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 |
| **Apr** | 10229 | 497 |
| **May** | 9015 | 1176 |
| **June** | 7392 | 2444 |

*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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