

# **Title: Update on Health System Preparedness for Covid-19**

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Action required:

- For noting
- For discussion
- For decision

Approved for future publication: **YES**

## 1. Summary

The emergence of Covid-19 worldwide and in Ireland has had a significant impact on the ongoing delivery of health and social care. Across primary, community, social and acute care, less non-Covid healthcare has been delivered in 2020 than in previous years. Worldwide, reduced utilisation of non-Covid health services is expected to be correlated with negative health outcomes in the immediate, medium and long-term.

Maximising the level of non-Covid care delivery in our services is therefore a key priority for the health system. The pandemic has required a substantial response to ensure protective measures are in place to support the provision of both Covid and non-Covid care. Within our long-term residential care facilities, structured supports and infection prevention and control measures have been stood up to protect both residents and healthcare workers.

The level of Covid-19 in the community will inevitably be a key determinant of the level of care that can be delivered across all settings, and of the associated risk to both healthcare workers and service users:

- Notwithstanding good infection prevention & control (IPC) practice, increased community transmission would be likely to drive outbreaks in hospitals and residential care facilities, resulting in closure of services where necessary
- Where outbreaks occur, these services are impacted by the loss of staff on Covid leave; other services are impacted due to the need to redeploy staff
- Any necessary redeployment of staff to respond to urgent Covid needs would impact the level of non-Covid care that can be delivered
- Significant numbers of Covid cases would lead to increased demand for primary and acute health services, displacing non-Covid care and potentially leading to an overwhelmed system in which quality care is not delivered and outcomes are poorer
- Irrespective of infection rates, services have had to be reconfigured to provide for the required physical distancing and IPC Covid requirements with an impact on levels of service available
- All health and social care services must be provided in a Covid context irrespective of the rate of transmission.

In managing and responding to an uncertain environment, the focus will be on continuing to deliver Covid and non-Covid care side by side, safely; on maximising the volume of non-Covid care and catch up where possible; and on embedding reform in the delivery of services. This will be supported by the significant investment in the health services in 2021. However, the reality is that the success of these efforts is inextricably linked to the levels of transmission of Covid in the community.

The six-week period of Level 5 restrictions is due to end on 1 December. In that context, this paper sets out a high-level summary of the current position on the delivery of health services, Covid and non-Covid, across the health system, to help inform NPHE's consideration of next steps. More detailed data is attached in appendices to this paper.

## **2. Primary Care Services**

### ***GP Services***

General practice has continued to operate during the public health emergency and GPs are still seeing patients in person where necessary and providing advice via telephone where appropriate. Data suggest that at the peak of the pandemic, patient contacts with GPs fell by up to 70%, although this trend has been reversed more recently, with figures for October suggesting an attendance rate of approximately 10% below the same period in 2019.

There have been 1.38 million claims through PCRS for Covid-related activity for the period March to October. This activity is in addition to the regular activity undertaken by GPs and clearly shows why so many GPs have been speaking publicly about the pressures that they continue to face in their surgeries. As with HSE-provided services, our GPs are under pressure and there is a limit to the resilience of their practices. Maintaining levels of service in hours and out of hours continues to be challenging.

### ***Community Assessment Hubs***

Under the agreed Model of Care for COVID-19, several local Health and Primary Care Centres were repurposed as Community Assessment Hubs. The hubs provide timely community based acute clinical assessment for COVID-19 positive patients (presumptive and confirmed) in their local area. They provide the clinical support to enable people to manage their symptoms safely at home, although, if necessary, the clinical team can facilitate the timely transfer of patients to either acute hospitals or community isolation units.

This allows GPs to focus on non-COVID care in a safer environment and minimises inappropriate attendance or admission to acute hospitals, reducing the risk of community transmission of COVID-19.

The development of Community Assessment Hubs is especially significant in terms of the primary care response to Covid. It is among numerous changes in work practices and the development of new methods of service delivery. These include the enhanced use of technology (including telehealth and assistive technology initiatives); greater integrated working across the sector; and developments of clinical, palliative care and infection prevention supports and infrastructure. There are currently eight Community Assessment Hubs open.

On a national level, hubs consistently have operated at far below their potential capacity, although in some regions, notably the Dublin area, the hubs served and continue to serve a greater number of clients. Hubs are staffed by the existing limited GP workforce, and thus at higher rates of transmission, will continue to put a strain on the delivery of wider GP services.

### ***Community Therapies***

The pandemic has led to unprecedented interruption to normal healthcare activity in the primary care setting, with disruption to service delivery and infrastructural development. Business Continuity Plans developed by the HSE as a framework for its organisational response resulted in a prioritisation of service delivery with services identified into four levels ranging from “must do/critical” to “lower priority/desirable”.

This response framework has meant that essential services for the most vulnerable were maintained, albeit sometimes at a reduced level of service. However, the pandemic has had and continues to have a significant impact on the delivery of more routine HSE primary care services and has exacerbated the challenges associated with historical underdevelopment of the sector in Ireland. More detailed data is set out at Appendix 1, but in summary, all NSP 2020 targets for therapy services are currently being missed and are categorised as red in HSE reporting on performance metrics.

The challenge facing primary care is two-fold. On the one hand, the need for IPC measures and social distancing has impacted on the capacity of the system to deliver services, particularly in terms of limiting the scope for group work. At the same time, service restoration is being hampered by staffing challenges, both in terms of staff absence and redeployment to the Covid response. In combination, these business and staffing capacity challenges have resulted in an unavoidable curtailment of core services across a range of disciplines, including OT, SLT, physiotherapy, audiology, optical, podiatry service and dental and orthodontic services.

The recruitment and development of a sustainable Covid-19 specific workforce is essential if frontline services in the primary sector are to be restored to maximum capacity. The recent recruitment campaign and onboarding of new staff in this respect is therefore very welcome although there is a need for continued oversight and monitoring in this area to ensure it has the desired impact.

Beyond the effects on clinical professionals, it is also worth noting that managerial and administrative staff in primary care are also supporting the Covid response, thus straining the ability of the system to manage demands relating to non-Covid care.

These impacts are a direct result of the challenge of responding to Covid as a disease, and any increase in transmission rates will heighten the pressures on primary care and reduce the capacity to deliver services to those who are waiting.

### ***Strategic Reform of Primary Care***

Budget 2021 has provided €150m in new development funding plus a further €30m in Sláintecare funding to implement a model of Enhanced Community Care. This funding will allow for the development of new pathways of care for primary health services and will enable delivery of enhanced care services across the country for those that need them. This funding is intended primarily to enable the long-term reform and development of the primary care sector in line with Sláintecare, but planned recruitment should also bolster the resilience of primary care in managing the competing demands of Covid and non-Covid care. Use of digital/telehealth technologies which were innovatively deployed during Covid as alternative means for provision of services will also contribute to enhanced capacity in 2021 and beyond.

### **3. Mental Health Services**

A number of measures have been taken to ensure that mental health services can operate within the context of Covid.

- In March 2020, the Department introduced legislation for mental health tribunals, which review involuntary detentions, for one-person tribunals to address clinical staff availability in Covid-19 and prevent infection. To date, no one-person tribunal has been held, although the legislation has been extended to 9 June 2021.

- The Mental Health Commission developed a Covid-19 risk monitoring and reporting framework for residential facilities. Data is collected and weekly reports provided to the Department and HSE. The Department, HSE and the Commission are establishing an oversight group to monitor developments to ensure a rapid response to issues as they arise.
- HSE has also increased capacity within the NGO sector and has facilitated a forum of community partners to ensure cross-sectoral shared learning, while Budget 2021 provides funding for a range of developments designed to enhance capacity in the sector.

Mental health services underwent a rapid reconfiguration in response to Covid-19 as face-to face consultations were scaled back and telehealth solutions and online supports were enhanced.

Currently, it is estimated that access to mental health services is between 85-90% of pre-Covid figures. Current challenges relate to the need to slightly reduce capacity in inpatient settings to allow for social distancing, and outbreaks of Covid in some approved centres which have affected admissions.

Overall, referrals and inpatient activity are in line with expectations for this time of year, although there is anecdotal evidence of increased acuity in services. This relates to self-harm and reports of increased rates of eating disorder in adolescents. It is likely that this trend will continue in 2021 leaving the HSE and mental health services with the challenge of addressing the mental health effects of 2020 even if a vaccine is successfully rolled out in 2021.

In relation to wider mental health impacts in society from the pandemic, trends, including for suicide and self-harm, are not showing any significant change compared to 2019 based on local and international data. This area continues to be monitored closely.

#### **4. Pre-hospital Emergency Care**

Since the beginning of the COVID outbreak, the National Ambulance Service (NAS) has met expanding residential and pop-up testing requirements, and will continue to provide this important function as part of the ongoing response to Covid-19. Normal activity has continued alongside this additional testing role. The NAS uses dynamic deployment of resources as part of ordinary care delivery, and this workforce flexibility, as well as enhanced IPC measures, has ensured that patients continue to receive a timely response. Throughout 2020 ordinary service delivery has been maintained, with over 1,000 emergency and urgent call outs and approximately 90 calls completed by the NAS Intermediate Care Service daily.

The NAS has expanded the use of alternative care pathways, including community paramedicine and a pilot “see and treat” pathfinder project, as an alternative to ED conveyance. The NAS reports that Community Paramedics have attended to approximately 1,900 patients to end October, avoiding approximately 1,650 unnecessary emergency transports to an ED. The pathfinder service attends circa 30 patients per month, and the NAS advises that non-conveyance has avoided 20 unnecessary emergency transports to an ED monthly.

#### **5. Acute Services**

As the pandemic continues, the acute sector continues to grapple with the need to provide necessary non-Covid services while at the same time responding to Covid itself and minimising risk to patients and healthcare workers. The position throughout the acute hospital system has been well documented for NPHET in previous papers, including the work undertaken to maintain provision of

time-critical care throughout the pandemic, and the impact on scheduled care generally, but these areas are reviewed more briefly below again.

### ***Cancer Care***

- While numbers attending Rapid Access Clinics (RACs) were down in March-July, data indicate that more urgent cases were being recognised at primary care stage and appropriately triaged. Currently, GP e-referral data indicates a recovery in referrals to RACs.
- Medical and radiation oncology capacity is affected by the need for physical distancing and infection prevention and control, and there has been an increased focus on providing chemotherapy outside of the acute hospital setting.
- Surgery is the area of greatest concern. Public patient cancer surgery numbers for the full year to June stand at 70% of 2019 levels. In the early period, many hospitals moved time sensitive and complex surgeries to private hospitals that had the required facilities and support services.
- Overall, the greatest threat to cancer services at this stage is the risk of staff contracting, or being in contact with, Covid-19, giving rise to absences by those staff and their contacts.

### ***Scheduled Care***

- As a result of the significant disruption in services, hospital waiting list figures are higher than at the start of the year. While there has been some recovery and increased activity from June onwards, it is anticipated that all waiting lists will be higher at the end of 2020 than they were at the end of 2019.
- The Department is currently working with the HSE and the NTPF to prepare the Access to Care Plan 2021 which will set out targets for waiting-list related care and seek to address the impact of the pandemic on scheduled care activity in the public sector.

### ***Unscheduled Care***

- The provision of unscheduled care has continued throughout the duration of the pandemic. However, a marked decrease in attendances was noted from late March 2020. Numbers recovered slowly from mid-June but were reducing again from late September.
- This attendance pattern, along with measures taken to reduce delayed transfer of care (DTC) cases and other initiatives to improve emergency care has led to an improvement in ED performance metrics. There is a concern that people who require healthcare may avoid or delay seeking it in EDs, which may lead to sub optimum outcomes for some patients. The Department and HSE are again providing reassurance to patients that it is safe to attend EDs.

### ***Impact of Outbreaks***

- Data show there were 51 “open” hospital outbreaks on 23 November across the country. These outbreaks are associated with 602 individual cases, 238 of whom are healthcare workers. There have been eight admissions to ICU and 30 deaths arising from those outbreaks.
- From the monitoring data provided by the HPSC, it is clear that the number of COVID-19 outbreaks in acute hospitals is increasing; this reflects higher rates of transmission in the community.
- Such outbreaks are particularly disruptive as staff diagnosed with Covid and staff deemed close contacts are unable to attend work, thus quickly and dramatically reducing capacity to deliver services. This was demonstrated recently in Naas, Letterkenny and Limerick and more recently in St Colmcille’s.

### ***Modelling Demand for Critical Care and General Acute Care Capacity***

- The IEMAG Service Demand Modelling Subgroup developed a Hospital Utilisation Planning model to assist with planning acute hospital capacity requirements during the outbreak. This model can generate estimates for numbers of Covid-19 cases per day and weekly average demand for critical care and general acute hospital beds based on a range of epidemiological scenarios.
- Currently the IEMAG is reporting the R0 as being between 0.7 and 0.9. The model suggests that if the country continued at this R0, there would be 10 patients in critical care beds and 50 patients in general acute beds by the end of January. However, in a scenario where the R0 were at 1.1 over the same period, there would be a requirement for 20 critical care beds and 150 general acute beds by the end of January. If the R0 were at 1.8 over this period, there would be a requirement for 610 critical care beds and 3,900 general acute beds.
- While these scenarios are illustrative only, they underscore the impact of a higher R0 on the system's ability to provide safe, high quality care to all who need it. As importantly, the figures highlight the critical importance of low levels of transmission in ensuring availability of acute hospital capacity for non-Covid care.

### ***Private Hospital Capacity***

- The provision of care in acute hospitals is further limited due to Covid-19 related restrictions for the safety of patients and staff. The HSE is therefore currently completing a procurement process to secure access to additional acute services and diagnostics from private providers.
- However, private hospitals are indicating that they are working almost to full capacity mainly to deal with the backlog of private work as a result of the earlier agreement to make available their full capacity to the HSE between March and the end of May.
- Discussions are also ongoing between the HSE and private hospitals with regard to a Safety Net arrangement.
- Despite these measures and the fact that the NTPF has recommenced arranging treatment for patients on acute hospital waiting lists, there will continue to be serious pressure on scheduled care waiting lists in 2021.

## **6. Influenza Surveillance**

There are concerns about the potential challenge to the health system in coming months arising from coincident circulation of Covid-19 during the period of anticipated seasonal influenza circulation. Internationally, in the European region, influenza activity has remained below inter-seasonal levels to date. The WHO has reported that despite continued or even increased testing for influenza in some countries, influenza activity remains at lower levels than expected for this time of the year.

HPSC surveillance data indicates no evidence to date of seasonal influenza activity in Ireland. This is extremely welcome, but at this point it cannot be assumed that such favourable circumstances will persist, and the risk of an influenza outbreak must remain part of consideration as public health guidance is framed for December and beyond.

## **7. Social Care Services**

The considerable impact of Covid-19 on services for older people and those with a disability, including long-term residential care, nursing homes, homecare and day services has been well described to NPHET over the course of the pandemic.

The pandemic has had, and continues to have, a substantial and challenging impact on their ability to live their lives as normal, with reduced opportunity for socialisation, restrictions on movement and visiting both at home and in residential care, and decreased access to day services are having consequences for physical and mental health as well as their wider quality of life through isolation and loss of independence.

Significant investment in social care services for 2021 including an additional 5 million homecare hours will enhance the supports in place. However, the protective infection prevention and control measures will continue to impact on capacity and access to services. A substantial structured response to support social care services to prevent and manage COVID-19 has been stood up.

### ***Long-term care facilities***

As the disease has progressed and new information emerged, a range of enhanced protective measures for long-term residential care settings, including nursing homes, recommended by NPHE on 31 March 2020 and 3 April 2020 continue to be implemented.

In particular, similar to other countries' experience, nursing homes have been significantly affected by Covid-19. In order to ensure learning from the first Covid-19 wave, and that the appropriate supports in place, on 19 August the Covid-19 Nursing Home Expert Panel's report was published. In addition to the range of measures in place significant work is ongoing in implementing the Panel's recommendations through the implementation structures established by the Minister, with a particular focus on the measures as requiring immediate and short-term focus.

The level of community transmission has led to several new COVID-19 outbreaks in nursing homes in October and November. Since 1 September, 71 new outbreaks have been opened (17 in September; 40 in October and 14 in November so far), across the 574 registered nursing homes. These outbreaks mean that there are additional burdens on nursing homes, their staff and residents to manage infection, prevention and control including increased visitor challenges. Nursing homes with outbreaks are closed to admissions which can impact on hospital capacity through delayed discharges. Of note, last week, the European Centre for Disease Control published its latest risk assessment with regard to long-term care facilities<sup>1</sup>. It reiterates that the probability of COVID-19 introduction into a long-term care facility depends on the level of COVID-19 circulation in the community, with a higher risk associated with higher incidence rates in the community. Therefore, suppressing the level of the virus in the community is one of the primary measures for protecting nursing homes and other long-term residential care services.

### ***Social Care Capacity***

- **Residential beds:** The additional infection, prevention and control requirements have reduced long-stay capacity. It is notable that the projected outturn for short-stay HSE beds this year is approximately 500 below target and the outturn for people supported through transitional care is projected to be 3,000 below target.
- **Homecare:** Homecare provision was repurposed to focus on those clients with most need in March, April and May to take account of public health measures. In addition, some service users

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<sup>1</sup> European Centre for Disease Prevention and Control. Increase in fatal cases of COVID-19 among long-term care facility residents in the EU/EEA and the UK. 19 November 2020. ECDC: Stockholm; 2020.

temporarily ceased their service to reduce their contacts. Reduced homecare hours were provided in April and May. The numbers of individuals in receipt of homecare have increased, and while they are now approaching 2020 target levels it is likely that 1 million fewer hours than anticipated will be delivered.

- **Day Services:** Day services for older people have not reopened since the start of the pandemic, given the difficulties in reopening the relevant centres in a way that complies with public health guidance, including the difficulties in ensuring safe transport to and from day services. Some alternative options are being provided, including in-home care and remote solutions. The HSE resumed disability day services in the autumn, but with reduced capacity due to social distancing, and the closure of off-site community activities in which participants would normally engage, putting pressure on day service hubs. Day services reopened in August and September at 38% capacity, with most service users attending for only part of the week. Approximately 5,000 day service users in residential care now receive support in their homes.
- **Children's Disability Services:** services were stepped down and repurposed. services continued to be provided on the phone/online and also, face to face for some children and families with high prioritised needs. The HSE and its funded disability partners continue to provide therapeutic supports to children with disabilities in line with public health guidance having regard to the availability of resources.
- **Respite Services:** A number of Respite Centres continued to operate during the pandemic, albeit at a reduced capacity while others were temporarily re-purposed as isolation facilities. Family Carers Ireland published a report in June 2020 entitled 'The state of caring 2020' which looked at the impact which COVID-19, and in particular the lockdown, had on carers. Many of these carers highlighted the need for respite and emotional support given that they felt their caring role had intensified to such a degree as to become unmanageable.

## 8. Infection Prevention and Control

Covid-19 has resulted in a very significant increased requirement for infection prevention and control (IPC) capacity across the health system. In recognition of the fact that IPC practices are of critical importance to protect the functioning of healthcare services and a key enabler for the delivery of safe Covid and non-Covid care, significant additional funding is being provided in 2020 and 2021 to enhance the health service's IPC responses in an integrated way across acute and community services.

Funding of €3.9m was allocated for IPC in August and the HSE has advised that all approvals for new posts and for minor capital works have issued. Hospital Groups are identifying the hospitals for each new post and progressing the necessary recruitment. The capital projects to upgrade equipment and facilities are advancing in association with HSE Estates.

It is also recognised that there is a need to incrementally build IPC capacity in a co-ordinated manner over the coming years, and, in that context, Budget 2021 provided additional development funding of €7m for comprehensive integrated IPC developments across acute and community services. This investment will facilitate the expansion of the National Antimicrobial Resistance and Infection Control Team, the extension of infection surveillance, as well as further increased integrated capacity across services.

## 9. Staffing

In the year to date, staffing has increased across the services by 4%, or 4,751 whole time equivalents. These increases have been spread across all staff categories, with the largest percentage increases in

medical and dental, following by health and social care professionals. The increase is directly related to the expansion in the workforce in response to the pandemic and will support the service in the context of pressures arising where Covid has impacted staff availability due to sick leave and/or self-isolation.

The HSE's Winter Plan and Budget 2021 set out plans to increase the workforce by an additional 12,523 WTEs. The detail of actual staffing requirements against the service developments and increased capacity requirements will be outlined as part of the NSP. The resourcing strategy employs a range of approaches to increase the workforce, including a blended approach of national and local recruitment, utilisation of external agencies to expand recruitment capacity, international recruitment along with a managed service provider.

Nursing and Midwifery accounts for 23% of all health care worker COVID 19 cases. In disability services 55% of cases COVID-19 cases have been staff, while there have been 975 detected cases of COVID-19 in staff in Nursing Homes from 6 May 2020 to 16 November 2020. The Serial Testing of Healthcare Workers in Nursing homes Programme commenced on 23 June and provides a structured approach to regular monitoring and early detection.

Given the implications of increased COVID-19 infection amongst healthcare workers (HCWs), there is an urgent need to determine the hospital settings and the HCWs with highest risk for COVID-19 infection, transmission and acquisition, in order to ensure that adequate measures are in place to mitigate and address any risks. This work is underway within the HSE.

The experience of the last number of months has been very challenging for staff. The ongoing pressures and demands have placed extraordinary strain on staff for a prolonged period of time. As we approach winter and the ongoing reality of Covid, the HSE is examining the supports and actions that can be put in place to provide appropriate support in these times. Already services such as occupational health and HR are providing a lot of support to staff. The wider issues will be considered and addressed further in the Service Plan for 2021.

## **10. Indirect Impact of COVID-19 on Population Health and Wellbeing**

The importance of examining the indirect impact of Covid-19 on the totality of population health and non-Covid healthcare is well recognised, and the Department is currently working on the development of an indicator framework for the continuous monitoring and reporting of such indirect effects.

Although some high level indicators are available to describe the acute impact of the pandemic on health outcomes (e.g. excess mortality), it is to be expected that other outcome measures may only demonstrate significant changes at a later date, as the full health cost of a reduction in service provision in 2020 may take months or even years to manifest.

In the interim the monitoring of health service activity may serve as a proxy measure of the impact on the health of the population, with reduced utilisation expected to be correlated with negative health outcomes in the acute, medium and long-term.

The data highlight how much ground is already to be made up in the delivery of non-Covid services and reinforces the importance of maintaining restrictions where appropriate to control the virus and allow the health system to address both Covid and non-Covid care in as balanced and structured a manner as possible.

## **11. Investment to support reform in Budget 2021**

The budget settlement for the Health Vote had a central focus on the imperative to protect and restore core health services, provide for the ongoing direct costs associated with Covid-19 and enhance the capacity and resilience of the health service in 2021. Budget 2021 provides for a net-non-capital expenditure of €20,371m, an increase of €3,534m (21%) over the original amounts provided in the 2020 budget.

Covid-19 has highlighted the key capacity challenges in our health system and the unprecedented level of investment for 2021 is being targeted to support the resilience and preparedness of the health service, to increase capacity, in line with the recommendations of the 2018 Health Service Capacity Review and to accelerate the Sláintecare vision and the “shift left” in delivery of medical services in primary and community care settings, where appropriate, rather than acute settings.

Some specific areas of investment have been highlighted above. More generally, some key initiatives funded in 2021 which are focused on reducing pressure on our acute hospitals include €150m for the rollout of Community Health Networks and the national rollout of successful pilots such as integrated care pathways for older persons and chronic disease management, €125m for community beds including 600 new rehab beds, €25m for GP access to diagnostics, €5m for additional mental health step down beds, €210m to fund Access to Care initiatives and €35m for restart measures in acute hospitals. As the investment supports recruitment of a very significant number of staff, it will take time for the resulting increase in capacity to be realised.

## **12. Conclusion**

It is clear from the above summary and the data presented below that Covid has presented an unprecedented challenge to the operation of the health system across all services. Moreover, this challenge has presented itself in a myriad of ways, including business capacity, staff capacity, delivery models, infection prevention and control, staff safety and so on. The system and those who work within it are at the edge of their resilience. The priority must be to maximise the provision of services across all areas of service need, in order to support attainment of the best possible outcomes across the population in the short, medium and long term.

ENDS

## Appendix 1

### Covid-19 and HSE Primary Care Services

Although essential services have been maintained in so far as possible, the number of service users seen across Primary Care Services has fallen:

- 29,680 users have been seen in **Primary Care Psychology** at end of September, compared to 33,924 seen in the same period last year, a decrease of 12.5%.
- **Speech and Language Therapy** (SLT) demonstrates a similarly concerning situation, with total number of patients seen being 46% below the target for the year to date with 114,978 patients seen.
- **Occupational Therapy** exhibits the same impact on services where the total number of patients seen is 24.4% below the target for the year with 220,927 seen to date.
- **Physiotherapy** continues this trend with the total number of patients seen being 31.6% below the target for the year with 301,097 patients seen.

Given these trends, waiting lists have continued to grow, with the numbers of those waiting over a year for an appointment being exacerbated by the pandemic. The numbers of “long waiters” across the therapy services are as follows;

- Assessment:
  - 8,669 waiting over a year for **Physiotherapy** assessment – up **5,797** on SPLY.
  - 13,491 waiting over a year for **OT** assessment – up **4,195** on SPLY.
  - 3,651 waiting over a year for **SLT** assessment – up **2,258** on SPLY.
- Treatment:
  - 4,243 waiting over a year for **SLT** treatment – up **3,195** on SPLY.
  - 4,769 waiting over a year for **Psychology** treatment – up **2,133** on SPLY.

A total of 6,929 CAH (from referrals of 8,718) appointments have been offered in the period 16<sup>th</sup> April to November 20<sup>th</sup>, while the actual number of appointments attended was 6,829. The majority of those who attended an appointment returned to their own homes to self-manage symptoms.

The 454 appointments scheduled to date in the month of November is significantly lower than the 963 appointments scheduled in October and, moreover, than the 1,645 appointments in May.

## Appendix 2

### Covid-19 and Acute Hospital Activity

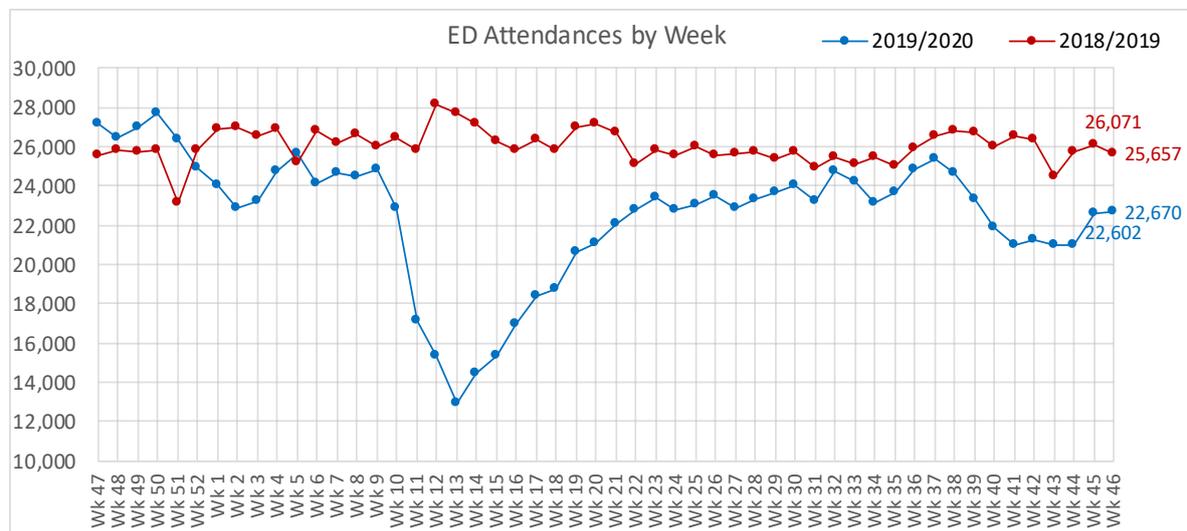
#### Unscheduled Care Performance

There were 395 in-patient beds available on 23 November. It should be noted that **five** sites account for over 50% of this capacity. There were 441 beds reported closed/blocked on 23 November. The numbers of reported Delayed Transfers of Care is 371.

**Table 1: ED Attendances**

There was an increase in the number of patients attending EDs for Week 46 of 68 (0.3%) since the previous week, and a decrease of 2,987 (-11.6%) compared to the same week last year.

<b>Attendances 2020 Wk. 46:</b>	22,670	<b>Attendances 2020 Wk. 45:</b>	22,602
<b>Attendances 2019 Wk. 46:</b>	25,657		

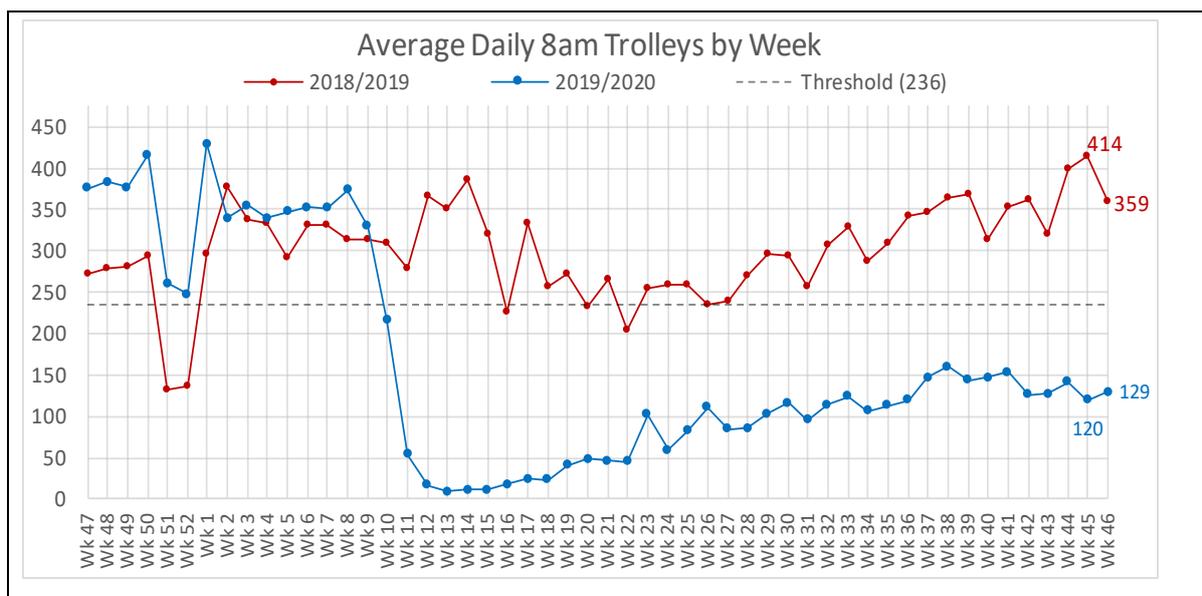


**Table 2: National daily average trolleys**

The daily average number of patients on trolleys for Week 46 was 129, compared to 120 (+7.7%) for the previous week, and 359 (-64.0%) for the same week last year.

<b>Average 2020 Wk. 46</b>	129	<b>Average 2019 Wk. 46</b>	359
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A table of daily average trolleys by site compared to last week and last year is appended in Table 2.



- Attendance patterns can change quite quickly, particularly in the winter especially if there is an outbreak of flu or other infectious diseases. It should not be assumed that ED attendances and consequently trolley numbers will remain below expected levels based on previous years due to Covid. This can be seen in the graph in table 1 where attendances have fluctuated in recent months and would be expected to increase further over the Winter period to end March 2021.
- Improved performance nationally masks some sites that have consistently high numbers of patients on trolleys. Eight sites were over the TrolleyGAR red threshold on more than 11 occasions in September and 4 of these were over the threshold on more than 20 days. This includes Cork University Hospital and Limerick University Hospital. Other sites including Letterkenny and Naas have come under severe pressure due to Covid outbreaks and had to cancel elective surgery to manage.
- Sustained, continuous improvement in ED performance is dependent on implementation of the Winter Plan and Budget 2021 initiatives. This is dependent on recruitment of appropriate staff, procurement of IT systems, delivery of physical infrastructure, developing new integrated ways of working and appropriate leadership and governance arrangements.

### **Scheduled Care Performance**

- In response to the Covid-19 pandemic the HSE, in line with the recommendations of NPHE, had to take measures to defer most scheduled care activity in March, April, and May of this year. This was to ensure patient safety and that all appropriate resources were made available for Covid-19 related activity and time-critical essential work.
- Scheduled care activity was significantly impacted by this necessary decision with most routine elective care appointments and procedures deferred in March, April, and May.
- As a result of the significant disruption in services, hospital waiting list figures are higher than at the start of the year, with the Inpatient / Daycase waiting list 12% higher than at the start of January, the Outpatient waiting list 11% higher, and GI Scopes 53% higher.

- The resumption of services from June onwards has however allowed for increased activity, with the HSE utilising innovative methods including telemedicine to facilitate patient appointments. As a result, the rate of growth in the Outpatient waiting list has been slowed in recent months.
- The numbers of patients awaiting an inpatient or daycase procedure has continued to decrease in the last five months and has reduced by 14% since May 2020. There has also been a slight decline in the GI scopes waiting list since July. Notwithstanding this, it is projected that the IPDC and OPD waiting lists will be 11% higher and the GI scopes waiting list 59% higher at the end of 2020 than at the end of 2019.
- An additional €240 million has been provided in Budget 2021 for an Access to Care Fund, €210m of which will be allocated as required to the HSE and €3 m to the National Treatment Purchase Fund for the provision of treatment in both private and public hospitals in order to address capacity issues in acute hospitals and waiting lists.
- The Department is currently working with the HSE and the NTPF to prepare the Access to Care Plan 2021 which will set out targets for waiting-list related care and seek to address the impact of COVID-19 in 2021 in terms of lost scheduled care activity in the public sector.

### **Cancer Care**

- RACs have continued to operate throughout the Covid-19 period. Patients are being triaged in advance of their appointments, including through utilising virtual/telephone clinics where appropriate. Numbers were down in the March-July period. September attendance figures show breast and lung numbers above the average monthly figures in 2019, with prostate slightly less than last year's rate. In the year to end September, attendance numbers stand at 81% of the numbers attending RACs in 2019.
- Cancers diagnosed in RACs to end July stood at 2,682 - 88% of the comparable figure in 2019. As attendances were at approx. 76% at that time, this would most likely indicate that more urgent cases were being recognised at Primary Care stage and appropriately triaged.
- The number of new patients commencing chemotherapy up to June 2020 is at 88% of 2019 activity. There has been an increased focus on providing chemotherapy outside of the acute hospital setting.
- The number of day case Radiotherapy Sessions (patients would have multiple sessions) to end June is at 84% of 2019 activity, while the number of patients completing treatment to end August is at 97%. Public patient cancer surgery numbers for the full year to June stand at 70% of 2019 levels. In June, the breakdown of public patient provision was approx 50% in public hospitals and 20% in private hospitals. There is a significant time lag in getting information on cancer surgeries, and data on private hospital activity is inadequate. Surgery would be the area of most concern in relation to cancer.

## **Appendix 3**

### **Covid-19 and Social Care Services**

The scope of long-term residential care (LTRC) covers older people, disability and mental health residential care settings. LTRCs provide long term care and short stay, transitional care and respite support either through the State, section 38s and section 39s or privately. All these facilities are registered with either HIQA or the Mental Health Commission for quality and adherence to standards for the sector. The impact of COVID-19 is also apparent in other older persons and disability services, particularly in the community.

The impact of COVID-19 on vulnerable service users, including those over 65 as well as those living in congregated settings and those who are reliant on day services has been considerable. The pandemic has had, and continues to have, a substantial and challenging impact on their ability to live their lives as normal, with the restrictions on visiting and the removal of day services having well-reported consequences for mental health and quality of life.

As the disease has progressed and new information emerged, a range of enhanced measures for long-term residential care settings, including nursing homes, recommended by NPHET on 31st March 2020 and 3rd April 2020 continue to be implemented. At local level, HSE outbreak control teams are managing the public health led response. The State's responsibility to respond to the public health emergency created the need for the HSE to set up a structured support system in line with NPHET recommendations. This has been a critical intervention in supporting the resilience of the residential care sector in meeting the unprecedented challenges associated with COVID-19. Ongoing supports include:

- Enhanced HSE engagement;
- Temporary HSE governance arrangements for some non-public nursing homes;
- Multidisciplinary clinical supports at CHO level through 23 COVID-19 Response Teams;
- Access to supply lines for PPE, medical oxygen etc.
- Serial testing of all staff in nursing
- Access to staff from community and acute hospitals – from an early stage the HSE mobilised considerable staff resources
- Suite of focused long-term residential care (LTRC) guidance;
- Temporary financial support scheme for private and voluntary nursing homes (€92.5m 2020; €42m 2021);
- Temporary accommodation to nursing home staff;
- HIQA COVID-19 quality assurance regulatory framework.

#### **COVID-19 Nursing Homes Expert Panel**

On 19 August the COVID-19 Nursing Home Expert Panel's report was published. The Panel, formed in May 2020 on foot of a NPHET recommendation, was established to examine emerging best practice and recommendations to ensure that all protective COVID-19 public health and other measures to safeguard nursing home residents are planned and in place to respond to the ongoing impact of the COVID-19 pandemic over the next 6-18 months.

The Panel makes a substantial package of recommendations having regard to the real-time learnings and, what is felt, is required to ensure ongoing protection and support for nursing homes residents. The COVID-19 Nursing Home Expert Panel report has added further to our knowledge and learning. The Panel’s report clearly outlines the key protective measures that we must ensure are in place across our nursing homes. These actions are based on learning from our own and the international experience of COVID-19 to date.

**Serial Staff Testing Programme – Nursing Homes**

The below table represents a breakdown of detected cases between Staff and Residents in Nursing Homes, from 6<sup>th</sup> of May 2020 to 16<sup>th</sup> of November 2020.

The Serial Testing of Healthcare Workers in Nursing homes commenced on 23<sup>rd</sup> of June and therefore the below data sample includes any testing of healthcare workers before the commencement of this programme.

Health Care Worker or Resident	Number tested with a Detected Result	Number tested with a Not Detected Result	Total Tested
Health Care Worker	975	292,974	293,949
Residents	593	13,230	13,823
<b>Total</b>	<b>1,568</b>	<b>306,204</b>	<b>307,772</b>

A Breakdown of Detected Cases by Private and Public Nursing Homes and HCW Staff vs. Resident’s is provided below.

NH Type	Healthcare worker	Resident/non-HCW	Grand Total
Private	791	531	1322
Public	184	62	246
<b>Total</b>	<b>975</b>	<b>593</b>	<b>1568</b>

Source: HPSC – Serial testing programme nursing home sta

**Current epidemiological position – Nursing Homes**

Public Health Data HPSC	
Nursing Homes	
	#
# Clusters in nursing homes up to midnight 21/11/2020	348
of which are OPEN	48
of which are CLOSED	300

# OPENED in the last week	5
# of deaths in nursing homes linked to NH outbreaks in last 7 days	14
# of deaths in nursing homes linked to NH outbreaks (up to 20/11/2020)	1,082
# of cases in nursing homes linked to NH outbreaks (up to 22/11/2020)	7,519
# of hospitalisations from nursing homes linked to NH outbreaks (up to 22/11/2020)	531 <sup>2</sup>

**Current epidemiological position – Disability residential care services**

HPSC reports data relating to disability status where the person was living in disability residential care or the notification was linked to an outbreak in another disability facility such as a day service. The below table represents a breakdown of detected cases in disability services as of midnight 21<sup>st</sup> November.

<b>Up to midnight on</b>	<b>21 November</b>
Cumulative total outbreaks	153
Of which closed outbreaks	128 (84%)
Open outbreaks	25
Cumulative lab confirmed	783
Cumulative deaths in residential centres	15*

\*In addition one death related to a person receiving home care disability support has been reported

While there are limits on the data on the breakdown of disability outbreak cases between staff and service users, figures suggest that around 54% of these cases have been staff, and 46% have been service users.

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<sup>2</sup> including all case classifications – possible, probable and confirmed

## Appendix 4

### Healthcare Workforce

- There are 124,568 WTEs, equating to 142,740 personnel (30 Sept 2020) directly employed in the provision of health and social care Services by the HSE and the various Section 38 organisations.
- Overall, Year to Date (YTD) staffing has increased by 4,751 WTE (+4%), equating to an increase of 4,970 personnel. All staff categories have increased YTD with the largest percentage staff category increase in medical and dental, (+8.7%) followed by health and social care professionals (+4.1%).
- This year's increase is directly related to the expansion in the workforce in response to the national pandemic COVID-19, with 4,292WTE increase since February 2020.
- In September 2020 the Winter Plan and Budget 2021 set out the plan to increase the workforce by an additional 12,523 WTE (see table below). The detail of actual staffing requirements against the service developments and increased capacity requirements will be outlined in the resourcing strategy as part of the NSP.
- The estimated recruitment profile by staff category and month will underpin recruitment performance measurement. The resourcing strategy has commenced and employs a range of approaches to increase the workforce, including a blended approach of national and local recruitment, utilisation of external agencies to expand recruitment capacity, international recruitment along with a managed service provider.

Winter Plan Staff Category	Oct	Nov	Dec	2020 Total	2021					2021 Total	Grand Total
				Jan	Feb	Mar	Apr				
Medical & Dental	276	49	54	379	356	16	21	-	1	392	772
Nursing & Midwifery	651	175	96	921	879	102	362	102		1,446	2,367
Health & Social Care Professionals	678	149	54	880	573	81	95	258		1,007	1,888
Management & Administrative	1,214	396	39	1,649	374	170	83	10		636	2,285
Patient & Client Care/General Support/Other	642	293	222	1,157	2,332	785	745	194		4,055	5,211
<b>Grand Total</b>	<b>3,461</b>	<b>1,062</b>	<b>464</b>	<b>4,987</b>	<b>4,515</b>	<b>1,154</b>	<b>1,305</b>	<b>563</b>		<b>7,536</b>	<b>12,523</b>