Title: Update on Acute Hospital and Primary Care Preparedness for COVID-19

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Action required:
☒ For noting
☐ For discussion
☐ For decision

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Summary

The emergence of COVID-19 worldwide and in Ireland had a significant impact on the ongoing delivery of health and social care during 2020. As 2021 begins Ireland, like much of Europe, is experiencing a dramatic and extremely worrying rise in cases. Case numbers are now extremely high, with 39,005 new cases seen in the 14 days up to 6 January. This has inevitably impacted across all settings of our health system.

It is acknowledged that the level of COVID-19 in the community is a key determinant of the level of healthcare that can be delivered and of the associated risk to patients, service users and healthcare workers. The effect of the widespread level of the virus has now resulted in significant impact on the delivery of non-COVID care including the deferment of all but essential time-critical elective care in our hospitals and pausing/reduction of some community services in order to meet the highest priority needs in residential, community and home delivered services. The situation across all settings is continuing to deteriorate in line with growing case numbers.

- As of 2pm on 6 January, there were 954 patients with COVID-19 in hospital, an increase of almost 500 when compared to the previous week (30 December). Of those 954, 105 had been diagnosed within the previous 24 hours, with a further 200 patients awaiting test results.
- As of 2pm on 6 January, there are 87 patients in intensive care. This compares to 39 patients just seven days earlier on the 30 December.
- On 2 January, the HSE issued correspondence to the acute hospital system recommending that only critical time-dependent elective procedures are undertaken due to the on-going and significant increased demand for bed capacity related to COVID-19.
- Data provided by the HPSC indicates that there were 78 open hospital outbreaks in hospitals on 5 January, comprising 1,099 cases, including 493 cases in healthcare workers. A total of 81 deaths have been associated with these open outbreaks.
- It is clear now that the situation in our acute hospital system is one of extreme pressure. The further increases in the numbers of patients hospitalised with COVID-19, which are expected to be seen in the coming days, will further reduce the ability of our hospitals to provide safe, high-quality care. Such a scenario presents a significant risk to both patients and staff, who have been working in extremely challenging circumstances for some time now.

Similarly, primary care services are coming under increasing pressure as they try to operate in an environment with widespread transmission and prioritisation of service delivery is taking place, particularly in some geographic locations with higher levels of community transmission and outbreaks. The service impacts of open outbreaks in long term residential facilities (131 reported as of 6 January) are most visible in availability of staff and are impacting on other care areas, with nursing staff being redeployed from primary care services.

Additional information in relation to the current status of the health system, the impact of the ongoing increase in COVID-19 cases, and mitigation measures, is set out below.
1. Escalation in COVID-19 Confirmed Cases

Data provided by the HSE confirm that growth in cases of COVID-19 has accelerated significantly (albeit skewed somewhat by reporting constraints). As of Wednesday 6 January 2021, the total number of confirmed cases to date is 121,154.

The 14-day moving average of daily confirmed cases has moved from 381 on the 20th December to 712 on the 27th December to 2293 on 5th January, a six-fold increase of the average daily case rate.

2. COVID-19 Confirmed Cases in Acute Hospitals

The total number of confirmed, hospitalised cases at 2pm on 6 January is 954. The previous highest level of admitted COVID-19 cases in hospitals occurred on 13th April when there were 879 COVID-19 patients. The previous highest one-day total of admissions occurred on 4th April when 112 COVID-19 patients were admitted. The total number of available general acute beds as at 2pm on 6 January is reported by the HSE to be 380.

3. Critical Care Capacity and Occupancy

As of 6 January at 2pm, there were 278 adult critical care beds available and staffed. 258 of these were occupied including 87 COVID-19 patients. This number of COVID-19 patients has not been seen in ICU since the first wave of the pandemic – on 11 April there were 156 COVID-19 patients in ICU with 286 beds occupied (NOCA data). While we are at over half that figure now of COVID patients, the figures indicate 180 non-COVID patients in ICU now compared with 130 on 11 April.

Clinical risk profiling of critical care capacity based on available competent critical care staff and appropriate space and equipment allows the identification of manageable or unacceptable clinical risk service planning scenarios. HSE has advised that surge capacity up to around 350 (Surge 1) is possible while maintaining clinical risk at an acceptable level. Beyond this level, there is unacceptable clinical risk and the advice is that standards of care cannot be maintained with resulting impact on patient outcomes.

If the number of COVID-19 patients in ICU continues to rise at the rate it has done in recent days (48 additional patients over the course of one week), critical care services could shortly be overwhelmed.

Measures to increase base and surge critical care capacity

- There has been significant investment in critical care over the past nine months, with current bed capacity of 280-285 beds up from the 255 beds available in January 2020 (as reported by the Critical Care Bed Capacity Census).
- Further investment of €52m was provided in Budget 2021 for critical care development, and the focus is on ensuring that additional permanent beds are brought onstream in line with funding allocations as soon as possible. The HSE anticipates that the baseline will increase to 301 beds by the end of Q1 2021; recruitment is ongoing.
- The capacity of the critical care system has also been bolstered since the beginning of the pandemic by training over 1,500 nursing staff to allow them to provide support to critical care as required in circumstances where there are not enough fully trained critical care nurses to support the service; and identification of additional ICU and ventilation spaces and procurement of additional ventilators to meet requirements. As part of these efforts, around 950 ventilator units have been procured.
- Upgrades in oxygen delivery capacity have been complete at sites with critical supplies and oxygen telemetry is being rolled out at 30 of the acute hospitals
- COVID and non-COVID pathways are being delivered at all acute sites, with all admissions scheduled and unscheduled, being risk assessed and testing required.
- The intensive care capacity of the public health system can also be supported by the private health sector, and the HSE continues to negotiate with private hospitals. However, additional ICU capacity in the private sector is relatively modest, estimated at approximately 44 beds.
4. Presentations in Primary Care

GP Services

GPs are under pressure and this is likely to intensify in the coming days and weeks as more people present with symptoms. HSE advise that the number of calls to GP Out of Hours Services increased significantly over the first weekend in January, and this will inevitably impact on services over the coming days as GPs return to regular practice hours. GP practices and Out of Hours Service have advised that they are seeing significant increased numbers of call requesting a test referral; latest data show that there were just over 45,000 GP referrals for COVID-19 testing over the two days 4 and 5 January.

Community Assessment Hubs

Community Assessment 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.

Up to the week ending 3 January, there was little evidence of significant increase in the numbers attending the CAHs, with 232 scheduled appointments across the eight hubs that are currently open. This represents an average of just over 33 per hub. This may have been partly due to the general reduction in presentations over the festive period or may also reflect the fact that the majority of people have generally been able to manage their symptoms at home while more serious cases have required hospitalisation. However, over the last two days (4-5 January), CAHs have seen 240 patients which is a significant increase.

There remain challenges in resourcing the CAHs, in context of GP availability and redeployment of nursing staff to outbreaks in residential care facilities or COVID vaccination. The HSE continues to keep the utilisation of the hubs under review, including engagement with local GP Liaison leads, and will expand the network of hubs if necessary.

5. Impact on Non-Covid Care

Cancer Services

With lower levels of activity scheduled across the Christmas period, the NCCP advises that the impact of the large increase in COVID-19 cases on cancer services has not been severe to date. The single biggest concern at this point is the possible loss of staff from cancer services due to COVID-19 infection or due to isolation requirements as a result of close contact with a confirmed case of COVID-19.

Cancer diagnostics

While there was a reduction in referrals received from GPs in the early part of the COVID-19 pandemic, GP e-referral data showed a recovery in referrals to cancer rapid access clinics (RACs). The trend continued and there was no drop off in e-referrals to RACs during the period of Level 5 restrictions in October/November. Patients are being triaged in advance of their appointments, including through utilising virtual/telephone clinics where appropriate. The continued availability of endoscopy and biopsy services are a vital element in supporting diagnostic clinics.

Typically, attendance numbers are low across the Christmas period and any impact of the current situation will only start to become clear later this week. Services remain available but it is not yet clear if the reluctance of patients to attend hospitals previously seen in March-May 2020 will recur; the NCCP is focused on ensuring every effort will be made to avoid this.

Surgical Oncology

Continuation of required cancer surgeries will be challenging with the increasing pressures on ICU and HDU capacity. As previously, urgent surgery will be prioritised and there is an emphasis on maintaining
safe patient pathways for this. Private hospital capacity will most likely be needed to deal with cancer surgery.

Radiation Oncology

Radiation oncology services are continuing, but sick leave is currently impacting on the Dublin (SLRON) service. Some access to private capacity will therefore be important.

Demand is linked to the level of surgeries and therefore, any reduction in the level of cancer surgery will result in falling demand for radiation oncology. Radiation oncology units are accommodated in buildings that are largely separate from other hospital services, which may reassure patients who are nervous about presenting to hospitals in the current climate.

Medical Oncology

Services continue in all 26 hospitals and guidance has issued to clinicians regarding the provision of Systemic Anti-Cancer Therapy (SACT). This includes details on treating cancer patients with COVID-19, or with potential COVID-19.

Oncology/Haematology SACT day ward planning includes provision for relocation of day wards where necessary. Some impacts are likely due to restrictions in hospitals and the nature of the treatment areas involved. Some minor capital works have been planned, to improve access and service to patients, although it’s likely this work will need to be re-evaluated in the context of the current surge.

The potential to move services to private hospitals again is being considered but overall, a combination of hospital, community and home care is likely to see patients’ needs being met.

Renal Services

COVID-19 infection causes some form of kidney injury in 40% of patients who present to hospital. Patients with COVID-19 infection admitted to an intensive care unit require acute dialysis support in approximately 15% of cases. Not all recover kidney function. There is a clinical imperative to maintain hospital-based dialysis capacity to treat these patients as they require enhanced isolation and HSE-contracted satellite dialysis service provision has therefore been expanded.

Patients on in-centre haemodialysis are between five and 10 times more likely to acquire COVID-19 infection (and 5 to 10 times more likely to die) compared to people on home dialysis therapy. Where possible patients are facilitated in choosing home dialysis therapy as it is associated with a much lower risk of patient death (noting that not all patients are medically suitable for home dialysis therapy).

Outreach

Acute hospitals are providing outreach and increased off-site treatment for vulnerable groups including home infusion therapies and for patients with severe debilitating chronic neurological conditions including the commencement of non-invasive ventilation in the home. In addition, outreach has been provided to support at risk nursing homes.

Deferral of Non-urgent Scheduled care

On 2nd January 2021, the HSE advised Hospital Groups of the need to curtail non-urgent scheduled care. This decision was made arising from the rapid increase in COVID-19 admissions and the projected trend in admissions based upon community transmission levels of the virus.

The HSE recommends that only critical time-dependent scheduled procedures are undertaken due to the on-going and significant increased demand for bed capacity related to COVID-19. The HSE has confirmed that this position can be reviewed weekly throughout January but has also cautioned that further escalation actions may be required in the coming days and weeks.

Primary Care Therapy Services

HSE Community Therapists are continuing to deliver as many services as possible to those that need them, utilising telehealth and virtual consultations where possible. Nonetheless, given the current
pressures on wider community system, some staff will have to be redeployed to support Covid related absences largely associated with residential outbreaks.

This pressure means that in the short-term, primary care is likely to underperform against NSP targets and there will continue to be upward pressure on waiting lists notwithstanding the potential for the significant investment announced in Budget 2021 to have a positive impact in the second half of the year.

The previously utilised Community Service Continuity Planning Framework is being updated to report on expected impact on paused/reduced services across all areas including primary care. Decisions on reductions in service in this wave will be made based on risk assessments and in the context of improved IPC practice, availability of PPE and virtual clinics.

National Ambulance Service

The NAS has advised that 68% of ECHO (life-threatening cardiac and respiratory) calls nationally being responded to within 18 minutes; this compares to 75% of calls in October. A similar decline in performance has been seen in DELTA (other life threatening calls), with 47% of calls being attended within 18 minutes compared to 55% of calls in October; lengthy turnaround times at Emergency Departments and staff absences are reported to be influencing factors in this regard. Approximately 100 of the 1,600 NAS clinical workforce are currently on sick leave; this is close to absence levels seen in November.

6. Surge Plans

Surge plans are in place across Hospitals Groups and individual hospitals, have been reviewed in the last 2 weeks and are being activated as required; as noted above, the system is already curtailing non-urgent work on inpatient and daycase and OPD services.

Acute hospital oxygen groups are meeting to ensure good communication and understanding of the challenges of delivering supplementary oxygen to large numbers of patients and in particular with the use of high flow nasal oxygen devices.

Medical devices are ensuring that mechanisms are in place for the rapid deployment of additional equipment if required.

Critical care surge plans will also generally entail redeployment of staff from other areas of the hospital to ICU, and utilisation of physical space beyond the walls of the ICU including theatre space, with associated consequential effects on non-COVID services.

The NAS surge plan has not yet been activated in response to the latest surge in COVID-positive numbers, although the NAS has reduced its activity in terms of inter-hospital transfers and private ambulance providers have been used by acute hospitals to support the service in this case. It can be noted also that the NAS currently has 6 pop-up testing teams available to support CHO testing requirements; three of these teams were operating in Limerick as of 3rd January.

7. Private Hospital Capacity

Governance and Performance Division has advised that, following termination of the original private hospital agreement in June, the Government mandated the HSE to seek to agree with the private hospitals a new arrangement which would provide the HSE with access to private hospital capacity to include a safety net arrangement for any further surge of Covid-19 cases. Following engagement with individual private hospitals and hospital groups the HSE set out the principles underpinning the proposed agreement and a Service Level Agreement has been issued to each of the private hospitals/private hospital groups. A Memorandum has now been submitted to Government seeking its approval to the HSE agreeing the arrangements with the individual private hospitals or private hospital groups.

The Service Level Agreement reflects lessons from the original private hospital agreement which was in place in April, May and June of last year. An overarching agreement will last for 12 months. The
HSE can invoke the arrangement within that period if one or more of the metrics set out below are triggered.

<table>
<thead>
<tr>
<th>Trigger Metrics</th>
<th>Phase 1 Surge</th>
<th>Phase 2 Surge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical indicator of COVID-19 transmission</td>
<td>14 day Clinical incidence &gt; 150, R value &gt; 1</td>
<td>14 day Clinical incidence &gt; 200, R value &gt; 1</td>
</tr>
<tr>
<td>COVID-19 hospital beds occupied (confirmed plus suspected cases)</td>
<td>&gt;825, &lt;1100</td>
<td>&gt;1100</td>
</tr>
<tr>
<td>COVID-19 ICU occupancy</td>
<td>130-160</td>
<td>160+</td>
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</tbody>
</table>

It is envisaged that the HSE could access between 15%-30% of the capacity of the participating private hospitals. This final figure is dependent on disease indicators within the general population.

There are provisions for exiting the arrangement and it can be invoked one or more times during the 12-month period of the agreement, depending on trigger metrics being met.

The agreement would see the private hospitals provide a full service including medical services and they will be reimbursed at the standard commercial rate. The agreement would allow for the ongoing treatment of private patients and the operation of the traditional private healthcare market alongside the provisions of this arrangement, insofar as is commensurate with the requirements of the overall national pandemic response.

The agreement will also enable a local relationship between private hospitals and public hospitals in each area, which should result in a more streamlined service for both hospitals and patients.

8. Infection Prevention & Control and Hospital Outbreaks

Data provided by the HPSC indicate that were 78 open hospital outbreaks in hospitals on 5 January, comprising 1,099 cases, including 493 cases in healthcare workers. A total of 81 deaths have been associated with these open outbreaks.

Nosocomial outbreaks are important amplifiers of local outbreaks (ECDC). Given the exponential increase in the rate of community transmission of COVID-19, acute hospitals represent a specific risk with respect to the transmission of infection. While there has been investment and improvements in infection and prevention and control across the system, serious concerns remain regarding the prevalence of COVID-19 in our acute hospitals.

In light of the ongoing concerns regarding the transmission of COVID-19 in the acute hospital sector, specific measures are being implemented by the HSE to reduce the risk of nosocomial infection and to manage and control hospital outbreaks. This includes the establishment of the National Working Group for control of transmission of COVID-19 in the acute hospital setting and the introduction of mass testing in the context of significant hospital outbreaks, as well as a trial programme of serial testing of healthcare workers which will be rolled out in early January.
9. Vaccination of Healthcare Workers

The possible loss of staff due to COVID-19 infection or isolation requirements as a result of close contact with a confirmed case remains the single biggest concern for the provision of cancer services and other time-critical care. The delivery of the COVID-19 vaccination programme will need to remain agile and responsive to this and other emerging concerns.

As of Friday January 01, the HSE distributed 2,000 vaccines for provision to healthcare workers at 4 hospitals, with over 1,800 of those having been administered. A further 2,000 were distributed for administration at the weekend throughout the South/South West Hospitals Group. This week, the rollout will continue across 25 hospitals across all Hospital Groups, and 23 older persons’ residential facilities. Hospital Groups may add additional hospital sites to this total during this week, as the rollout progresses, and a further 160 long term residential facilities are planned for next week. It is expected that approximately 35,000 doses will be administered this week.

Conclusion

The level of transmission and associated rise in cases and in patients requiring hospitalisation, means that we will not be able to continue to protect the delivery of non-health and social care to the same extent as was possible in the summer and autumn of 2020.

However, the Department and HSE will continue to work together to ensure all possible mitigation actions are taken in response to the gravity of the current situation, and to maximise the use of the innovative approaches and practices, adopted earlier in the pandemic, to maintain delivery of care.

Appendix 1, attached, sets out some further background detail on the continued provision of essential care.

ENDS
Appendix 1
Further detail on provision of essential services

1. Trauma Care
Reconfiguration Plan
At the beginning of the emergency, the Department of Health requested the National Clinical Lead for Trauma Services (NCLTS) to develop a national plan for the reconfiguration and streamlining of trauma and orthopaedic surgical services around the country. In summary, nearly all hospitals that have trauma and orthopaedic surgical services on site developed innovative arrangements which included:

- the use different facilities for trauma of a lesser severity
- increase in day of surgery admission for appropriate trauma cases
- the use of virtual trauma assessment clinics (telemedicine)
- better use of minor injury units
- sourcing of alternative rehabilitation facilities for many long stay orthopaedic patients

Ongoing mitigation actions
The NCLTS has continued to engage with trauma and orthopaedic colleagues throughout the country on a continuous basis to mainstream many of the changes made during the initial COVID-19 Emergency.

In general, the principle of managing trauma patients is to minimise the time they spend in the ED (or eliminate it altogether) to reduce the potential for infection and to reduce the burden on the ED. This principle continues to be followed by encouraging patients to attend Injury Units either directly or after assessment in the navigation hubs, expansion of Trauma Assessment Clinics and developing planned trauma care arrangements. Virtual clinics have been rolled out to support the continuity of outpatient services including as part of Trauma Assessment Clinics.

It is recognised that patients with more significant injuries or with co-morbidities will need to be admitted from the ED and will not be suitable for assessment in Injury Units.

Further actions being planned
The NCLTS is currently engaging with hospitals that have trauma and orthopaedic surgical services on site to ensure that they are making arrangements to use different facilities (acute elective hospitals) for trauma of a lesser severity and to ensure that the range of cases that can be moved can expand in response to the increased pressure on the acute system caused by growing COVID positive numbers. For example, it is expected that Cappagh National Orthopaedic Hospital will treat non-elective trauma of a lesser severity from the Mater, Beaumont, Connolly and St James’s. It should be noted that some hospitals used private hospitals for planned trauma care during the first wave of the virus and the availability of these private hospitals will need to be clarified. In general, the larger acute hospitals will continue to provide treatment for more complicated trauma cases such as hip fractures and major trauma.

2. National Ambulance Service
Surge Plan
The NAS surge plan was put in place on 20 March 2020, and it sets out response options at levels designed to safeguard the most vulnerable patients. The plan envisages use of dynamic resource deployment. Ongoing assessment of internal and external capacity will inform surge responses
including reallocation and recruitment of new staff, and activation of surge support from external agencies in order to protect patient critical activities.

While the surge plan has not yet been activated in response to the latest surge in COVID-positive numbers, the NAS has reduced its activity in terms of inter-hospital transfers and private ambulance providers have been used by acute hospitals to support the service in this case. In terms of staff absences, approximately 100 of the 1,600 NAS clinical workforce are currently on sick leave; this is close to absence levels seen in November.

Response Times
The NAS has advised that 68% of ECHO (life-threatening cardiac and respiratory) calls nationally being responded to within 18 minutes; this compares to 75% of calls in October. A similar decline in performance has been seen in DELTA (other life threatening calls), with 47% of calls being attended within 18 minutes compared to 55% of calls in October. The NAS has highlighted lengthy turnaround times at Emergency Departments and staff absences as influencing factors in this regard. Data from the NAS shows there have been over 100 incidents per week since mid-December of ambulances being held for over 2 hours at EDs while awaiting patient transfer.

Pop-up testing
In response to localised public health measures, the NAS will continue to establish pop-up testing centres, utilising existing and external staff capacity as a rapid response to dynamic testing priorities. This aligns with testing commitments given in the Resilience and Recovery Plan and has worked well to date. The NAS currently has 6 pop-up testing teams available to support CHO testing requirements; three of these teams were operating in Limerick as of 3rd January.

3. Maternity and Gynaecology Services
Maternity services, like a limited number of other acute hospital services such as cancer and dialysis, are essential and cannot be deferred or easily transferred to the community setting. All maternity units/hospitals have put in place specific measures to manage and maintain services during the pandemic, while at the same time endeavouring to minimise infection risk for their patients and staff. Therefore, in maternity settings, care delivery will continue as usual with precautions for staff and patients implemented as necessary and in line with protocols.

It is likely, given the exponential rise in community transmission, and the potential risk to importing the virus into maternity hospitals, that some hospitals/units will review visitation policy. Indeed, it is understood that the Coombe Women & Infants University Hospital has already moved to prohibit post-natal visits whilst the Rotunda Hospital no longer permits partners to attend anomaly scanning. While such restrictions are regrettable it should be noted that they are introduced to protect patients, staff and service delivery, and are only implemented following a risk assessment.

The National Women & Infants Health Programme has, and will continue to, engage with the Clinical Leads for Maternity Services/Women’s Health in each of the six Hospital Groups and the Directors of Midwifery in each maternity unit, regarding COVID-19 preparedness.
Day Case and Outpatient Gynaecology Services
It is understood that the HSE has decided that from 6th January, all adult hospitals will cease non-time dependent work including inpatient, day case and outpatient gynaecology services. Essential services and urgent time sensitive procedures will continue to be provided and the expectation is that the potential for remote consultations will be maximised.

Termination of Pregnancy Services
Termination of Pregnancy (ToP) services continue to be provided in line with a revised, temporary model of care which will apply for the duration of the COVID-19 pandemic. This revised model of care provides for remote consultation with a medical practitioner for the purposes of accessing ToP in early pregnancy. Where a medical practitioner judges it to be clinically necessary, a face-to-face consultation may be held with the patient.

4. Renal Services
COVID-19 infection causes some form of kidney injury in 40% of patients who present to hospital. Patients with COVID-19 infection admitted to an intensive care unit require acute dialysis support in approximately 15% of cases.

Since the onset of the COVID-19 pandemic in Ireland, the absolute number of patients requiring dialysis has increased by 16 patients per month: the HSE is providing (as of 18 November) in-centre haemodialysis to an additional 89 patients (13,884 additional treatments per year) and home dialysis treatment to an additional 38 patients (13,290 additional treatments per year). These patients require additional consultant supervision, dietetic support, medical social worker support and nursing support to provide the dialysis therapy compared to transplantation.

5. Paediatrics
The relatively mild presentation of COVID-19 in children has meant that the impacts on paediatric acute services have been more limited than in other areas of the health system. As at 3rd January 2021 there were just three cases of children with COVID being treated in Children’s Health Ireland (CHI), and CHI expects that incidences of COVID paediatric patients will remain low. Elective surgery is continuing (spinal/cardiac) with patients onsite and scheduled, and essential services are likewise continuing (e.g. paediatric cancer care).

However, there has been a significant increase in relation to cases of mental health where children are presenting with anxiety issues due to COVID-19. Currently there are around 22 beds occupied as a result of this. In addition, there is a significant risk to CHI services if staff contract COVID from parents/family attending hospital along with their children. Any reduction in staff numbers due to COVID-19 will have a resultant effect on capacity and ability to offer services, so managing this challenge is of utmost importance to CHI/Paediatric Services.

6. Blood and Transplant Services
Current position
The Irish Blood Transfusion Service (IBTS) has recommenced collections from first time donors. Laboratory teams and processing staff are back at normal capacity wearing appropriate PPE and ensuring social distancing. In recent months the demand for red cells reached 98% of pre-COVID levels, and demand for platelets has returned to normal levels.

National Kidney Disease Clinical Patient Management System (KDCPMS/Emed)
The impact of the current significant rise in COVID-19 numbers is not yet clear. A number of clinics were cancelled recently by the IBTS as a result of staff shortages (25 IBTS staff currently out sick). The IBTS advises that donor recruitment is becoming more difficult as the pandemic continues. There has also been a number of ‘no shows’ at clinics in recent weeks which the IBTS advise is due to the high level of fear amongst the public.

On the other hand, the IBTS advise that the expected cancellation of elective surgeries will reduce demand and ease the pressure on the supply of blood.

Transplant Services
A total of 190 transplants took place in 2020 – a very good outcome in the context of the problems raised by the COVID-19 pandemic.

While all transplant programmes remain active, it is expected that transplants will be curtailed in the coming weeks due to the issues raised by the higher COVID numbers. Assessments for admission to transplant waiting lists will also be impacted due to reduced bed capacity.

Dedicated ringfenced facilities for transplant – including theatres, ICU beds and recovery beds are required to sustain safe provision of transplant services, particularly in the context of COVID-19.