

# Health Service Capacity Review 2018

Laura Casey  
Tony Flynn  
Adam Monaghan

Health Systems and Structures

Policy and Strategy Division

Department of Health



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# Background



The Health Service Capacity Review 2018 fulfils a commitment in the Programme for a Partnership Government.

At the outset, it was agreed to extend the scope of the Review beyond acute hospital bed capacity and to include key components of primary care and services for older persons, in acknowledgement of the interdependencies of capacity across the system and the need to consider reform proposals as part of the analysis.

## Aims of the Review

To provide analysis and assessment of future capacity requirements.

To provide quantitative data on the impacts of reform to support changes in the model of care.

To provide an evidence base for additional resources.

As the Review progressed, to change the narrative on the need for additional acute capacity.

## Terms of Reference

To determine and review current capacity, both public and private, in the health system and benchmark with international comparators.

To determine drivers of future demand and estimate impact on capacity requirements to 2031.

To consider and analyse how key reforms to the model of care will impact on future capacity requirements across the system.

To provide an overall assessment, including prioritisation and sequencing, of future capacity requirements on a phased basis for the period 2017 – 2031 at a national and regional level, cognisant of resource availability.

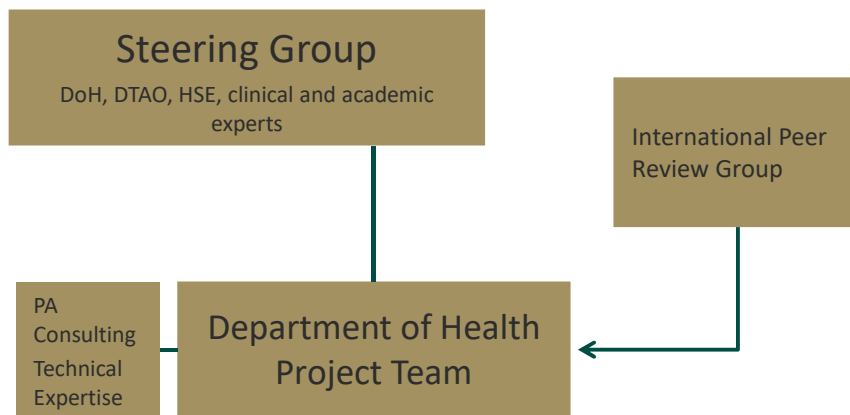
## Out of Scope



Given the time constraints, the following were not considered:

- Mental Health Services
- Disability Services
- Some aspects of Primary Care, Palliative and Ambulance Care
- Workforce Capacity (except primary care)
- Costing of additional capacity requirements
- Costing of replacing/upgrading existing capacity

## Guiding the Review



## Stakeholder engagement

### Workshops with key stakeholders [PA Consulting]

**First Wave Workshop:** Testing baseline assumptions and consideration of policies and reforms for alternative scenarios

**Second Wave Workshop:** Testing baseline results and further consideration of potential reform scenarios as well as identifying evidence to support the assessment of the impact

### Bi-lateral Consultations

PA met with a range of key stakeholders including:

HSE Leadership  
Insurers  
Private hospital sector

Hospital Groups  
Department of Health &  
HSE units

### Public Consultation [DOH]

The Department ran a public consultation from August to September 2017

The consultation called for submissions from interested stakeholders based on a consultation paper

## Methodology

1. Baseline Demand: 2016 Activity + Unmet Demand.
2. Projected forward using:
  - I. Demographic Projections [CSO M2F2]
  - II. Non-Demographic Factors [Trend analysis 2012-2016].
3. Waiting List Reduction.
4. Baseline Demand Forecast.
5. Convert to Capacity using assumptions on resource usage [LOS], resource availability [opening hours] and resource utilisation [OR].
6. Apply an improvement in occupancy rates for acute beds
7. Overlay Reform Scenarios



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Informed by the consultation process and discussions at Steering Group meetings, three reform scenarios were identified.

**Reform 1**  
Improved Health and Wellbeing

**Reform 2**  
Improved Model of Care  
Centred around  
Comprehensive Community-  
Based Services

Reform Scenario 2 focussed on:  
**Developing a comprehensive primary and community care service through raising CHO capacity and:**

- More proactive management of chronic diseases in the community leading to a reduction in ED, IP EL and NEL admissions for 65+
- Increases in primary and social care activity (Public Health Nursing, Homecare, ST residential care and CIT services)
- 15% reduction in ED admissions and Medical NEL (>65s)
- Cohorted wards within hospitals and reduced LOS for 65+ population

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**Reform 3**  
Hospital  
Productivity  
Improvements

Reform Scenario 3 focussed on:  
**3A. More efficient use of acute HG resources through:**

- 10% of day case surgery moving to OPD + primary care
- IP LOS reduction due to better patient flow from better separating IP EL and NEL
- IP EL operating at a higher safe occupancy rate (90%)

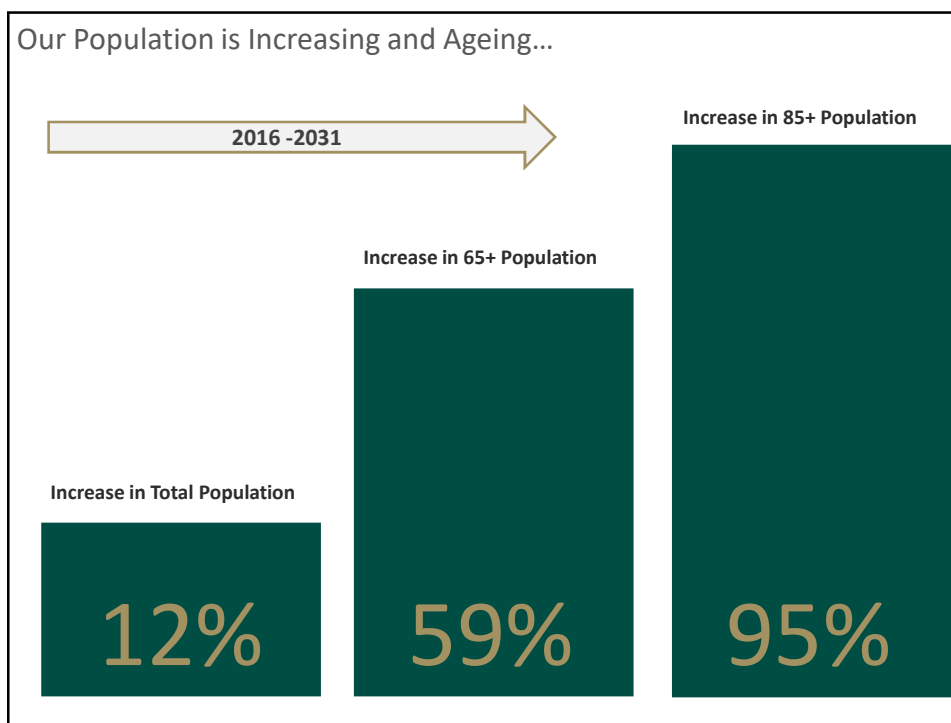
**3B. Improved patient flow and productivity / throughput :**

- ALOS reduced to national median LOS (max reduction 20% per HG)
- 30% daycase throughput improvement (from 2.0 to 2.6 cases)
- 40% increase in AMU throughput
- Reduction in ratio OPFA to OPFU
- 20% medical day case to OPD

**Data  
Limitations**


1. Data Availability.
2. Trend Analysis for Non-Demographic Growth.
3. Reform Assumptions.
4. One Population Projection Scenario Used.

Drivers of Demand Growth



Age Profile of Service Users (2016)

AGE GROUPS	ED	AMU	DAY	IP EL	IP NEL	ACC	OPFA	OPFU	GP-GP	GP-PN
0-15	22%	0%	4%	11%	14%	0%	15%	11%	10%	12%
16-64	59%	55%	57%	49%	55%	45%	65%	60%	65%	56%
65+	19%	45%	39%	39%	31%	55%	21%	28%	25%	31%
AGE GROUPS	AHP-PHY	AHP-OT	AHP-SLT	PHN	CIT	RC-LT	RC-ST	HC	IHC	HH
0-15	13%	28%	80%	9%	0%	0%	0%	0%	0%	0%
16-64	46%	23%	12%	21%	0%	5%	5%	15%	15%	15%
65+	41%	50%	8%	69%	0%	96%	96%	86%	84%	86%

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## Non-Demographic Growth

- Epidemiological Trends
- Lifestyle risk factors (smoking, alcohol consumption etc)
- Technological Developments (new drugs etc.)
- Socio-economic changes and changes in expectations of services
- Population with private health insurance
- Supply induced demand (e.g. additional funding for services unlocking demand)

**Examples of Non-Demographic Growth calculations (acute and social care)**

POD	Growth Period		Demographic Growth	Non-Demographic Growth - Calculated Forecast	Non-Demographic Growth - Adjusted Forecast
	No. of years	Range of years			
Day Case	4	2012-2016	1.7%	1.3%	1.3% à 0.3% *
IP EL	4	2012-2016	1.5%	-4.0%	-1.5%
IP NEL	3	2013-2016	1.2%	-0.1%	0.0%
ACC	3	2013-2016	2.3%	-2.0%	0.0%
Residential Care Long Term	3	2013-2016	3.9%	-2.1%	-1.6%



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\*During future years 1-5 (2017-2021), non-demographic growth is amended to the first activity growth percentage listed, and in the subsequent years 6-15 (2022-2031) non-demographic growth changes to the second percentage listed, reflecting potential saturation in shift from Inpatient to Day Case.

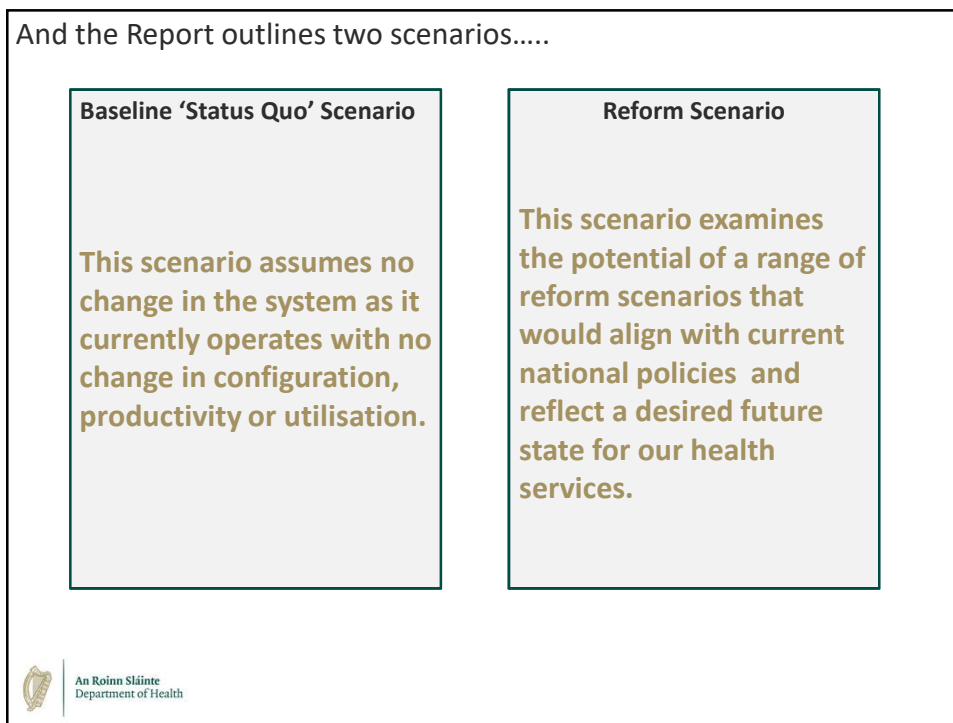
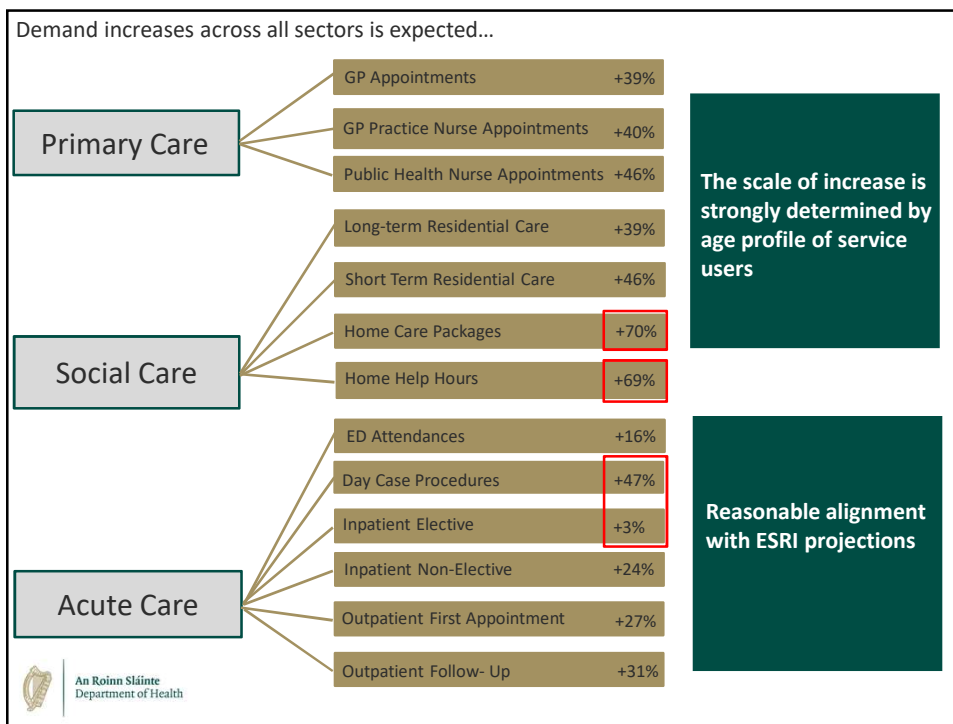
## Key Findings\*



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\*Figures contained here are rounded as described in the Capacity Review Reports





Without Reform	Primary Care	With Reform
<b>39%</b> [+1,400]	<b>GP Workforce</b> Reflects the increased role for Practice Nurses in chronic disease management and the shift in tasks to reflect a better skill mix in General Practice	<b>29%</b> [+1,030]
<b>40%</b> [+500]		<b>89%</b> [+1,200]
<b>46%</b> [+700]	<b>Public Health Nurses</b> Moving towards comprehensive community care	<b>67%</b> [+1,100]
PHY <b>38%</b> [+200] OT <b>32%</b> [+160] SLT <b>-6%</b> [-30]		<b>Allied Health Professionals</b>

Without Reform	Social Care	With Reform
<b>39%</b> [+10,100]	<b>Long-term Residential Care</b> This aligns with the current policy focus on greater levels of home-care & short-term step up/down respite-type care. The focus is on keeping people at home and out of the acute setting as much as possible	<b>39%</b> [+10,500]
<b>46%</b> [+11,000]		<b>62%</b> [+2,500]
<b>70%</b> [+11,000]	<b>Home Care Packages</b>	<b>122%</b> [+19,000]
<b>69%</b> [+7.2m]	<b>Home Help Hours</b>	<b>118%</b> [+12.5m]

Without Reform	Acute Care	With Reform
<p><b>37%</b> [+160]</p>	<p><b>AMU Beds</b> Improved throughput through improved management of services</p>	<p><b>0%</b></p>
<p><b>47%</b> [+1,000]</p>	<p><b>Day Case Beds</b></p>	<p><b>14%</b> [+300]</p>
<p><b>56%</b> [+5,800]</p>	<p><b>Inpatient Beds</b> Reduced LOS in IP surgery due to better patient flow and reduced NEL admissions due to enhanced community care services</p>	<p><b>20%</b> [+2,100]</p>
<p><b>79%</b> [+190]</p>	<p><b>Beds</b></p>	<p><b>79%</b> [+190]</p>

# Next Steps



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## High-level Recommendations

- Reform is needed to drive more appropriate models of care and to protect the sustainability of the system and investment must act as a catalyst
- There is a need for investment in capacity across all sectors, particularly in out-of-hospital care
- There is a need for a short-term increases in bed capacity to address potentially unsafe bed occupancy levels
- Further work required:
  - workforce requirements
  - Other services such as disabilities or mental health.
  - Roadmap for reform (Sláintecare Implementation)
  - Planning process for infrastructure development
  - developing evaluation frameworks to monitor and assess reform initiatives along with the development of robust and comprehensive data systems.
- Capital investment will be needed to enhance service provision and to drive reform. It is clear however that investment should go hand in hand with reform as the current configuration of the system is not optimal



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The Capacity Review findings and recommendations informed the development of the National Development Plan, which has committed €10.9bn in capital spending for Health over the next 10 years, including:



**2,600**

Acute hospital beds

**3**

New Elective Hospitals in  
Cork, Galway and Dublin

**4,500**

Long- and short-term  
residential care beds



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## Planning and Delivery of Capacity and Reform

### Capacity

- Capacity Review and NDP provide starting point for capital development
- There is a need for increases in bed capacity in the short term to address potentially unsafe bed occupancy levels
- Detailed planning for:
  - Elective Hospitals
  - Acute Capacity Planning
  - Nursing Home Programme

### Reform

- The Sláintecare Report provides the vision for the future of the health service
- The Implementation Strategy, which was published in August, outlines 106 interlinked actions needed to realise this vision
- A number of recommendations outlined in Sláintecare have already been actioned
- Clinical, patient and broader stakeholder engagement throughout the reform process will be essential to success



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## Questions?

E-mail: [Adam.Monaghan@health.gov.ie](mailto:Adam.Monaghan@health.gov.ie)

Capacity Review Executive and Main Reports available at:  
<https://health.gov.ie/blog/publications/health-service-capacity-review-2018/>



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