REPORT ON STAKEHOLDER ENGAGEMENT:

Understanding the Causes of Hospital Waiting Lists

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Sinn Féin spokesperson on Health

Sinn Féin

• All-Island Cancer Research Institute (AICRI)

• Irish Wheelchair Association

• Sligo

• Derry

• Enable Ireland, Meath

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- Tá constaicí tromchúiseacha roimh Sheirbhísí Sláinte ó thaobh earcú foirne agus foireann a choimeád toisc easpa céimithe, ráta ard cloíteachta, iomaíocht dhomhanda, cé chomh iargúlta is atá roinnt láithreáin, srianta ar sheirbhísí in ospidéil ar leith, costas aird maireachtála i gcathracha, agus deacrachtaí maidir le cothromaíocht oibre is saoil go forleathan i measc na gcomhairleoirí, na sain-altraí, agus beagnach gach grad, rud atá ag dul in olcas toisc folúntais faidréiseacha agus an próiseas fadálach earcaíochta,
- Tá an próiseas dearbhuithe caipitil ró-anásta, áit a mbíonn sé ró-fhada dearbhú a fháil do luath-chéimeanna an Chóid Caiteachais Phoiblí agus ag cur le maoluithe a mhaireann na blianta, rud a chuireann le costais a bhaneann le boilsciú tógála in áit iad a chur faoi smacht,
- Toisc go mbíonn easpa chinnteachta faoin maoiniú ilbhliantúil, bíonn moill sa bhreis ar dhul chun cinn na dtograí caipitil trí chéimeanna an chóid caiteachais phoiblí, agus teorann ar chumas na n-ospidéal dul ar ceann riain maidir lena bhforbairt féin, rud a chuireann srianta ar sheirbhísí agus a bhíonn tionchar aige ar bhaol sábháilteachta na n-othar,
- Toisc nach bhfuil próiseas cinnteoireachta comhtháite agus iomlánaíoch le fáil sna seirbhísí príomha, pobail agus géarchúraim go laethúil agus, níos leithne, go stráitéiseach, tarlaíonn neamhéifeachtúlachtaí in ospidéil, ar nós cealuithe agus maoluithe ar dhaoine a scaoiliú amach,
- Tá an tSeirbhís Náisiúnta Otharcharrana gann ar fhoireann agus faoi bhrú ollmhór glaochanna amach a fhreagairt de réir chaighdeáin an Údaráis um Fhaisnéis agus Cáilíocht Sláinte (HIQA), rud a chuireann sábháilteacht na n-othar agus deá-bhail fóirne go mór i mbaol,
- Mar thoradh ar ghanntanas i gcás toilleadh obrádlainne agus fáthmheastach, ní baintear dóthain úsáide as saineolas máinliachta agus eile leighis, agus is é seo an cúis ba mhó ag cur brú ar dhochtúirí bogadh go dtí an éarnáil príobháideach agus iad ag iarraidh an méid is mó dá gcuid ama agus is féidir a chaitheamh ar obair le othair,
- Bíonn cealuithe mar thoradh ar an easpa toilleadh d'othair cónaitheach nuair a thagann borradh neamhsceidealaithe ar chúram éigeandála, rud atá níos measa fós toisc an géarghanntanas ó thaobh toilleadh na ndochtúir ginearálta de atá mar thoradh ar drochphleanáil agus polasaí frithghníomhach,
- Tá ospidéil ag lorg neamhspleáchas freagrach chun lúfaireacht agus solúbthacht a chruthú i gcinnteoireacht chun freagra a thabhairt nuair a thagann dúshláin chun cinn agus chun dul ar ceann riain mar gheall ar sriocanna straitéiseacha chun gluais agus torthaí d'othair a fheabhsú, agus ar mhaithe le comhordanú níos fearr ar sheirbhísí géarchúraim agus pobail.

Key Findings

- Health Services are facing serious difficulties in recruiting and retaining staff due to a lack of graduates, high burnout, global competition, remoteness of some locations, limitations on services at some hospitals, high cost of living in cities, and difficulties in work-life balance, across consultants, specialist nursing, and almost all grades, which is made worse by prolonged vacancies and the long recruitment process,
- The capital approval process is too cumbersome with approval for earlier Public Spending Code stages taking too long and leading to years-long delays which increase, rather than control, costs due to construction inflation,
- Lack of multi-annual funding certainty leads to additional delays in capital projects advancing through public spending code stages, and limits the ability of hospitals to set the pace of their own development which constrains services and impacts on patient safety risks,
- The lack of joined-up and holistic decision making across primary, community, and acute services on a daily and wider, strategic basis leads to inefficiencies in hospitals, such as cancellations and delayed discharges,
- The National Ambulance Service is severely understaffed and under immense pressure to respond to callouts within HIQA standards which is a serious risk for patient safety and staff welfare,
- A lack of theatre and diagnostic capacity is resulting in an underutilisation of surgical and other medical expertise, which is a primary driver of doctors to the private sector as they seek to maximise time spent on patient-facing work,
- A lack of inpatient capacity is leading to cancellations from surges in unscheduled emergency care which is worsened by severe shortages in GP capacity caused by poor planning and reactive policy,
- Hospitals are seeking accountable autonomy to create agility and flexibility in decision making to respond as challenges arise and move on strategic objectives at pace to improve patient flow and outcomes, and a better coordination of acute and community services.

Príomh-Moltaí

- ⊕ Seirbhísí sláinte agus cúraim sóisialta a ailíniú agus a imeascú faoi Limistéir Sláinte Réigiúnta atá cumhachtaithe le feidhm suntasach maidir le pleanáil foirne agus caipitil chun institiúidí láidre a chruthú atá in ann na máistirphleananna straitéiseacha cuí a sheachadadh chun freastal ar riachtanais sláinte an daonra.
- ⊕ Straitéis foirne sláinte agus cúraim sóisialta a sheachadadh atá comhtháite, réamhghníomach agus cuimsitheach chun spásanna oideachais agus deiseanna oiliúna a mhéadú idir na Rannaí Sláinte agus Ardoideachais, an FSS, Grúpaí/ Limistéir Sláinte Réigiúnta, agus institiúidí ardoideachais,
- ⊕ Buiséid caipitil ilbhliantúil a sholáthar, faoi threoir ag chreatlach infheistíochta straitéiseach chun próiseas caipitil an Chóid Caiteachais Phoiblí a cuíchóiriú le chinnteacht do mhaoiniú thograí trí buiséid LSR-leithdháilte agus éifeachtúlachtaí a chruthú i ndearadh agus sainfháiliú trí dearuithe caighdeánacha a shocrú,
- ⊕ Grúpa Oibre ar Thodhchaí an Chleachtaidh Ginearálta a bhunú chun páirithe leasmhara sa bhunchúram leighis a thabhairt le chéile chun tabhairt faoi na bun-fadhbanna sa Chleachtadh Ginearálta agus plean a fhorbairt don chúram ginearálta uilíoch lena n-áirítear seirbhísí taobh amuigh d'uaireanta gnó, dochtúirí bunchúraim poiblí, agus toilleadh traenála a fhorbairt chun freastal ar an éileamh amach anseo,
- ⊕ Uasdátú na gcórais cúram sláinte a chur chun cinn agus buiséid don r-Sláinte agus d'uasghrádú treallamh a imfhálú,
- ⊕ Freagracht i leith daoine a scaoileadh amach a chineachadh go cláraitheoirí agus altraí sinsearacha chun comhordanú pras a dhéanamh orthu agus chun pleananna scaoileadh amach a fhorbairt atá otharoiriúnaithe chun laethanta pleanáilte do scaoileadh amach a ailíniú le toilleadh tacaíochta baile agus/nó íoschéimnithe cosanta,
- ⊕ An tSeirbhís Náisiúnta Otharcharranna a acmhainniú go hiomlán bunaithe ar an athbhreithniú toilleadh atá le teacht, caighdeáin cliniciúla a fhorbairt chun seirbhísí 'éist agus treorú' agus 'cóiriú agus treorú' a sholáthar, agus paraleigheas pobail a chur ar fáil,
- ⊕ Cur le na éachtanna atá bainte amach leis an gcomhoibriú uile-oileánda cheana féin chun an dtairseach chriticiúil agus scála a threisiú ar mhaithe le torthaí níos fearr d'othair agus creatlach uile-oileánda a fhorbairt maidir le taighde, nuálaíocht, oideachas agus cóiriú leighis a fheabhsú.

Main Recommendations

- **Align and integrate health and social care services under Regional Health Areas empowered with substantial executive authority in the areas of workforce and capital planning to create robust institutions which can deliver on strategic masterplans appropriate to population health needs,**
- **Develop a joined-up, proactive, and comprehensive health and social care workforce strategy to increase education places and training opportunities between the Departments of Health and Higher Education, the HSE, Regional Health Areas/Hospital Groups, and higher education institutions,**
- **Provide for multi-annual capital budgets guided by a strategic investment framework to streamline the Public Spending Code capital process by giving project funding certainty through RHA-allocated budgets and create efficiencies in design and procurement by setting standardised designs,**
- **Establish a Working Group on the Future of General Practice to bring together stakeholders in primary care medicine to address the root problems in General Practice and develop a roadmap for universal GP care including out-of-hours services, a new GP contract, public primary care doctors, and to develop training capacity to meet future demand,**
- **Prioritise healthcare systems modernisation and ringfence budgets for eHealth as well as equipment upgrades,**
- **Devolve discharge responsibility to registrars and senior nurses to coordinate timely discharges and develop patient-specific discharge plans to align planned discharge days with protected step-down and/or home support capacity,**
- **Fully resource the National Ambulance Service based on the forthcoming capacity review, develop clinical standards to provide for "hear and refer" and "treat and refer" services, and rollout community paramedicine,**
- **Build on the successes of existing all-island cooperation to leverage scale and critical mass to achieve better patient outcomes and develop an all-island framework for enhancing research, innovation, education, and treatment.**

Réamhrá

Is iad na liostaí feithimh gan teorainn, síorfhairsingíoch an fhadhb is inláimhsithe sa Choras Sláinte agus Cúraim Shóisialaigh. Níl aon áit do liostaí feithimh fada sa Choras Chúraim Uilíoch atá ag teastail agus tuillte ag muintir na hÉireann.

Is comhartha iad na liostaí feithimh seo d'easpaí struchtúracha agus infreastruchtúracha a chuireann bac ar achmhainn, agus nach dtugann spreagadh d'oibrithe fanacht sa chóras. Mar chuid dár bhfís do Sheirbhís Sláinte Náisiúnta Uileoileáin, caithfear dul i ngleic leis na liostaí seo agus curam sláinte uilíoch á cur ar bun.

Táimse díreach tar éis trí mhí a chaitheamh i dteagmháil le geallsealbhóirí ar fud na tíre (an stáit) chun tuiscint níos fearr a fháil ar cad go cruinn atá ag teastáil ó na hospidéil, agus na hoibrithe sláinte agus cúraim shóisialta, chun dul i ngleic leis na liostaí feithimh seo.

Thaistil mé ó Phort Láirge go Doire, go Báile Átha Cliath, go Ciarraí, go Gailimh agus go háiteanna eile nach iad. Bhuail mé le muintir bainistíochta cúig ospidéal géarmhíochaine déag, chomh maith le baill Fheidhmeannacht agus Ceannaireacht Chliniciúil na Seirbhíse Sláinte agus na Grúpaí Ospidéil.

Anuas ar sin, táim tar éis a bheith i gcumarsáid go díreach le ceardchumainn, le hoibrithe, le pléadálaithe (tacadóirí) othair agus le heagraíochtaí deonacha/pobail chun tuiscint níos doimhne a fháil ar a dtaithí agus na dúshláin atá rompu, agus a dtuairimi a fháil ar réitigh na bhfadhbanna seo.

Chun tabhairt faoin mhí-oiriúnú idir éileamh agus achmhainní sa chóras, tá gá le cur chuige úrnua chun cinnteoireacht deimhneach a chur ar fáil don earcaíocht agus do phleanáil chaipitil.

Agus feidhmniú céimneach ar Cheantair Réigiúnach Shláinte (CRS) ar siúl againn, caithfimid instiúidí láidre a chruthú chun cúram comhtháite a sholáthair in aonaid phríomhúla, aonaid phobail agus in aonaid ghearchúraim.

Caithfidh go mbeidh na CRS freagrach as, agus cumhachtaithe chun earcaíocht agus pleanáil caipitil, le tosaíochtaí Náisiúnta mar bhonn agus taca acu, a sholáthair. Tá gá le dílárú suntasach ionas go gcumhachtófar cinnteoirí gar don othar, próisis dírithe ar thairgthe, bunaithe ar riachtanais áitiúla, a thapú.

Sa cháipéis seo leagfar amach na dúshlain a bhíonn ag ospidéil, agus ag cur oll-infheistiochtaí costáilte san áireamh, conas a athródh Sinn Féin na próisis agus na córais chun iad a dheanamh níos éifeachtaí.

Tá mianbhac i measc geallsealbhóiri nár chuireadh mórchuid de na hathruithe seo i bhfeidhm cheana féin. Le déanaí chuireamar réimse de bhearta costáilte ar fáil sa chaipéis Do Chóras Sláinte Infheidhme: Buiséad Roghnach Sláinte 2022 in a leagadh amach na céimeanna a bheadh ann chun gluaiseacht i dtreo Seirbhís Sláinte Naisiúnta, agus ina rinneadh cur síos ar chuid de na hinfheistiochtaí achmhainne a bheadh gá leo chun dul i ngleic leis na Liostaí Feithimh.

'Se atá sa cháipéis seo ná machnamh ar an méid atá foghlamtha agam ó na cúirteanna ar ionaid chúraim shláinte agus ó bheith ag éisteacht le tuairimí na ngeallsealbhóirí ar céard atá ag teastáil.

Introduction

The most tangible problem in the health and social care system in this State is the never-ending, ever expanding hospital waiting lists. Long waiting lists have no place in the universal healthcare system that Ireland wants and deserves.

Hospital waiting lists are a manifestation of the much deeper, chronic structural and infrastructural deficiencies which limit capacity and drive workers away. These must be addressed in the move to universal healthcare and our vision for an all-island National Health Service.

To gain a greater understanding of the needs of hospitals and health and social care workers if they are to tackle waiting lists, I have spent the last three months engaging intensively with stakeholders across the State.

This has taken me on a journey from Waterford to Derry, to Dublin, Kerry, Galway, and more, where I have met with the management of 14 acute hospital locations as well as members of the executive and clinical leadership of the HSE and Hospital Groups.

I have also engaged directly with trade unions, workers, patient advocates, and voluntary/community organisations to get a sense of their experience, the challenges they face, and the solutions as they see them.

To address the dangerous mismatch between demand and capacity, we need a step change and a change of approach to deliver decisive decision making in recruitment and capital planning.

We must create robust institutions to deliver integrated care across primary, community, and acute settings as we rollout Regional Health Areas (RHAs). RHAs, similar to the Health and Social Care Trusts, would underpin the move to a universal National Health Service across the island.

RHAs must be accountable for and empowered to deliver on workforce and capital planning, underpinned by national priorities. Significant devolution to regions is essential to empower decision makers closer to the patient and inject speed into processes which are focussed on outputs tailored to local need.

This document will set out the challenges which hospitals face and how Sinn Féin would, alongside major costed investments outlined elsewhere, change processes and systems to create efficiencies.

There is a frustration among stakeholders that many of these changes have not been made. These are not new problems or new solutions. We have provided separately for a range of costed measures most recently in For a Health Service That Works: Alternative Budget for Health 2022 which details the steps for moving towards a National Health Service, and outline some of the capacity investments needed in Tackling Waiting Lists.

This document is a reflection on what I have learned from site visits and engagements with stakeholders on the ground and their vision for what needs to change.

• **Portlaoise**

Integrated Care

Integrated care is essential to reducing the burden on acute hospitals and removing the reliance on cancellations which are a major driver of waiting lists.

When alternative care options do not exist in community settings, there is an over-reliance on acute hospitals. Similarly, when decision making in community settings is not linked with acute hospitals, the disjointed system can cause high-cost inefficiencies when looking to make savings.

One example which came up at several locations was the closure of community beds required for discharge from acute hospitals. These beds can be closed, often for financial reasons, with no consultation with their feeder hospitals. This causes delayed discharges from the hospital and the unnecessary closure of a similar number of acute beds. With a joined-up approach, the savings could be made in closing less acute beds, which is always regrettable, but would keep more beds overall open. This example would achieve the required savings while keeping the system running smoother.

A lack of GP services, particularly out-of-hours services, and a lack of primary, preventative, and chronic condition/pain management services in the community have resulted in excessive emergency department presentations. The overreliance on acute hospitals results in congestion and cancellations of scheduled care to create capacity for unscheduled care which could be better delivered in the community.

The solution is not solely in joining up community and acute services and moving more care to the community as hospitals could still struggle to deal with the volume of unscheduled and scheduled care without additional capacity. However, it would go a long way to creating a more sustainable system less reliant on cancellations.

Enhanced GP, Primary, and Community Care

A recurring theme from hospital management was an over-reliance on referrals to acute hospitals from GPs and excessive presentations at Emergency Departments due to the inaccessibility of GPs, both regular hours and out-of-hours services.

This is caused by an acute shortage of GPs and primary/community care alternatives to acute hospitals. The Irish Medical Organisation and the Irish College of General Practitioners have warned that this was coming for some time now.

Expanding access to GP care as well as a wider array of primary/sub-acute care in the community is essential to reducing our over-reliance on more costly hospital care.

We need to roll out the enhanced community care programme as agreed by the Oireachtas to manage chronic conditions, provide pain management, and treat minor illnesses and injury in the community.

The right care at the right time in the right place is more than a slogan, but a principle which every stakeholder supports and advocates. That means care closer to home and the home where possible.

Delivering this will require strategic alignment and integration of health and social care providers on a regional basis through Regional Health Areas. RHAs must have the autonomy in budgets to deliver on core and regional strategic objectives to join up acute and community service decision making and move care out of hospitals and into the community.

Recommendations

- **Integrate and align access and delivery of primary, community and acute care to ensure sharing of resources, improved governance, holistic decision making, and the creation of synergies across settings coordinated across regional health areas, funded, operated, and planned on a population health needs basis,**
- **Continue to rollout the Enhanced Community Care programme as a priority to step up community services capacity for primary and preventative care, condition management, as well as the range of community services, such as physiotherapy, public health nursing, counselling and OT services, speech and language therapy, and disability services.**
- **Establish a Working Group on the Future of General Practice to pull together stakeholders in primary care medicine to address the root problems and develop a roadmap for universal GP care including out-of-hours services, a new GP contract, public primary care doctors, and to develop training capacity to meet future demand,**
- **Develop a public model of multi-disciplinary primary care service provision, including direct hiring of general practitioners as primary care doctors, practice nurses, and allied health and social care professionals, to meet diverse primary care needs and prevent unnecessary hospitalisation,**
- **Continue to develop greater streamlined access to diagnostics for GPs,**
- **Re-commit the State to guaranteeing access to dental care in the community, starting with screening in schools and provision of public dental services in underserved communities,**
- **Expand Community Healthcare Networks throughout every county in the State, ensuring delivery of all 96 proposed CHNs with capacity to triage patients with sub-acute needs to treat and refer or manage and stabilise within community settings to avoid unnecessary hospital admissions,**
- **Rollout community paramedicine, intervention, and chronic disease management teams and ensure adequate skills mix to manage complex needs in or close to the home,**
- **Ensure adequate provision of home support packages to enable more people to recover in the home instead of costly stays in hospital.**

• Letterkenny

• Day Care, Kerry

Delayed Discharges and Step-Down

It is widely recognised that delayed discharges are a cause of sluggishness in the health service. Every day a patient spends in a bed when they could have been discharged to a step-down facility or to their home is a day lost for the patient and for the delivery of treatment.

The aim should not be to rush patients out of hospital, but to ensure that patients are being treated in the most appropriate setting at the right time. Where a patient no longer requires an acute level of care but is not fit to be discharged to the home or where home support hours for such a discharge are not available, they should be discharged to a step-down facility for recovery closer to home.

An issue which came up repeatedly was the requirement for consultants to sign off on discharges. Owing to the severe shortage of consultants in the health service, there is not always time for completing daily rounds. This is a particular issue on weekends, where a patient might be ready on a Saturday but was not ready on the Friday when the consultant did the rounds.

To improve patient flow, we need to make better use of the skillsets across teams, foster a team approach to improve planning and coordination, and create efficiencies in discharge procedures.

Recommendations

- ⊕ **Make provision for devolving discharge responsibility to a registrar, a senior nurse, or advanced nurse practitioners, as appropriate, to coordinate for timely discharge, particularly on weekends,**
- ⊕ **Ensure the availability of step-down beds in community healthcare facilities to ensure appropriate recovery and recovery beds closer to home,**
- ⊕ **Deliver on statutory home care entitlements and the coordination of packages between hospitals and a regional office for home support within RHAs to ensure adequate and timely provision of home support to facilitate recovery in the home,**
- ⊕ **Provide for patient-specific discharge plans which align planned discharge days and protected step-down and/or home support capacity.**

Ambulance Service and Community Paramedicine

As with other areas of healthcare, National Ambulance Service and Dublin Fire Brigade paramedics are at burnout. They have a severe lack of capacity with only 2,000 staff in this State in comparison to the Scottish service compliment of 5,000. On a pro rata basis, this equates to 4,600 ambulance staff.

Half of NAS shifts go over time, often by 3-5 hours. This makes the career highly unattractive and results in serious health consequences for NAS staff.

We need to adequately staff the NAS while also continuing to develop and modernise the

service. We must also ensure 24/7 tactical and operational management to address deficits identified by the NAS in this area.

This includes developing community paramedicine, which would empower paramedics, whether through the NAS or community services, to deliver primary and preventative healthcare services in the home or community setting and avoid the unnecessary admission of patients to hospitals.

This cannot be done by an understaffed service, as time pressure and constraints on staff necessitate the delivery of patients to hospitals before rushing to the next emergency. Much of this care is already delivered by paramedics on site or on the journey to hospital.

Recommendations

- **Commit to resourcing the forthcoming NAS capacity review, including proper resourcing of the ambulance fleet and dispatch centres, to reduce overtime hours and ensure adequate cover for breaks and leave,**
- **Develop new clinical standards to provide for "hear and refer" and "treat and refer" services to reduce unnecessary reliance on hospitals, and further develop and rollout community paramedicine services,**
- **Provide for 24/7 tactical and operational management cover to address deficits in effective leadership in this area, as recognised by the NAS,**
- **Better support NAS staff by improving critical incident stress management and PTSD supports, including employment transfer opportunities for paramedics who can work but not on the frontline,**
- **Raise public awareness on appropriate use of emergency services and community-based alternatives to reduce unnecessary callouts, supported by expanding out-of-hours GP care and "hear and refer" services.**

Workforce Planning

The health service workforce is exhausted and burned out.

It feels unsupported with a reliance on overtime, pay disparities for new entrants, ill-equipped hospitals which cannot provide sufficient theatre time or modern equipment for maintaining skills or upskilling, and so on.

I have published costed proposals elsewhere to deal with these big staffing and infrastructural deficiencies and delivering on the 2018 capacity review.

In my discussions leading up to this document, I wanted to focus on how we can better plan for workforce expansion, fill posts quicker, retain workers and reduce attrition rates.

Training and Recruitment

Roughly half of nursing and midwifery registrations every year are domestic graduates, and the other half are international recruits.

This is a clear indication that we are not training enough nurses and midwives, and there is also evidence to suggest that we are also losing far too many of our graduates (though this is also an issue related to retention and an unavoidable desire to travel).

The question of "where will we get the staff?" comes up in discussions around not only doctors and nurses, but also in relation to psychology, counselling, practice nurses, mental health nurses, physiotherapy, speech and language therapy, carers, healthcare assistants, and so on. It is a constant across the health and social care system.

The Departments of Health and Higher Education, the HSE and Regional Health Areas, and higher education institutions need to develop a comprehensive plan for training, and then retaining, the required staff.

We also need serious reform of the recruitment process. Voluntary public hospitals do not use the HSE National Recruitment Service and tend to balk at the suggestion, with the inefficiency of this system widely remarked on across all stakeholder groups. It is simply not fit for purpose and takes 2-3 times longer to fill posts than local panels built up over sustained and ongoing recruitment campaigns ran by in-house HR departments in voluntary hospitals.

One HSE hospital provided an example of a staff member who was to go on maternity leave. Despite months of notice, the post was not advertised until the staff member went on leave and was not filled until after they had returned from leave when there was no longer a temporary vacancy.

Furthermore, hospitals know their own attrition rates and are in a unique position to plan to fill their own vacancies. This can be coordinated on a regional or local basis, and the strategic decision on where to allocate HR resources and develop panels is best left to each RHA to decide for itself.

When it comes to safe staffing levels, there is already a scientific metric for deciding how

many nurses and healthcare assistants should staff a ward based on the number of patients and the complexity of care needs.

The Framework on Safe Nurse Staffing and Skills Mix is proven to improve patient outcomes and should be put on a statutory basis to hardcore safe minimum staffing ratios. This would be similar to, though more complex than, the pupil-to-teacher ratio. The remaining phases of the Framework relating to emergency departments (said to be complete and for implementation next year) and community settings must be rapidly advanced and operationalised.

It was stated that as few as 16 wards are covered under the Framework with a further 248 awaiting implementation. There were concerns that the expenditure allocations towards implementation have not been spent on the Framework, and it is important that, if an underspend has occurred, that the full allocation is retained on a recurring basis and used for this purpose.

Implementation of the Framework should be factored into Existing Levels of Service funding to ensure ongoing implementation and adherence to this practice.

Recommendations

- **Develop a joined-up, proactive, and comprehensive health and social care workforce strategy to increase education places and training opportunities between the Departments of Health and Higher Education, the HSE, Regional Health Areas/Hospital Groups, and higher education institutions,**
- **The recruitment process should be devolved to Regional Health Areas with the ability to develop regional and local panels to enable speedier recruitment and fill vacancies as they arise, including approval of new posts,**
- **Phase 1 of the Framework on Safe Nurse Staffing and Skill Mix must be applied to every ward in every public hospital, and implementation of phases 2 and 3 relating to Emergency Departments and Community Settings must be rapidly advanced, with an obligation to implement the Framework put on a statutory footing and delivered similar to a pupil-to-teacher ratio,**
- **Steadily increase undergraduate and post-graduate course and training places for health and social care professions based on evidence for required staffing levels and projected population needs to reduce reliance on overtime and international recruitment,**
- **Provide incentives to trainees to enter specialist areas of most acute shortages, such as proleptic appointments (similar to a provisional job offer),**
- **Explore options to provide career advancement across professions building on the HSE sponsorship programme for health service employees such as healthcare assistants to become nurses and midwives.**

Addressing the Retention Crisis

Every acute sector stakeholder expressed concerns about the health service's ability to retain staff, particularly medical and nursing and midwifery staff.

There are severe levels of fatigue and burnout owing from consistent overtime, a lack of breaks, and an inability to take annual leave which is leading to stress and moral distress. Workers cannot take their breaks or sick leave without feeling guilty that they have made work harder on their colleagues.

It is a widely held view that the pandemic has only temporarily stemmed the exodus of young graduates to Canada, Australia, New Zealand, and the United States.

Health and social care professionals are in high demand globally and poor labour relations pushes talented graduates abroad.

This tension and resentment stems in part from a sense of bad management but also from a culture of overworking. Stakeholders, including management, expressed concerns that the structural reliance in some hospitals on overtime is a significant contributing factor to desire to leave the health service. This can only be addressed by adequate staffing.

Beyond staffing levels, stakeholders also stressed the need for pay agreements to be offered. Unions expressed frustration that every time there is an agreement, "the implementation becomes a new negotiation." Honouring the latest public sector pay agreement as well as addressing the spread of other workforce concerns will be essential to rebuilding trust between the HSE and health and social care workers.

In addressing the doctor recruitment and retention crisis, we must ensure we are treating NCHDs with respect. That means paying them, as well as other service workers, the correct amounts on time according to the correct terms of employment.

There are widespread reports of months-long delays in implementing already agreed overtime rates which further erodes desire to continue a career in the public health service.

There were also concerns raised that not all nurses and midwives who are entitled to the enhanced practice salary scale are paid it, and that new posts are not advertised with this scale when they should be.

We must support doctors and nurses with adequate support staff for patient management and administrative burdens. Specialist healthcare professionals should be maximising their value to patients and not be buried under paperwork.

We must also develop opportunities for career progression which keep talented and specialist nursing/midwifery staff "at the bedside." To secure higher wages, they are pushed into managerial roles that many do not want, and which do not make the optimal use of health service resources.

We need to stem the drift of health service workers abroad and offer incentives to entice those who do emigrate to return. One option which has been deployed in some circumstances is the proleptic appointment which is essentially a provisional job offer.

The Department of Health and the HSE should explore the potential for offering a provisional

job offer to a number of workers who are emigrating for training or otherwise who would like to return. It can be difficult to return after a number of years abroad without any job certainty. The knowledge that there is a job waiting for you will let these workers know that we value them and that we want them working in the Irish health service.

Another significant barrier to retention, particularly in Dublin and Cork but increasingly across the State, is the cost of living. The cost of housing in particular has been cited by multiple stakeholders as a significant challenge for workers, particularly graduate nurses, which is pushing many out of our largest hospitals and even out of the State. We need to strategically plan affordable housing for healthcare workers along transport linkages to major hospitals and other healthcare facilities. One mooted option which I want to explore further in consultation with the local community and health stakeholders is the utilisation of a major site in Crumlin to develop affordable housing for workers at St James', the Coombe, and the National Children's Hospital.

Recommendations

- **Honour pay agreements, address pay disparities, and pay workers the correct amounts on time,**
- **Explore options for enticing the high proportion of part-time nursing and midwifery staff into full-time employment,**
- **Support doctors and nurses with adequate support staff for patient management and administrative burdens to maximise patient care,**
- **Develop opportunities for career progression which keep talented and specialist nursing/midwifery staff in patient-facing roles,**
- **Allow Regional Health Areas to approve a limited number of provisional job offers to workers who are emigrating for training or otherwise to incentivise them to return within a given timeframe and factor this into workforce planning,**
- **Strategically develop affordable housing which can address the needs of healthcare workers in future housing development policy.**

Capital Planning

A recent Expenditure Review published by the IGEES unit at the Department of Health noted "a lack of centralised strategic direction for healthcare" in capital planning with limited longer-term strategic investment decisions and, consequently, a historical underspend in capital investment equating to only 66% of the investment made by EU peers from the 1970s to 1996.[1] It noted that "while the gap in spend has closed in recent years, it is likely that this has left a legacy of lower capital stock."

This view is widely held among the stakeholders I have engaged with who have pointed to capital planning and approval procedures which "take too long" and are "very reactive," "not forward thinking," "nonsensical," "overly bureaucratic" and "[do] not facilitate good planning."

These factors combined have led to poor infrastructure outcomes and capacity constraints such as a lack of surgical ward beds, protected critical care beds (we have just over half the critical care beds that the 2009 capacity review recommended for 2020 and started that year with less than we had in 2009), and reserved inpatient recovery beds which have led to cancellations of planned procedures.

Stakeholders also contend that hospitals need to be redeveloped every 50 or so years to modernise infrastructure and keep up with advancing clinical standards.

Poor planning has also meant that we face a shortage of surgical theatre capacity, a lack of diagnostic capacity in hospitals and in the community, and out-dated, not fit-for-purpose multi-occupancy wards and antiquated buildings. This has created conditions in hospitals which are not only less safe than they should be, but dangerous in the face of a novel infectious disease epidemic such as the one we are experiencing.

Approval Process and Multi-Annual Budgets

The capital funding process takes too long. While there is good reason for the Public Spending Code processes, many stakeholders have suggested that this needs to be reviewed in a health context.

In a similar vein, a recurring theme has been the need for a strategic investment framework for health capital planning.

As an example, Children's Health Ireland (CHI) needs 18 theatres but only has 13. A single new theatre will open in the coming months, but paediatric orthopaedic surgeon Connor Green, when giving testimony at the Health Committee, expressed frustration that there could have been two additional theatres at Cappagh Orthopaedic Hospital for 'Cappagh Kids' to deliver more elective care.

Management across hospitals expressed similar concerns that capital projects were not getting approval on an ambitious enough scale and that this was causing dysfunction within the health system.

In my own constituency of Waterford, we have been waiting a number of years for the

1 Hennessy, M., Shine, C., and Walker, E. (2021), Healthcare Capital Investment in Ireland: Analysis of Historical Capital Investment in Healthcare. Available at: https://www.gov.ie/en/collection/87ee1-spending-review-2021/

delivery of a second catheterisation laboratory which received Ministerial approval in 2018. It took nearly three years for construction to begin after that. A similar project, from concept to delivery, was delivered by a private clinic in about 6 months which was then procured for HSE services until the public lab could be built.

The capital process needs to build in resilience, accessibility, adaptability, and regional balance. Regional Health Areas will be uniquely situated in the health system to plan on the basis of population health needs on the basis of these principles.

We must empower RHAs to develop masterplans and controlled development plans for their locations to maintain and increase standards and capacity in hospitals, as well as developing capacity for public primary/community care facilities.

These masterplans would contrast the existing stock with future demand needs to identify gaps across service divisions, viewed on a holistic and strategic regional basis.

By developing masterplans, we can get ahead of the PSC process by getting the early stages out of the way to ensure a pipeline of standardised designs for shovel-ready projects as investment opportunities arise and funding becomes available.

We can also create efficiencies in the process by guaranteeing funding availability on a multi-annual basis to allow local management set the pace for development. Multi-annual capital budgets with flexibility on project prioritisation devolved to RHAs will give certainty on funding opportunities for strategic investment which would allow completion of PSC phases in rapid succession, not delayed by the need to wait for phase-by-phase funding applications to a central, national unit.

The National Development Plan, as it stands, is an indicative envelope but not guaranteed which creates uncertainty. The need for a more certain medium-term capital investment plan has been highlighted by IFAC among other stakeholders, including within the Department of Health.

All facets of the health service have long equipment lists detailing the infrastructure which requires upgrading or replacement parts. It is a fact that far too much of the equipment stock is outdated, with many MRI scanners, for example, being a decade or more old. These are less efficient than modern counterparts and at constant risk of breakdown.

We would empower RHAs to ensure that hospitals and other facilities develop medical equipment management plan and equipment needs lists which would be funded on a recurring basis for purchase, installation, maintenance, replacement, upgrade, and training. RHAs would strategically prioritise across lists to target investment where it is needed most.

RHAs could also build on existing approved multi-party framework agreements for minor works to expedite quick tenders for priority projects. We would keep the scope of projects applicable under such schemes under review to balance cost control/effectiveness with speed of project delivery.

Fundamentally, reforms to the approval process and budgets must enable the development of cogent national and regional investment roadmaps which is based on evidence and population need with regional balance.

Recommendations

- ⊕ **Devolve responsibility to RHAs to ensure the development of masterplans and controlled development plans for all sites within their remit and to develop regional masterplans, coherent with national strategic objectives, which deliver on regional priorities to develop:**
  - **Surgical theatre capacity,**
  - **Hospital and community diagnostic capacity,**
  - **Plans for achieving bed capacity objectives while phasing out antiquated stock for hospitals and community services,**
  - **Plans for developing community facilities to enable the rollout of public primary/community care services, including step-down recovery and rehabilitation facilities, targeting underserved populations,**
  - **Repurpose existing footprint to maximise clinical space as beds are moved into new build single occupancy units,**
  - **Plans for providing affordable accommodation for healthcare workers in conjunction with local authorities and communities,**
  - **Plans for refitting and redeveloping clinical sites on a rolling basis to ensure equipment and infrastructure is not being used past its end of life.**
- ⊕ **Provide for multi-annual capital budgets and multi-party framework agreements of approved contractors for quick tenders to generate efficiencies in the PSC capital process and give project certainty to prevent stage-by-stage delays,**
- ⊕ **Create standardised designs which deliver best clinical standards for new build units across varying purposes to speed up design stages and streamline procurement,**
- ⊕ **Develop a strategic investment framework which, along with RHA masterplans, will create a pipeline of shovel-ready projects to be delivered as need arises,**
- ⊕ **Strategically align regional medical and ICT equipment management plans and upgrade/replacement lists to be prioritised managed within RHA and sub-unit budgets.**

• SIPTU, Cork

• Galway University Hospital

Elective Centres

There is widespread agreement among stakeholders on the need for elective centres to provide protected facilities for scheduled care and should not include emergency departments to avoid unscheduled care-related cancellations.

Cappagh National Orthopaedic Hospital has shown the effectiveness of divorcing scheduled and unscheduled care in separate facilities. By delivering only scheduled elective care, Cappagh has protected elective capacity without the competing demand of emergency care.

Elective centres would deliver protected treatment space for elective surgeries. The largest backlog of elective lists is in day cases. Clearing this must be a priority.

There is a robust debate on whether these facilities should include beds and the additional overheads these would bring. The main argument in favour of this is the need to plan for future demand. It is important that the possibility for inpatient bed capacity is factored into considerations with options for future expansions should it become necessary. The HSE and Regional Health Areas should continue to examine whether there would be a need to expand inpatient capacity at elective centres as part of multi-year capacity planning.

The important thing is that elective centres get up and running as soon as possible to clear the massive backlog on day case waiting lists. This will help to end the costly reliance on outsourcing of day case elective care to the private sector or bus trips to the North.

By shifting scheduled care to elective centres, we can free up clinical space in acute hospitals to repurpose capacity for other inpatient and emergency care.

Recommendations

- **Rapidly advance the development of three Elective Centres to deliver scheduled elective treatment and cut the backlog on waiting lists,**
- **Ensure repurposing of freed up clinical and surgical space to create additional beds to build in headspace for unscheduled emergency care as part of a multi-pronged approach to reducing reliance on cancellations of scheduled care,**
- **Keep the need for inpatient capacity at Elective Centres under review and factor this into site acquisition and multi-year capacity planning.**

eHealth and ICT

Stakeholders are unanimous in the view that, when it comes to ICT and eHealth, the health service is 10-15 years behind where it should be.

There are massive deficiencies in the health service when it comes to electronic patient records, patient management systems, booking systems, and financial and procurement systems, not to mention the difficulties that outdated systems and hardware create for cybersecurity.

This makes patient management less efficient. Reforms such as ePharmacy and telemedicine as well as a centralised referral system and an integrated waiting list management system can speed up processes for patients and for clinicians.

Electronic records, with proper safeguards in place, can ensure that when a patient is seen at a different hospital or where they change GP, their doctor can know their medical history, their lab results, their previous treatments, and so on, without waiting on the transfer of paper files.

The lack of integrated financial and procurement systems across the HSE is no doubt contributing to waste and delay. It is not possible to properly account for expenditure and ensure value for money in an organisation with a €20bn budget without these systems.

Similarly, there are major deficiencies in HR systems. The central HSE does not have the capacity to collate information on vacancies, length of vacancies, part-time workers, overtime, grades on shifts, agency workforce, and so on because data is held at a local level, often in physical records, and not part of a service-wide system.

When Regional Health Areas are rolled out, they need to know every detail across each of their sectors and service divisions. This is essential to knowing and planning for patient needs, prioritising investment, and ensuring value for money and savings which can be reinvested in strategic priorities.

It is also essential that the central HSE and the Department of Health have ongoing access to this information to monitor the effectiveness and implementation of policy.

Healthcare modernisation will rely on the successful rollout of individual health identifier numbers. These will allow for the appropriate collation of patient data so that systems can communicate with one another and RHAs know the health needs of the populations they serve.

Recommendations

- **Prioritise healthcare systems modernisation in a strategic healthcare investment framework,**
- **Ringfence budgets for both hardware and software to ensure that both are being adequately funded to modernise systems and ensure up-to-date ICT equipment,**
- **Ensure a common approach and integration of health systems to deliver conformity, transferability, and standardisation across major technology investments while allowing scope in RHA budgets to fund technological innovation.**

Opportunities for All-Island Cooperation

Throughout my engagement with stakeholders, there was an eagerness to discuss opportunities for taking advantage of the scale of the island-wide population to deliver a critical mass which would not exist in either jurisdiction alone.

Examples of highly successful all-island cooperation already exist in the North West Cancer Centre at Altnagelvin and the All-Island Congenital Heart Disease Network at Crumlin and Belfast. The former has introduced a huge benefit in convenience for cancer patients across the north west to access treatment closer to home. The latter has allowed for the development of highly specialist services in Crumlin and Belfast which would not be sustainable without the critical mass of the all-island population.

In these two areas alone, there are significant further opportunities for deeper cooperation. It is my ambition that we create an all-island framework to enable medical professionals to continue to deepen this relationship, both through Regional Health Areas and HSC Trusts as well as directly between hospitals with specific concentrations of specialties and through expert networks.

An area which was particularly interesting is the proposed Academic Health Science Centre (AHSC) being developed between St James' Hospital and Trinity College, Dublin, and the Paediatric AHSC championed by Children's Health Ireland. The combination of treatment, education, and research is known to improve patient outcomes. Developing further AHSC's across the island and linking them through a truly national Academic Health Science Network or an all-island Health Science Centre would bring immense benefits to research and innovation, treatment of patients, and the education of healthcare professionals.

One network I met, with my colleague Colm Gildernew MLA, Chair of the Assembly Committee on Health, was the working group on an All-Island Cancer Research Institute (AICRI). AICRI's goal is to widen research and funding opportunities on both sides of the border as well as widen access to clinical trials for innovative treatments. Despite the aims of the Cancer Strategy and the enthusiasm of patients, researchers, and clinicians, less than 5% of Irish cancer patients are on clinical trials. By comparison, upwards of 20% of NHS England patients have such access. Investment in novel treatments such as CAR-T are also presenting, with commitments from the National Cancer Control Programme to invest in such services for children through Children's Health Ireland.

An area which is in dire need of cooperation is paediatric pathology. The island is facing a critical shortage of paediatric pathologists. According to the reckonings of the RCPI Faculty of Pathology, the island needs 8 paediatric pathologists. There are none in the north and only 2 in the south, with 2 other posts struggling to be filled (one on a proleptic appointment – showing the value of this mechanism). This is not a service which can be sensitively exported from the island. The consequences of this, particularly for parents, are unconscionable. We need an all-island strategy to develop expertise in this area and service the island-wide population.

The new National Children's Hospital will present further opportunities for all-island approaches to paediatrics, and this is something which Children's Health Ireland is actively championing and developing. It is crucial that the political systems on both sides of the border get behind this effort to deliver the best care for our children, while giving the

medical profession the space to develop services. CHI have also indicated that there is great potential in paediatric orthopaedics – for children with scoliosis, spina bifida, and other musculoskeletal conditions – for all-island cooperation.

There are many more opportunities for all-island cooperation presenting in nascent and underdeveloped fields where we can take advantage of scale to deliver in the areas of genomics and rare diseases, advanced therapies in neurology and neurosurgery, complex pain management, and more.

Recommendations

- **Build on the successes of existing all-island cooperation to leverage scale and critical mass to achieve better patient outcomes,**
- **Develop an all-island framework for medical professionals and organisations to deepen cooperation, expand access to research opportunities and clinical trials, and integrate care pathways,**
- **Develop an All-Island Academic Health Science Strategy to enhance research, innovation, education, and treatment in hospitals and research institutes across the island.**

• Irish Ambulance Representative Council, Cork

Concluding Remarks: Regional Health Areas

The potential of Regional Health Areas has featured strongly in my discussions with the vast majority of stakeholders.

As illustrated throughout this report, they serve as an opportunity to relax overcentralisation and introduce regional management which is strategically responsive to local needs.

Workers in health and social care at all levels across the State are not only ready for but excited for such a change in approach.

Regionalisation and accountably autonomy is critical on three interlinked grounds.

Taken together, it makes sense to strategically devolve responsibility for workforce and capital planning and the implementation of redesigned models of care to regional authorities, overseen and kept coherent by the central HSE which is in turn steered by policy from the Department of Health.

It is important that in the move to regionalisation that nationally integrated care organisations and specialties – such as Children's Health Ireland and the regulation of paediatrics – are not forgotten in regional structures. It is important that paediatrics, and other affected specialties, continue to have a seat at the table and are coordinated along regional and national lines.

Multi-year budgeting and the alignment, in partnership, between care organisations through RHAs will give regionally integrated care organisations agility and flexibility in decision making with strong national institutions to hold them to account and ensure best outcomes. This will give real meaning to the principle of accountable autonomy.

Accountable autonomy will facilitate the creation of synergies, sharing of resources, integration of services, alignment of structures and improved governance through strategic, holistic decision making.

It will remain a priority for us that these reforms are underpinned by a strong national direction set by Government policy. RHAs would continue to utilise national systems such as a centralised referral system and an integrated waiting list management system. These would prioritise services closest to home and within local and regional structures, but which can transfer care where necessary, whether on the basis of concentrations of speciality or in the event of excessive local/regional wait times.

Regional Health Areas provide a balance between local and central levels of control which is optimised for delivery of national priorities tailored to local need.

Accountability and Clinical Governance

The current model of primary and community care is disjointed and poorly planned.

It is not properly integrated with one another or with the acute hospital system.

This is evident in the structure whether Community Healthcare Organisations are not aligned

with Hospital Groups and existing organisations serve wildly different populations.

This creates difficulties in accountability and performance measurement as well as complications for care pathways.

There are unclear lines of accountability, management, and referral, with no oversight of structures and care delivery performance.

This is a difficult task for a single centralised HSE to perform on its own.

Accounting and Population Need

The current method of budgeting on the financial needs of previous years does not make sense.

Budgets should be based on the population needs and organisations need to be flexible in how they expend their resources.

Different communities and regions have different pressure points, and varying demographic profiles present different challenges.

By aligning structures and devolving priorities to RHAs, we can end the competition and segmenting of budgets between service providers who should be cooperating.

Budgets based on population need will ensure greater transparency and accountability as they can be better judged on performance against targets and one another.

Outcome Observation

Following from the previous two factors, outcome observation is greatly enhanced by planning on a regional basis.

Once the stock and gaps are identified across regions and budgets are apportioned on a population needs basis, we will benefit from inter-regional comparisons in outcomes which are balanced on a demographic basis.

RHAs can facilitate a more accurate measurement of access to entitlements, effectiveness of delivery, and the generation of better information as well as providing opportunities for innovation in reaching objectives within Government-approved strategic frameworks.

The closer management is to the coal face, the more in touch with reality they are.

The more empowered and localised we can make decision making, the quicker we can turn around improvements to integration of care, recruitment, retention, capital planning, and project delivery.

Appendix 1. Locations and Stakeholders

CONSTITUENCIES VISITED:

1. **Cork**
2. **Sligo**
3. **Galway**
4. **Limerick**
5. **Waterford**
6. **Laois**
7. **Meath**
8. **Kerry**
9. **Derry**
10. **Donegal**
11. **Roscommon**
12. **Dublin Central**

HOSPITALS VISITED:

1. Waterford University Hospital
2. Cork University Hospital
3. Sligo University Hospital
4. Galway University Hospital
5. Limerick University Hospital
6. Midlands Regional Hospital Portlaoise
7. University Hospital Kerry
8. Letterkenny University Hospital
9. Portiuncula University Hospital
10. St James' University Hospital
11. Children's Health Ireland Crumlin
12. Mater Misericordiae University Hospital
13. Children's Health Ireland Temple Street
14. The Rotunda

GROUPS ENGAGED ON VISITS AND IN ALTERNATIVE BUDGET PROCESS:

1. All-Island Cancer Research Institute working group
2. ARD Resource Centre
3. City Centre Penny Dinners (Cork)
4. Connect (Galway branch)
5. Croí
6. Donegal Cancer Care
7. Enable Ireland (local branches)
8. Fórsa (various branches)
9. Galway Traveller Movement
10. Grasp
11. HSE Community Healthcare Organisations
12. HSE South East Disability Services
13. Irish Ambulance Representative Council
14. Irish Cancer Society and local cancer support groups
15. Irish Carers Association
16. Irish College of General Practitioners
17. Irish Dental Association
18. Irish Heart Foundation
19. Irish Hospital Consultants Association
20. Irish Medical Organisation
21. Irish Nurses and Midwives Organisation (national and local branches)
22. Irish Patients Association
23. Irish Wheelchair Association (various branches)
24. Jigsaw (Galway)
25. Laois Carers group
26. Lifford Hospital Campaign
27. Local Dentists and Service Advocates in Kerry
28. Local GP practices
29. Local primary care centres
30. Magee University School of Medicine
31. Medical Laboratory Scientists Association
32. Mental Health Reform
33. National Ambulance Service
34. NCBI
35. Neurological Alliance of Ireland
36. Northland Addiction Centre
37. North-West Stop Suicide
38. Samaritans
39. Saolta Hospital Group
40. SIPTU (various branches)
41. Sligo Childcare
42. St Celicia's School for children with learning disabilities
43. Stop Maternity Restriction Campaign in Cork and Dublin rally
44. University Hospital Kerry Consultants group
45. Waterford Intellectual Disability Association
46. Waterford paramedics
47. Waterford Wheelchair Association branch
48. Westside Resource Centre (Galway)

• Children's Health Ireland, Crumlin

• The Rotunda

• St James' University Hospital

• Mater Hospital

• National Ambulance Service

• Limerick

• Children's Health Ireland, Temple Street

• Roscommon

• Waterford

• Dublin

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