



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# HIQA submission to the Department of Health's 2017 Health Service Capacity Review

September 2017

## **Introduction**

The Health Information and Quality Authority (HIQA) has been Ireland's health and social care regulator since 2007. During that time, we have been responsible for the development and monitoring of standards in health and social care services, the registration and inspection of designated services and the conduct of a wide range of health technology assessments (HTA). We have also played a major role in facilitating and advising on Ireland's eHealth infrastructure.

HIQA is committed to working with the Department of Health and the bodies under its aegis to promote sustainable improvements in the health and social care services. We welcome the decision to carry out a broad health service Capacity Review and are pleased to have an opportunity to contribute to it.

In preparing this submission, we have considered our experience of the regulation of health and social care services and our involvement in a range of quality- and service-improvement initiatives over the past ten years. Furthermore, through our monitoring of pre-hospital emergency care services, we have observed at first hand the conduct of a capacity review in an Irish context.

In this paper, we examine how changes to the way care is provided will affect capacity requirements, consider how to use current capacity as efficiently as possible and recommend areas that should be prioritised for capital investment over the next 15 years. The following areas are considered: acute hospital care, integrated care, commissioning, evidence-based decision-making, eHealth, alternative social care models and revising the current social care services regulation model.

Our submission makes a range of recommendations that will require investment in both the immediate future and over a longer period. Overall, however, there is a clear need for a long-term capital investment plan that will ensure our health and social services are adequately financed to meet Ireland's needs into the future.

### **Acute hospital care**

HIQA's experience of monitoring the acute hospital system over the past number of years informs our awareness of the increasing difficulties associated with capacity and access challenges. It is important that both workforce planning, which is informed by international benchmarking, and the overall model of care are taken into account in the Capacity Review.

International experience shows that bed occupancy rates in excess of 85% result in constrained and inefficient patient flow. However, current health system configuration, capacity, workforce resourcing and deployment patterns, and work practices result in occupancy rates often in excess of 100%. It is clear that we must now plan ahead to ensure sufficient capacity is available in the health service.

Acute hospital bed capacity should be considered along with non-acute capacity, with the intention of rebalancing the health service away from the predominant hospital-centric model currently employed. The necessary rebalancing towards non-acute care will take a significant period of transition, as recognised by the Houses of the Oireachtas Committee on the Future of Healthcare's recent Sláintecare Report. In the interim, our hospitals face immediate challenges that may result in major overcrowding in acute services during the coming winter period. There is, therefore, a requirement for immediate measures to increase bed capacity in particularly challenged acute hospitals. This should be combined with short-to-medium term measures to provide additional acute capacity that may then be re-diverted towards primary care when this capacity can be brought on stream. We discuss the need for investment in integrated care in more detail in the following section.

The greatest level of crowding in our acute hospital system is currently being experienced in model four and some model three hospitals. These are the hospitals which tend to treat the sickest patients in each region and, therefore, have the longest length of stay for patients. It is likely that a number of these regional hubs fundamentally lack the required level of bed, human and diagnostic capacity to deal with their workload. There is a pressing need for targeted investment in a number of acute hospitals to address the greatest bottlenecks. These bottlenecks should be identified and addressed in the short term while the capacity review is ongoing through an empiric evaluation of current crowding rates and through benchmarked comparison of relative length of stay (which may identify the potential for improved operational efficiency within current resources or may in fact reveal an efficient service which fundamentally lacks capacity).

Any change to the model of care will be predicated on having the required workforce to deliver that care. There is currently a recruitment and retention crisis in the health service, in particular amongst frontline and some specialist staff. Addressing this challenge will take time, but immediate measures to properly and comprehensively address these challenges through the implementation of recent reports, including the *Strategic Review of Medical Training and Career Structure* and the *Interim Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing*, should be expedited as a matter of urgency.

Investment is required to ensure access to necessary diagnostics and senior decision-makers is available in all settings. Full implementation of the acute medicine programme should also continue to be supported. In addition, there is scope for enhanced use of allied health professionals to allow more effective utilisation of senior clinicians.

In planning capacity up until 2030, greater recognition is needed of the influence of emergent antimicrobial resistance, both in terms of greater length of stay and

increased hospitalisation rates due to infection. Indeed, the impact of an above-average incidence of influenza in winter 2016–17 demonstrates the importance of this challenge on a system already struggling with capacity. Increased availability of isolation and critical-care bed capacity will, therefore, be necessary.

It is clear that the built environment in a number of hospitals is inadequate. Recent monitoring inspections against the *National Standards for the prevention and control of healthcare-associated infection in acute healthcare services* have identified infrastructural and capacity issues. HIQA has found that implementation of comprehensive infection prevention and control programmes was limited by the daily need to address the placement of patients requiring isolation in frequently overcrowded hospitals with poor inpatient accommodation infrastructure and a lack of isolation facilities.

The lack of patient flow through the acute hospital system, in particular, during and following public holidays, is well recognised. The initial focus of this review should be to urgently examine current work practices while making greater use of existing alternate-care pathways to address priority bottlenecks.

More efficient use of existing resources could be achieved through increased investment in intermediate-care transport capacity in the National Ambulance Service. This could enhance patient flow through more timely repatriation of patients who have completed acute treatment in model four hospitals to regional model two or three hospitals. Implementation of the *National Ambulance Service Vision 2020* strategy, with its revised models of care for patients who call 999, may also assist in reducing acute bed pressures. We also note the findings of the *National Ambulance Service of Ireland emergency service baseline and capacity review* and support the provision of necessary resources and equipment needed to implement its recommendations.

## **Integrated care**

There is a consensus that Ireland needs to move away from the current hospital-centric model of care and introduce integrated care pathways across primary, community and secondary health and social care structures. HIQA believes this should be expedited.

Such a model would promote seamlessness in the transition of people across services, providing multi-disciplinary care at the lowest level of complexity closer to where people live. The focus should be on improving access to, and the responsiveness of, primary and community care services, and making more specialised services available at the local level, including the provision of enhanced diagnostic and treatment capability.

Examples of best practice include integrated early intervention teams, age-related care units, stroke-care clinical pathways, the new national maternity strategy, and numerous examples from other jurisdictions, including the dementia-care model in Scotland. The experience from other countries has shown that integrated care is more efficient, reduces costs, enhances the quality of care and improves the overall health and wellbeing of the community.

In order to better understand the work currently being carried out in community settings and to ensure the best use of resources, the Department of Health should complete the National Framework for Strategic Health Workforce Planning.

General practitioners (GPs) have a central role in providing integrated care. However, clear challenges face this sector. In order to move to an integrated-care model, there is a need for investment in GP services in order to increase capacity.

Supporting alternatives to admission to an acute hospital bed, for example, through a dedicated frail elderly pathway or through the more uniform use of advanced nurse practitioners for minor injuries and chronic conditions such as COPD or heart failure, should also form a key element of the Capacity Review. Treatment of such conditions in primary care, allied to rapid access to diagnostics without hospital admission, should also be a key focus of any revised model of care.

Existing capacity in the area of rehabilitation following the end of a patient's acute treatment should also be examined as there is significant national variation in available capacity for such step-down care.

HIQA also supports the implementation of the national maternity strategy, which proposed an integrated care model. Achieving the improvements in services envisioned in the strategy will require it to be adequately resourced.

## **eHealth**

It is widely recognised internationally that eHealth has the potential to transform the healthcare system in much the same way as information and communications technology (ICT) has transformed other sectors. Furthermore, eHealth is a key enabler of government health policy in areas such as integrated care, patient empowerment and health promotion. This has been further highlighted in the recent publication of the Houses of the Oireachtas Committee on the Future of Healthcare's Sláintecare Report, which highlighted the need for investment in eHealth initiatives such as the Electronic Health Record and eHealth solutions to support an integrated health and social care model.

ICT has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication

to which they are allergic. Further to this, it can support a much faster, more reliable and safer referral system between the patient's general practitioner and hospitals. Without eHealth solutions, developing an integrated care model for Ireland will not be possible.

Although there are a number of examples of good practice, the current ICT infrastructure in Ireland's health and social care sector is highly fragmented with major gaps and silos of information which prevent the safe, effective transfer of information. This results in people using services being asked to provide the same information on multiple occasions. In the Irish healthcare system, information can be lost, documentation is poor, and there is over-reliance on memory. Equally, those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and the cost of care.

As a result of these deficiencies, there is a clear and pressing need to provide the investment needed to implement Ireland's eHealth strategy, which was published in December 2013. In addition to resources, effective and authoritative leadership, clinical champions and appropriate legislation on the governance of data is required.

The establishment of eHealth Ireland, the setting up of the office of the Chief Information Officer and the publication of the *Knowledge and Information Strategy* were positive developments in achieving the goals set out in the eHealth strategy. However, in order to achieve the objectives, significant capital investment is required. The current average EU healthcare budget spend on eHealth solutions is just over 3%. In contrast, the Health Service Executive (HSE) allocates around 1% of its budget to this agenda. Significant investment is required in the following areas, which will enable the foundations for a more efficient and effective healthcare system:

- national health identifier infrastructure — infrastructure to allow the use of the identifiers for people, professionals and organisations
- the national messaging broker (HealthLink), which allows communication between healthcare professionals using a standards-based approach
- the development of Electronic Healthcare Records (EHR) using a standards-based approach
- telemedicine, to support the management of chronic diseases
- ePrescribing systems
- online referrals and scheduling

- current ICT infrastructural hardware, for example PCs, within health and social care, in particular, in social, primary and community care settings

Ireland is one of the last developed countries to harness the technology currently available to advance our health and social care services. Most countries are investing heavily in eHealth because they realise that it can significantly reduce clinical errors, improve patient safety, create efficiencies, and, if properly installed and supported, reap economic benefits. However, Ireland currently predominately relies on paper-based solutions.

eHealth has the potential to transform current practice and to put the needs of the person using the service, rather than those of the service provider, at the heart of system. This will lead to a shift in focus from individual illnesses and conditions towards a more holistic, integrated approach to pathways of care.

Further progress with regard to eHealth requires not only significant capital investment, but also leadership, buy-in and commitment of frontline staff and senior healthcare management. In addition, the Health Information and Patient Safety Bill, which sets the legislative remit for numerous health information initiatives, currently awaits refinement and enactment. This is essential in order to ensure sufficient capacity within our health service from now to 2030.

## **Commissioning**

We believe that the quality and safety of our health and social care services will be greatly improved by the introduction of a strong commissioning model. The introduction of such a model will have a positive impact on how the capacity of our health service is utilised.

Commissioning is only at a developmental stage in Ireland, but is already well established in other jurisdictions, for example, Northern Ireland and England. Here it has proven successful in the context of effective service provision, governance, financial efficiency and in improving the quality and safety of services.

Commissioning arrangements explicitly define and separate the roles of purchaser and provider of services: currently both of these functions are usually performed by the HSE. An effective commissioning body is responsible for purchasing health and social care services from providers. Procurement is always based on an agreed strategy, assessed need, best available evidence of service efficacy, value for money and the capacity and capability to deliver a safe and effective service. While cost is, of course, important, quality and the delivery of safe services should be the primary goals.

Implementing a national commissioning approach would involve a radical review of the current health and social care service funding model and allow for the

discontinuation of the ineffective practice of legacy block funding. Importantly, a successful commissioning model also allows for the decommissioning of certain services where there is evidence that they are no longer required.

Commissioning frameworks can provide for national and regional arrangements and enable local, person-centred procurement structures. This facilitates a focus on the health and wellbeing of local populations and on achieving the best possible outcomes within available resources. While procurement decisions are made locally, the service itself is delivered in the most effective, efficient manner, whether in the community or at a national level.

Local commissioning involves community and primary-care professionals and, most importantly, people who use services. This empowers them to become a partner in their care and exercise choice and control over their lives.

We propose an exploration of new approaches to service delivery and funding which empower individuals to make decisions on the type of care best suited to their needs and circumstances. The current funding model for the disability and older person's sectors, for example, whereby a large proportion of national funding is allocated to day-care and residential services, is outdated and a move towards commissioning and individualised or personalised budgets would provide flexibility and enable people to make independent decisions about their lives.

Local commissioning arrangements, in turn, inform national commissioning structures. A strong, country-wide model would contribute to effective medium- to long-term planning by gathering evidence of current and future service needs. It would also optimise service configuration based on sound strategic planning. The introduction of a standardised framework to commission services would help, by way of example, with the implementation of national clinical care programmes and plans such as the national maternity strategy.

Most importantly, such a framework would allow for effective oversight of service provision and hold providers accountable for the delivery of safe, quality services with the transparent, effective use of public resources. Strong, clearly-defined performance management structures and clear accountability arrangements are an essential component of a good commissioning model.

The introduction of commissioning to Ireland creates an opportunity to develop legislation providing for structural change to the health and social care systems, enshrining in law the crucial concepts of accountability and responsibility. This legislation would explicitly set out 'a statutory duty of care' for 'accountable officers', and make not only the providers of services, but also those procuring them, accountable for their decisions.



## **Evidence-based decision-making**

Fair, equitable and timely access to high-quality care is a central goal of our healthcare system. The efficient delivery of healthcare programmes minimises the wastage of resources, making funding available for new and innovative technologies that deliver better outcomes for patients, albeit at a higher cost.

The rationing of care is an inevitable consequence of a fixed healthcare budget. Currently, we have a system characterised by rationing by delay, crudely manifested in the form of waiting lists.

Health technology assessment (HTA) is evidence-based research widely used internationally to assess the costs and benefits of healthcare treatments. The aim of HTA is to guarantee the best use of resources through rationing by design. This ensures that the right healthcare is targeted to the right patient at the right time in the right place, delivering the best outcomes for the individual and the most efficient use of the healthcare budget. Since 2007, HIQA has been engaged in the delivery of HTAs at a national level to inform major health-policy and health-service decisions.

Using independent evidence to inform decision-making must be a fundamental principle of any strategy for the future of Irish health and social care. Expanding the use of HTA in the Irish healthcare system would ensure that this decision-making process is rigorous, fair and based on robust, high-quality information.

Decisions on investment in health and social care services over the coming years should be based on the best available evidence and supported by the increased use of HTA.

## **Alternative social care models**

Through the regulation of residential centres for both older people and people with disabilities, HIQA has a deep understanding of the problems facing these sectors. While many residents of disability centres are receiving a quality service and enjoying a good standard of living, a significant number of people are experiencing a quality of life that is well below that which would be expected in modern Ireland. These people have been living over a long period of time in institutionalised services that do not promote person-centred care and where abuses of their rights have happened. In some instances, HIQA has assessed the care being provided as unsafe. Furthermore, we continue to encounter difficulties with outdated nursing home buildings impacting on residents' privacy and dignity, and their right to be safe. Addressing these shortcomings will require significant infrastructural investment over the coming years.

The 2016 census showed that over half a million of the 65+ age group live in private households, while those in nursing homes have increased by 1,960 to 22,762 since

2011. The census also showed that 35.3% of people aged 75 or older live alone, while 45% of those over 85 live by themselves. In light of the ongoing capacity issues in our acute care system, and the desire of many older people to remain in their own homes, the Government has come under pressure to provide extra funding for homecare and to make it a statutory entitlement. The Department of Health is currently running a public consultation on homecare services, to which HIQA will make a submission. While HIQA advocates the extension of homecare packages, we, as the State's health and social care regulator, are aware of the specific vulnerabilities of people in receipt of personal care and support services within their own homes. Statutory regulation of the domiciliary care sector is, therefore, required. It is important to be clear that any regulatory mechanism for domiciliary care would apply to the service rather than to the physical location where the care is provided. In keeping with HIQA's current thinking on new approaches to the regulation of health and social care services, we propose that the provider of homecare services would be required to register only once, rather than every three years as is currently the case for designated centres for older people and people with disabilities. HIQA is willing to work with the Department of Health on the amendments to the Health Act that are required in order to implement these changes.

Providers would be monitored for compliance on an ongoing basis thereafter, but would not be required to renew their registration. This approach has numerous advantages, such as reducing the administrative burden for both the regulator and the service provider, and would allow for more thematic inspection programmes. Most importantly, however, this model would enable the regulator to target its resources at areas that pose the greatest risk

In accordance with the principle of providing person-centred care, and in recognition of the demographic pressures facing Ireland, more consideration needs to be given to developing alternative models for the delivery of services for older people and people with disabilities. Such models would potentially provide incremental pathways of support and care aligned with the changing needs of the person, thereby allowing them to be supported to remain in their own homes for longer, nearer their families and friends. This process should be supported by local commissioning arrangements.

HIQA is committed to improving health and social care services and supporting people to meaningfully direct their own care. Now is the time to explore new arrangements that allow people with chronic conditions, older people and people with disabilities, where possible, to be cared for safely in their homes and not in a hospital or residential setting. These arrangements will have significant implications for the capacity of Ireland's health and social care services.

One such arrangement is that of rehabilitation, whereby support services are provided to older people or people with disabilities in their own homes following a hospital stay, accident or illness. This service allows these individuals to regain confidence and relearn skills in familiar settings, while at the same time reducing unnecessary hospital admissions. This concept is known as 'reablement' in Northern Ireland and has shown to be an effective way to keep people independent for longer.

### **Revising the current social care services regulation model**

A safe, effective and high-quality healthcare system focuses on the needs and wishes of the patient. Putting the rights of vulnerable service users first is at the heart of everything we do in HIQA. We believe that through an increased focus on rights, service providers will become increasingly aware of their responsibility not only to protect those using services, but to provide safe, person-centred care.

Regulations for health and social care should reflect a rights-based approach and include an emphasis on quality of life. They should be developed with the person using the service in mind and shift the focus from what the provider is *required* to do, to what the resident or patient is *entitled* to. This would empower individuals accessing services and signify a move away from the traditional, paternalistic model of social care delivery towards a more inclusive, supportive approach.

Through its regulatory work, HIQA is aware of several different models of residential and non-residential care for older persons and people with disabilities. Some of these models of care do not sit within the current definition of a designated centre and present challenges in terms of ensuring that dependent and vulnerable service users are protected.

A service-based model of registration — coupled with a suite of regulations specific to each model of care — represents the best course for regulation into the future. Under such a system, the provider would be registered with the regulator rather than an individual centre or service being the registered entity. The provider may provide multiple services and would identify all the locations where it is providing these services.

Moreover, revision is required to the fixed, three-year registration cycle for designated centres. The current approach is too rigid and the arbitrary choice of a three-year period does not serve people using services and creates an unnecessary burden on compliant service providers. Regardless of the length of the registration cycle, HIQA would in no way be limited in the application of its powers of sanction and would continue to monitor and inspect all designated centres.

It should be borne in mind that a discussion on how to regulate services is only one component of a broader discussion on how to provide care to older persons and people with disabilities. It is essential that, where appropriate, funding should be targeted towards alternatives to expensive, long-term residential care.

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