place**
     - **Invest in a holistic approach to care with input from a range of specialties like geriatricians and public health and a programme of GP care for nursing home patients that reflects the complexity of care required;**

6. **Invest in ehealth**
   - **Invest in electronic patient records across all hospitals and community health centres. Each hospital or CHO may have different systems provided systems cans communicate and allow for embedding of national summary patient records;**
   - **Upgrade IT infrastructure, both hardware and software, to support safe remote-consultations and remote multi-disciplinary team-working;**
   - **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health;**

7. **Invest in Prevention**
   - **Community medical staffing levels must be increased to maintain the quality and safety of child health and vaccination programmes;**
   - **In preparation for the winter flu season, invest in the roll-out of a total population flu-vaccination programme in General Practice accompanied by a public education campaign to encourage older people and all healthcare workers to avail of the vaccine;**
   - **Public confidence has returned in our screening programmes. Investment in diagnostics and treatment pathways are needed to support the full re-establishment of these life-saving programmes.**

Rationale

Due to neglect by successive Governments over many years, our acute hospital system has huge capacity deficits in terms of bed numbers and manpower which urgently need to be addressed.

The arrival of Covid 19 brought these significant capacity deficits in our hospital systems to the fore requiring urgent measures to be taken including:

- the cancellation of all non-urgent or time sensitive care,
- the re-deployment of approximately 1600 staff to frontline Covid care
- agreement with the private hospitals association to make available an additional 2000 beds and approximately 100 Intensive Care Units (ICUs) and High Dependency Units (HDUs)to the public health system

Now due to the cancellation of all non-urgent care across the system:

- 570,000 people still waiting for an outpatient appointment and 230,000 people on a waiting list for an inpatient or day-case procedure or GI endoscopy.
- GP access to diagnostics and referral pathways for all patients have been closed down.
- Cancer screening programmes have been put on hold

Fortunately due to measures taken by the public, we have so far avoided the worst case scenarios However, it is likely that very low numbers of the population have been infected and we are not yet out of danger. Until we have, significant treatment options or an effective vaccine, we face significant uncertainty as to the timing and impact of a second and subsequent waves particularly as respiratory illnesses begin to circulate again in the winter period as early as September.

The HSE now faces significant challenges as it seeks to reopen services for elective, outpatients and other programmes. we simply cannot revert back to a situation where additional beds are being added to wards and dozens of patients including elderly patients, boarding on trolleys in an Emergency Department, Overcrowded waiting rooms waiting for outpatient clinics cannot be a feature in the health service that we now need.

The HSE recently published its Strategic Framework for the reopening of services - HSE Service Continuity in a Covid 19 Environment- Strategic Framework for Delivery. The Framework proposes the reopening of scheduled and non-scheduled non -Covid care on a phased basis with priority given to urgent and time sensitive care and the phased reopening of our screening programmes.

In order to maintain vital capacity needs the HSE proposes an acceleration of five on-going reform initiatives which are supportive of the National Service Plan:

- Enhanced Integration of Care Pathways with a shift in care from the acute to the community setting
- Enhancing and Supporting General Practice including grant aids to employ, practice doctors and nurses, access to diagnostics, access to AMUs and ASUs as well as enhanced use of eHealth including increased use of telemedicine.
- Enhancing Older Persons Services, including enhanced community supports including home support hours; Specialist Older Persons multidisciplinary teams (Community Intervention Teams (CIT); Chronic Disease Management; and Rehabilitation services

- Digitally Enabled Healthcare Delivery - Retaining and maintaining some of the telehealth innovations and advancing new initialitives including a primary care management system, ePharmacy and ePrescribing.
- Measures to Reduce Acute Hospital Admissions including Increasing senior decision making in Emergency Departments, protecting AMU and ASU capacity and shifting to a 24/7 model of care including access to diagnostics.

While the acceleration of these key healthcare reforms is to be welcomed they will need to be appropriately resourced. Unfortunately, though, the measures contained in the Strategic Framework fail to address the key capacity deficits right across the health system.

1. Strenghten Public Health Capacity

The Covid 19 pandemic has highlighted the role of our public health specialists in infection control and responding to global pandemics at national and local level.

Under Infectious Disease Regulations 1981 and subsequent amendments , Medical Officers of Health have statutory responsibilities in health surveillance, in protecting the public from infectious disease and environmental threats, and ensuring Ireland meets its commitments under national and international health regulations.

Specialists in Public Health Medicine by reason of their specialist training, experience and statutory responsibilities as well as their existing links with clinicians, community medicine, immunisation services. laboratories, international bodies, Department of Health etc. are uniquely qualified to play a pivotal role in the prevention and control of infectious disease, Covid- 19 and provide specialist clinical oversight for important public health functions of testing tracing.

In addition to their statutory role in infection control, Public Health Specialists carry out essential roles in health services including disease prevention, health services improvement and health intelligence. The need for Public health medical skill and expertise to oversee public health programmes like screening, vaccination, tobacco control or infectious diseases was highlighted in the 2018 report by Dr Gabriel Scally. [1]

There is an urgent need to strengthen Public Health Medicine services through the Immediate awarding of a consultant contract to Specialists in Public Health Medicine to ensure they are contracted to carry out their essential statutory functions in infection control.

Over 50% of Public Health Specialists are due to retire in the next five years and Public Health medicine is no longer seen as an attractive option for medical graduates due to the lack of consultant status and remuneration and poor career opportunities.

The Crowe Horwath Report on Public Health Medicine commissioned by the Dept of Health[2] made a number of recommendations to improve the role and function of public health specialists, as well as the training and career structure of public health medicine including the awarding consultant status to public health doctors.

[1] Scally G, Scoping Inquiry into the CervicalCheck Screening Programme, Final report April 2018
[2] Crowe Horwath, Final Report to the Department of Health on the Role, Training and Career Structures of Public Health Physicians, April 2018

We urgently need to strengthen Public Health Capacity

- **Immediate awarding of consultant contracts to Specialists in Public Health Medicine (SPHMs) in line with their specialist training and experience, allowing them to work to the top of their licence as per the recommendations of the Crowe Horwath report and the Scally Report in 2018;**
- **It is important also that the requirements of Senior Medical Officers in Public Health are supported to include clerical support and adequate rota cover;**

2. Immediately invest in the expansion of acute bed capacity

Key facts

- Ireland has one of the lowest number of public hospital beds per population in the EU, and our hospitals operate on average at 95% occupancy, with many hospitals operating throughout the year at more than full capacity .
- Even with essential reforms in place the ESRI predict that between 4,000 and 6,300 acute beds are required across public and private hospitals of which 3,200 to 5,600 are required in public hospitals[3] yet no additional investment is indicated either in the HSE Framework or the Draft Programme for Government.
- We have just 250 beds across out Intensive care and high dependency units compared to a minimum of 430 beds recommended in Health Service Capacity Review 2018.[4]
- The HSE estimate that social distancing and infection control measures will reduce capacity by on average 25% and up to 50% in some specialties such as surgery while at the same time 15-20% spare capacity is required in the likely event of a future surge.

While the National Treatment Purchase Fund (NTPF) cannot replace the urgent need to invest in acute bed capacity it can offer a short-term solution to our impending capacity crisis. Options should be explored to ensure that NTPF funding is used to the maximum benefit of patients and the taxpayer using available spare capacity in both public and private hospitals. Options include

- Supporting GPs with direct access to diagnostics in the private sector
- Issuing of tenders for whole care episodes to prevent the selection by private hospitals of low-, high-volume procedures and consequential fragmentation of patient care
- Support consultant-led initiatives in our public hospitals to improve quality and access to care, using weekends and evening availability and staff remunerated at a rate commensurate with their supra-contractual commitment. This should be done though specific units established within the hospitals and in conjunction with hospital specialists and not through third parties.

Immediate investment is required in the expansion of acute bed capacity

- **Immediate expansion of physical capacity through investment in temporary builds;**

[3] Conor Keegan Aoife Brick Brendan Walsh Adele Bergin James Eighan Maev-Ann Wren How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030, t*he International Journal of Health Planning and Management*, 2018, pp. 1-14 **https://doi.org/10.1002/hpm.2673**

[4] PA Consulting, Health Service Capacity Review 2018, Department of Health 2018

- **Immediate financing of a programme of Investment in 5,000 additional public acute bed capacity including investment in stand-alone public hospitals for elective care;**
- **Urgently increase critical care capacity by at least 300 intensive care beds;**
- **Examine options to ensure that NTPF funding is used to the maximum benefit of patients and the taxpayer;**

3. Address the shortage of Hospital Consultants

Key facts

- With 1.44 specialists per 1,000 population Ireland has the lowest number of medical specialists in the EU. (EU average 2.48 per 1,000 population) [5]
- over 500 posts are unfilled or filled on a temporary, locum basis,
- Across all specialties Consultant staffing levels across our health services fall far below recommended staffing levels contributing to excessive waiting lists for outpatient appointments and elective care (See table 1)

Table 1 - Table 1 – Consultant Shortages and Waiting Lists per Medical Specialty (larger waiting lists)

Specialty	Recommended ratio of Specialists per population	No. of consultants required as per current pop.	No. of Approved Consultant Posts 31/03/2020	No. of Consultant Posts Filled 31/03/2020	Current Shortfall of Consultants	Outpatient Waiting Lists NTPF - 30/04/2020	Inpatient/ Day case procedure waiting list - 30/04/2020
Otolaryngology ENT	1: 40,000	121	57	56	65	65,596	5,487
Orthopaedics*	1:24,000	202	112	107	95	70,734	13551
Dermatology	1:62,500	78	50	43	35	42,776	787
Opthalmology	1:33,000	147	48	46	101	41,401	9,822
General Surgery **	1: 25,000	194	183	174	20	49,582	15,305
Urology	1:50,000	97	47	43	54	30,037	10,614
Obs & Gyneacology		239	179	165	74	28,381	5,812
Cardiology	1:48,000	101	82	73	28	27,395	4,769
Neurology	1:70,000	64	46	44	20	22,372	262
Rheumatology***	1:79,000	61	39	38	23	18,568	729

*waiting lists for Orthopaedic Surgery include adults and children

**waiting lists include General Surgery, Vascular Surgery, Breast surgery and Gastro-intestinal surgery)

***Consultant numbers include General Medicine

- Based on pre-Covid 19 assessments and current ED configurations[6] we have a deficit of 33 Emergency Medicine Consultants.
- Across our mental health services, the College of Psychiatrists of Ireland estimate that we need to double the number of consultant Psychiatrists including at least an additional 72 Child and Adolescent Psychiatrists[7], while one in five consultants psychiatry posts are filled

[5] OECD Health Stats 2019 (Figures exclude Specialist General Practitioners)
[6] HSE - NDTP review of the Emergency Medicine Medical Workforce in Ireland 2017
[7] College of Psychiatrists of Ireland –Workforce Planning Report 2013-2023 – December 2013

on a temporary basis.[8] It is recognised that Covid 19 will impact further on demand for our Mental Health Services.

- Hundreds of newly qualified specialists have been leaving our shores each year in search of better pay and conditions in other English speaking countries including Australia, New Zealand, Canada, US and the UK.
- Covid 19 will continue to require an enhanced level of staffing across our health system to allow for:
    - deployment of staff to deal with a future surge in the virus
    - reduced productivity as a result of Infection control measures
    - the need to self-isolate or take sick leave if displaying symptoms or contracting the virus.

Urgent action is needed to address the shortage of Hospital Consultants

- **Urgently implement targeted measures to recruit and retain hospital consultants – The HSE is not an employer of choice and the Report of the Public Sector Pay Reform Commission, the HSE and the Government and many of our politicians recognise that the two-tier consultant pay issue is a major barrier to recruitment;**
- **In the meantime, all SpRs who have finished training should be offered a temporary consultant locum post;**
- **In light of current manpower shortages no NCHDs should be left without a post. Both Consultants and NCHDs have stepped up, working long hours and weeks at the frontline of Covid care;**

4. Pro-actively support General Practice in the shift of care to the community setting

With appropriate resources General Practice in can help to alleviate the increasing demand on the hospital system. Expanding access to diagnostic, radiology and laboratory services will support GPs to appropriately manage patients in the community. This will also help speed up the flow of patients through Emergency Departments. However, no detailed assessment has been carried out of diagnostics, radiology and laboratory service requirements to meet current and future demands or the potential impact the Covid 19 infection control measures has had on capacity.

Appropriate referral pathways through Acute Medical Units (AMUs) and Acute Surgery Units (ASUs) will ensure that GPs and hospital consultants can prioritize those with most urgent need for services, while at the same time relieving pressure on our Emergency Departments .

General Practice however is not without its own capacity issues. Ireland has a growing and ageing population, Since 2008, the number of people aged over 65 in Ireland has increased by 34pc this number is expected to double again by 2038 when about 1.2 million people will be aged 65 or over in Ireland. With increased age comes increased health need and a corresponding increased utilisation of GP services. It is essential that we increase GP numbers and capacity to meet the current and future increased demand for GP services.

[8] HSE NDTP- Opening Statement to the Oireachtas Committee on the Future of Mental Healthcare 9 May 2018

Over the past decade the FEMPI cuts have decimated General Practice. The recent GP deal negotiated between the IMO, the HSE and the Department of Health - which includes the reversal of FEMPI cuts and investment in chronic disease management programmes will at best stabilise General Practice and further resources are needed to promote the development of General Practice on an on-going basis including additional supports to employ additional GPs and practice nurses and other practice staff.

For young GPs seeking to establish themselves in a new community, the initial investment costs in premises, equipment, IT systems, insurance etc. and are particularly prohibitive.

General Practice has responded quickly to the pandemic. An early agreement in March 2020 saw the introduction of a telephone triage system with a clear public campaign informing patients to call their GP first before arriving at the practice. General Practice played a pivotal role in the referral for testing of patients suspected of being infected with Covid- 19 under the evolving algorithms. Many GPs volunteered to participate in the HSE Community Assessment Hubs The use of these Hubs has increased the ability of GPs to manage COVID-19 patients in the community outside of the GP Surgery thus allowing the surgeries to manage non COVID-19 patients more effectively.

These rapid developments in triage and telemedicine were made possible by an agreement negotiated between the Dept of Health and the HSE of a package of supports for Covid and non-Covid telephone triage as well as Covid 19 respiratory assessments. These supports are due to expire mid-August.

We urgently need to support General Practice in the shift of care to the community:

- **Appropriately resource diagnostic, radiology and laboratory departments to allow extended and timely access to investigations and the results of same for both hospital doctors and GPs in the community;**
- **Immediate reopening of AMUs and ASUs with clear referral pathways so that GPs and hospital consultants can prioritize those with most urgent need for services;**
- **Support GPs to employ additional GPs, practice nurses and other support staff;**
- **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**
- **Develop and resource a triage /telemedicine system in General Practice;**

5. Invest in Care for Older Persons

At any one time there can be in excess of 650 older people in our hospitals awaiting discharge to appropriate rehabilitation or long-term care or intensive home care supports. The tragic experience of Covid-19 among nursing home patients has highlighted the urgent need to plan appropriately for the health and social care needs of our older citizens. At national level there was absence of planning in how healthcare should be delivered to Covid-19 patients in nursing homes, including GP involvement, and a poor assessment of risk in transferring patients from hospital into residential care facilities. Key issues arose in terms of delays accessing, PPE, insufficient staffing levels and training in infection control as well as lack of isolation facilities. (See IMO Submission to the Covid 19 Expert Panel on Nursing Home Care).

Our demography is ageing. While we are ageing healthily there is a widespread need to prepare for loss of function and support our older citizens to remain at home as long as possible. Nursing home care should be a last resort after all options have been exercised. We urgently need to invest in rehabilitation beds for our older population and home care services to allow older people remain at home as long as possible. Currently resources for home care packages are insufficient to meet either demand or the complexity of care required. We urgently need to invest in the provision of appropriate home care services. Access should be based on need and eligibility standardised across the country

Even with investment in some intensive home care services there will still be a small percentage of older people that will require nursing home care. Nursing homes must be appropriately staffed and staff have received training in infection control, and that there are sufficient isolation facilities in place. We must invest in a holistic approach to care with input from a range of specialties like geriatricians and public health and a programme of GP care for nursing home patients that reflects the complexity of care required.

We urgently need to plan for the appropriate medical and social care needs for our older population:

- **Urgently increase the number of rehabilitative care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**
- **Where nursing home care is required**
  - **ensure that nursing homes are appropriately staffed and there are sufficient isolation facilities in place**
  - **Invest in a holistic approach to care with input from a range of specialties like geriatricians and public health and a programme of GP care for nursing home patients that reflects the complexity of care required/**

6. Invest in Ehealth

EHealth is to play a central role in the HSE's Strategic Plan for the Continuity of Services, however the development of IT services has taken place in a piecemeal fashion and significant IT deficits exist.

While Electronic Healthcare Records have been piloted in some hospitals, the majority of hospitals in Ireland are still using paper-based notes systems as the main patient record as well as paper-based systems for tracking patient referrals, Out Patient appointments etc

The use of paper-based records and the potential for vital charts and notes to be lost or mislaid increases the risk of error in clinical care, while difficulties in accessing paper-based health records between hospital sites and community services lead to long delays in Emergency Departments, duplication of tests or patients being treated with suboptimal information.

Outdated computer hardware and insecure software inhibits the safe deployment of telemedicine including teleconsultations with patients and teleconference meetings of multi-disciplinary teams.

In General practice, the majority of GPs have recognised the value of eHealth invested significantly in practice management systems. Under the deal reached between the IMO and the HSE and Department of Health in 2019 there was agreement to support GPs in the development of their practice systems and the roll-out of key ehealth initiatives over the next 4 years including:

- The Rollout of the Individual health identifiers (for which the legislation is already in place):

- Continued and expanded use of eReferrals;
- Co-operation with the specific agreed e Prescribing model
- Use of NImis for ordering of diagnostic imaging services;
- Use of the summary and shared care records system;
- Cooperation with the development and rollout of an integrated system management of immunisations;
- Continued and expanded use of Healthlink and Healthmail;
- Co-operation with the initial rollout of Medlis for the ordering of blood tests.
- Continued use of PCRS suite;

This co-operation is subject the HSE having the necessary developments in place and the continued honouring of the reversal of FEMPI process over the course of the agreement.

We urgently need to invest in ehealth to support integrated care

- **Invest in electronic patient records across all hospitals and community health centres. Each hospital or CHO may have different systems provided systems cans communicate and allow for imbedding of national summary patient records;**
- **Upgrade IT infrastructure, both hardware and software, to support safe remote-consultations and remote multi-disciplinary team-working;**
- **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.;**

7. Invest in prevention.

Investment in prevention is one of the most cost effective ways of reduce future demand on our healthcare services.

Community medical doctors work mainly in areas of Child Health and Immunisation, however the number of doctors employed in community health has fallen over the last ten years despite increased demand due to population growth and implementation of the secondary school HPV, Tdap and MenC vaccination programmes. Some additional posts have been allocated this year for extension of HPV programme, but at the same time, vacant posts arising as a result of resignations or retirements cannot be filled . Catch up school immunisation programmes are under way in a variety of temporary locations but social distancing requirements and slower throughput have further impacted on staffing requirements.

Each year the winter flu places increased demand on our hospital system. Seasonal flu vaccines can reduce hospitalisations and the need to visit your GP during the winter season. Misinformation on the internet and through social medial can lead to vaccination hesitancy. Research shows that patients particularly in the at-risk groups are more likely to take up the flu vaccine following advice from their GP.[9]

The IMO welcomes the announcement today that the CervicalCheck Screening programme is to reopen on a phased basis from July 6th, followed by BreastCheck, BowelScreen and the Diabetic Retina Screening Programmes in the Autumn. Public confidence is returning in our cancer screening

[9] Dexter L. J. et al., Strategies to increase influenza vaccination rates : outcomes of a nationwide cross-sectional survey of general practice, *BMJ Open* 2012;**2**:e000851 doi:10.1136/bmjopen-2011-000851

programmes and it is time to get these life-saving programmes back up and running. Our screening programmes can ensure that certain cancers are identified early, with better outcomes for patients and at reduced cost to the health system. Covid 19 has placed significant constraints on already under-resourced screening services. Urgent investment is need to ensure that diagnostic and treatment pathways are accessible for screened patients.

Investment is needed in prevention

- **Community medical staffing levels must be increased to maintain the quality and safety of child health and vaccination programmes;**
- **In preparation for the winter flu season, invest in the roll-out of a total population flu-vaccination programme in General Practice accompanied by a public education campaign to encourage older people and all healthcare workers to avail of the vaccine;**
- **Public confidence has returned in our screening programmes. Investment in diagnostics and treatment pathways are needed to support the full re-establishment of these life-saving programmes;**