Username

RCPI

Please indicate your sector of involvement/interest

Acute Care

Location

Dublin

1. **What changes in models of care and in the way we deliver care are (a) most urgent, and (b) what implications will this have on capacity requirements?**

The Royal College of Physicians of Ireland believes that the work to develop integrated models of care are a priority. In particular, the most urgent models of care for:

- Older persons
- Children
- Women's health
- Unscheduled care.

These models of care should provide the basis for workforce planning, costings and funding decisions and IT systems. They should also be used to measure performance and form the basis to establish governance around them.

The model of care for older persons should, for example, define the type of services that older people should expect to get from the health system, in their home, in primary care and spanning across the entire health system. This will require a fundamental shift in how decisions around these models of care are made. Managing capacity and demand is a dynamic process. There is a need to understand what the capacity limits might be to be able to meet the spike in demand.

There needs to be a national framework that is operated and implemented locally. Currently, for example, elements of these models of care are being funded whereas there is an opportunity to fund all of them in a more effective way to ensure their delivery across the system and in terms of patient outcomes.

It is imperative that there is an understanding of capacity requirements at each stage – the problem may manifest itself as an increase in patients attending an Emergency Department where the capacity issues may have been triggered due to an issue say, with GP access in the local area.

There is a need to be very aggressive in our approach to promoting prevention of ill health at every level of the health system. Health and wellbeing must be a fundamental component of all models of care.

Implications for capacity requirements

The development of these priority models of care will, if approached on the basis we are advocating above, could, for example, result in fewer people accessing acute hospital care.

Where these models of care are implemented across the community and are centred around the patient, this will have an impact on the need for how the service is delivered, the workforce requirements and associated costs. The key performance indicators could be measured in terms of the numbers of certain cohorts of people, such as older people, presenting for acute hospital care.

Hospital beds

There is a need for more hospital beds in the system currently, but it would be a mistake to think

this is the entire solution. There needs to be a systemic approach - as outlined above – this is the only approach that will be successful in tackling capacity issues in the long term.

2. How can current capacity be more effectively used?

To effectively manage the flow of patients through ED and to resolve the longstanding trolley crisis, it is important to understand that this "flow" begins long before the ED and continues long after. Patient flow is local. Aggregating data to national level is interesting and supports national planning but will not help to manage the flow of patients through a specific ED.
It is essential to have governance arrangements that allows for transparency, oversight, integrations and management of patient flow across community, primary and acute services.
This requires:
• Providing services within the community to enable people to live at home and manage conditions themselves with support in the community if necessary.
• Enabling GPs with resources and diagnostics to minimise referrals to acute services to those who need then.
• Providing expertise and resources within ED to effectively manage those presenting and to discharge and admit appropriately.
• Providing sufficient acute hospital beds, with all related resources, therapies and diagnostics to meet demand.
• Providing community services and capacity to enable patients to move from acute beds to a more appropriate rehabilitation, nursing home or home setting.
• Providing mental health services to meet the demand in community and other settings.
A capacity deficit at any point along the flow will usually manifest as a problem in the ED, which is often the place of last resort. The system must be able to adapt to address capacity and demand issues at any point along the patient flow.
For this we need:
• To manage flow continuously
• Have authority to make decisions across the flow
• Use real-time data to know what's happening
• Plan for contingencies
• Use science relating to management of flow from other industries and the healthcare sector.
The incidence of people waiting on trolleys will be minimised if patient flow pathways are:
1. Mapped out
2. Demand predicted
3. Resources are lined up in community and primary care
4. Diagnostics are available in community and acute settings at the time they are required
5. Patients are discharged as soon as acute care is completed
6. Sufficient rehabilitation and nursing home beds are available
7. Once home supports are adequately allocated.
This will also require:
• Agreement with staff to move resources to where they are needed
• Changes in working patterns to meet demand
• May require agreements with private providers to meet spikes in demand
• Dynamic management of patient flow applied with authority across the continuum of home, community, primary and acute care
• Skilled clinicians and managers working together with responsibility for managing patient flow across boundaries in real times, at a local level.
The critical enablers of this systematic approach are

1. Funding
2. Workforce
3. Performance management
4. Systems and data

If a systemic approach is taken, we should expect all local services to be able to deal with episodic spikes in demand, but no system can deal with sustained and gross mismatch between demand and capacity.

Using data to plan

Healthcare policies, strategies and plans should use research evidence and relevant data to make clear connections between population needs assessment and frontline planning decisions. Of crucial importance is the alignment of demand with capacity through the use of data an evidence.

We need to ensure we can accurately estimate population need, and design and implement costed models of care to meet that need with funding allocation aligned with the agreed models of care.

The health sector must continue to develop expertise in the systematisation of access to and the appropriate analysis of healthcare-related data to help inform decision-making processes.

Much of the current visible dysfunction in the system is a result of demand grossly exceeding capacity. This failure to align capacity and demand has contributed significantly to the current critical state of the public healthcare system. Unacceptably long waiting lists, recurrent and intractable trolley waits in emergency departments, and serious and worsening problems in recruiting core medical and nursing staff are just some indicators of how vulnerable the system is currently.

Currently there is a substantial mismatch between capacity and demand. The number of hospital beds per 1,000 population in Ireland is among the lowest in the OECD.

Between 2006 and 2015, the number of acute inpatient hospital beds has decreased by 13% from 12,110 to 10,473. During the same period, the demographic demand of people over 65 years increased by 29.5% from 467,900 to 606,000.

Current demand is not being met and, notwithstanding increases for health announced in the 2017 budget, there is no plan outlining how this level of future demand can be addressed.

Things we need to understand and approach differently:

• There is insufficient bed capacity to meet demand in both hospitals and nursing homes
• The problem manifests in ED but the solution may be elsewhere
• Inadequate capacity in primary, community and outpatients services increases demand in ED
• An unacceptable experience for patients and staff has been culturally normalised.

A more coherent approach:

• Joined up, long term planning for emergency care at national and regional level
• Dynamic management of unscheduled patient flow at local level
• Integrated pathways for unscheduled care across community, primary, mental health and acute care
• Data, including demographic data, to properly plan. Underpinned by systems.
• A will to face up to reorganisation of hospitals so that they can provide the emergency service that people require.

Crisis management will not and cannot resolve the fundamental problem. If underlying causes are no understood and dealt with, it is inevitable that the crisis will return and be worse each time.

Hospital groups

Hospital groups need to be mandated and resourced to re-organise the way health services are delivered across the population.

Supporting healthcare staff

Major, sustained emphasis is needed on strengthening and supporting the people who deliver care, and on rebuilding trust and confidence among the workforce. Successful organisations recognised

the importance of the people who work for them; they try to recruit the best; ensure they are enabled to perform to their best; are involved appropriately in decision-making; are trusted; and are provided with development opportunities. This is what we should aspire to for our health service.
Workforce planning that is based on healthcare demand will ensure that the workforce capacity is sufficient and appropriately skilled to meet future needs. New and expanded roles, based on international models of best practice, will be a feature of the healthcare workforce in the future, requiring new professional contracts with new definitions of roles and responsibilities.
Address Staff Recruitment, Retention and Morale Issues.

3. What do you consider to be the priorities for capital investment over the next 15 years?

eHealth
The individual health identifier and electronic health record must be implemented. The advent of the eHealth strategy provides an opportunity to adopt a long-term strategy to underpin joined-up care across community, primary care, acute hospitals, and mental health; and to simultaneously enable effective population needs analysis, prioritisation, planning, outcome measurement and performance accountability at local and national levels. Without significant, strategic and long-term investment in eHealth, the vision of caring for people in the community as close to home as possible, will remain a pipe dream.

Investing for change
There must be significant, targeted and sustained investment into implementing a system change (as recommended in the Sláintecare Report with leadership from the very top of Government).
One of the few recent examples of successful implementation of radical change was the National Cancer Programme. Lessons learned were on the importance of political and clinical leadership; the development of a long-term vision and plan; change based on evidence, appropriate authority and resources; and continuous communication with all stakeholders. Change is not possible without a vision that resonates with those who need to make it happen. But neither is it possible without a concrete plan with objectives, milestones, management, expertise and resources.
Making change happen requires investment. Without additional resources it will be impossible for change to occur on any meaningful scale. Any assumption that significant improvement can be achieved without specific investment to make change happen is not feasible. There must be deliberate, targeted and sustained investment in making change happen. Long-term investment is needed to enable changes over time.

Community and primary care service
Healthcare delivery should be oriented around the service itself rather than buildings and institutions or legacy arrangements. This includes the concept of a “hospital without walls” where many services delivered in hospitals can and should be delivered in the community, with greater collaboration across hospital, primary care and community care settings.
Hospitals cannot be a one-stop-shop for all care services but rather are one component of the healthcare system consisting of a network of providers working closely together to deliver joined-up care for patients.
People must be able to access care in the most appropriate care setting, including specialist opinion, some of which may be delivered outside the traditional acute hospital setting, perhaps using telemedicine or by electronically engaging with the GP.
Strengthening capacity in primary and community care will be crucial to achieve this. Equally important will be the appropriate mapping of hospital services for complex, specialised care and 24-hour emergency care. Some services will continue to require aggregation in a specific place.

Although much care can and should be devolved locally, this can only work if relevant secondary and tertiary services are also supported. Critical mass and adequate clinical throughput with specialised infrastructure will be necessary to ensure retention of skills, safety and quality in the delivery of those secondary and tertiary services.