IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Submission to the Health Service Capacity Review 2017

September 2017

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel (01) 676 72 73
Email : vhetherington@imo.ie
Website www.imo.ie

Executive Summary

The Irish Medical Organisation (IMO) is the representative body for Doctors in Ireland and welcomes the opportunity to submit the views of the Medical Profession to the Health Services Capacity Review. The IMO has consistently highlighted the capacity deficits that exist across our health services and the investment required in order to meet the challenges of a growing and ageing population as well as rising incidence of chronic disease. Changes to the model of care, more effective use of existing capacity and extensive capital investment are urgently required if we are to meet current and future healthcare requirements.

In order to ensure the future sustainability of the healthcare system, there is an urgent requirement to alter the model of care towards general practice and care in the community. An extensive body of international research shows that continuity of care and the patient-centred approach that is specific to General Practice is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services and long-term cost effectiveness. However, FEMPI cuts have seen a dramatic reduction in the level of resources allocated per person to General Practice and there is an imminent shortage of GPs. Experience from other jurisdictions shows that in order to reap the benefits, the development of General Practice and care in the community requires significant investment over time. The IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of General Practice in Ireland over the coming decade. In an era of reduced resources, the IMO is also warning the Government against investment in alternative models such as community-based nurse-led clinics where the evidence is poor and which will undermine continuity of care in General Practice and risk further fragmentation and duplication of care.

Investment in General Practice will not solve the crisis in our Emergency Department but it will reduce the rate of increase in demand on the hospital system. It must be realised that an expanding and ageing population will create additional demand on our hospital system. There is an urgent need to increase acute bed capacity to allow rapid admission from Emergency Departments for patients that require it. To ensure patient safety and allow for surges in demand, hospital planning must be based on 85% occupancy rates. Hospital planning must also include an assessment of diagnostics, radiology and laboratory service requirements in both the hospital and community setting as well as the human and financial resources required for the continuous and adequate delivery of services. Emergency Departments and Acute Hospitals will also need upgrading to cater for elderly, frail patients, and patients with complex needs while a greater number of single rooms are required to support both end-of-life care and infection control.

Within our mental health services, while the move away from the “asylum model” to care in the community was a welcome policy direction, there will always remain a need for longer term placements. In order to support the recovery model there is currently a desperate need for long term supported accommodation for people with mental illness who have behavioural and care needs which make them ineligible for housing within the non-statutory sector. There are also significant deficits in child and adolescent inpatient units as well as deficits in acute alcohol and drug detoxification units.

While there are no “magic bullets” that will rapidly increase healthcare capacity to the extent presently required, current capacity can be used more effectively as follows:

In addition to investing in General Practice there is an urgent need to increase the level of funding allocated to Health and Well-being. Prioritising disease prevention, health promotion and public health services has been highlighted as a key action to ensure the economic, social and environmental sustainability of healthcare systems.

Capacity within the acute hospital system can be used more effectively with the immediate reinstatement of the 1,500 inpatient beds removed from the system since 2007, accompanied by appropriate staffing and resources. Delayed discharges can be addressed with the appropriate provision of long-term care (residential and community), rehabilitative and palliative care as well as appropriate resourcing of extended care services in the community. National clinical programmes and models of care such as the National Clinical Programme in Surgery and the National Model of Care for Trauma and Orthopaedic Surgery will ensure the best outcomes for patients and should be fully implemented and resourced. Funding for the National Treatment Purchase Fund should be diverted to support the Model of Care for Elective Surgery. Information and communication technology will also support integrated care - facilitating the "seamless" transfer of patients between clinical settings and enhancing patient safety and quality of care, by reducing repetition and errors in diagnostics and treatments.

The IMO believe that the priorities for capital investment over the next 15 years should be as follows:

Incentives for Investment and Development of Infrastructure in General Practice

- Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report).

Investment in Acute Bed Capacity

- Capital funding must be provided to increase acute bed capacity to meet current and future demand. Bed capacity should be based on 85% occupancy rates to ensure patient safety and provide for seasonal surges in demand. Hospital planning and investment projects will need to be future-proofed with additional capacity available as the population grows.
- In addition to bed numbers hospital planning must also include an assessment of diagnostics, radiology and laboratory service requirements in both the hospital and community setting as well as the human and financial resources required for the continuous and adequate delivery of services.
- A greater number of single rooms are required to support both end-of-life care and infection control.
- Emergency Departments and Acute Hospitals will also need upgrading to cater for elderly frail patients and patients with complex needs.

Investment in Long-term and Rehabilitative Care

- Urgent capital investment is needed in appropriate long-term residential and rehabilitative care to ensure elderly patient do not remain in hospital longer than is necessary.

Address deficits in Mental Health Services

- Investment in supported accommodation for people with long term mental illness.
- the provision of 100 Child and Adolescent Mental Health in-patient units in line with the recommendations of A Vision for Change.
- Investment in acute alcohol and illicit drug detoxification units for those who wish to choose detoxification as part of their recovery.

Investment in Information and Communication Technology

- The Government must provide ring fenced funding to support the roll-out of a secure national system of electronic health records.

Please find below the IMO's detailed submission to the Health Service Capacity Review 2017.

Given the demographic and epidemiological changes discussed :

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?

With over 50% of inpatient beds occupied by patients over the age of 65 and chronic diseases accounting for two thirds of emergency hospital admissions, demographic change and the rising incidence of chronic disease are placing significant demands on the healthcare system.

Investment in General Practice

An alteration in the model of care to generate improved focus on the provision of care through General Practice is urgently required to ensure sustainability in healthcare.

Since the WHO Alma Ata Declaration of 1978 many countries have recognised the need to orientate healthcare towards General Practice and care in the community based on an extensive body of international research which shows that continuity of care and the patient-centred approach that is specific to General Practice is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services and long-term cost effectiveness. [1] [2] [3]

Numerous recent studies have reaffirmed the value of General Practice, for example:

- A seventeen year study of over 1,700 older patients found that continuity of care, attending the same General Practitioner, was associated with lower mortality.[4]
- Continuity of care in General Practice has also been linked to reduced probability of patient hospitalisation,[5] an uptake in screening programs and immunisation,[6] improved medicine use and adherence,[7] and lower healthcare costs.[8]

[1] Starfield B. Shi L and Macinko J, Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)

[2] Atun R, What are the Advantages and Disadvantages of Restructuring a Health System to be More Focused on Primary Care Services? Copenhagen, WHO Regional Office for Europe, Health Evidence Network report ; January 2004

[3] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012

[4] O.R. Maarsingh *et al.*, 'Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study', *British Journal of General Practice*, Vol. 66, No. 649, August 2016, e531-539.

[5] V.H. Menec *et al.*, 'Does continuity of care with a family physician reduce hospitalizations among older adults?', *Journal of Health Services Research and Policy*, Vol. 11, No. 4, pp. 196-201; J.M. Gill and A.G. Mainous III, *Archives of Family Medicine*, Vol. 7, No. 4, July 1998, pp. 352-357.

[6] S.A. Flocke, K.C. Stange, S.J. Zyzanski, 'The association of attributes of primary care with the delivery of clinical preventive services', *Medical Care*, Vol. 36, No. 8, August 1998, pp. 21-30.

[7] C.C. Chen, C.H. Tseng, and S.H. Cheng, 'Continuity of care, medication adherence, and health care outcomes among patients with newly diagnosed type 2 diabetes: a longitudinal analysis', *Medical Care*, Vol. 51, No. 3, March 2013, pp. 231-237; M.A. Brookhart *et al.*, 'Physician follow-up and provider continuity are associated

- Elements of high quality General Practice, encompassing robust continuity of care, greater first contact access and use, more person-focused care over time, greater range of services available and provided when needed, and coordination of care are strongly linked with superior patient outcomes and lower healthcare costs. In particular, areas with greater general practitioner activity have been found to be associated with lower hospital activity, more coordinated care, and lower healthcare costs. [9]
- The efficiencies and cost-saving delivered by investment in General Practice were demonstrated by an analysis conducted by Rhode Island's Department of Health that indicated that higher General Practice utilisation rates are associated with decreased per person healthcare cost trends, and improved health outcomes,[10]

Despite the known benefits of GP led care in the community, General Practice in Ireland has been decimated with a 38% reduction in the resource allocation per patient, through the heavy handed and arbitrary FEMPI mechanism. Ireland is facing a shortage of GPs as the current GP population is aging and our newly trained GPs see emigration as the only viable option. Countries that are considered to have a strong GP and Primary Care system spend up to 10% of the overall health expenditure on General Practice with a further 10% spend on allied community health and social services. Currently the Government spend on General Practice amounts to just 3 % of overall health expenditure.

Experience from other jurisdictions shows that in order to reap the benefits, the development of General Practice and care in the community requires significant investment over time. In line with the IMO recommendations to the Oireachtas Committee on the Future of Healthcare, the IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of General Practice in Ireland over the coming decade which includes:

a) A commitment to preserving the following positive traits of General Practice including the role of the GP as gatekeeper to the health system and coordinator of care which ensures more appropriate use of scarce healthcare resources.
b) A manpower action plan to address the growing shortage of GPs and practice staff
c) In order to halt the exodus of GP trainees, priority must be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st Century Health Service with a focus on:
    - Terms and conditions that ensure both existing and newly qualified GPs are attracted to a career in the health service. Investment in evidence-based Chronic Disease Management Programmes for which GPs are already trained

---

with long-term medication adherence: a study of the dynamics of statin use', Archives of Internal Medicine, Vol. 167, No. 8, April 2007, pp. 847-852.

[8] M.J. Hollander, 'Financial Implications of the Continuity of Primary Care', *The Permanente Journal*, Vol. 19, No. 1, Winter 2015, pp. 4-10.

[9] B. Starfield, 'Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012', *Gaceta Sanitaria*, Vol. 26, No. 1, March 2012, pp. 20-26.

[10] B.D. Steiner *et al.*, 'Community care of North Carolina: improving care through community health networks', Annals of Family Medicine, Vol. 6, No. 4, July 2008, pp.361-367; T. Leddy, 'RIte Care: Rhode Island's Success In Improving the Health of Children and Families', *Medicine and Health Rhode Island*, Vol. 89, No. 12, December 2006, pp. 391-396; Rhode Island Department of Health, *Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review*, Providence, 2012, pp. 7-9.

- Allowances for the employment of practice staff (including medical, nursing and practice support staff)
- Additional supports that address the real and specific needs of patients in both rural and deprived areas
- Appropriate adoption of new work practices such as telemedicine that are based on international best practice and assure continuity of care

d) Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT
e) Access to diagnostics and allied health and social care professionals in the community
f) The expansion of GP care that is free at the point of access on a phased basis taking into account income and medical need and that ensures there is sufficient capacity to cope with increased demand.

In an era of reduced resources, the IMO warns against proposals to address GP shortages with alternative community-based nurse-led clinics as proposed in the Department of Health's consultation paper on the *Development of a Community Nursing and Midwifery Response to an Integrated Model of Care.* Contrary to the evidence supporting GP care, there is currently insufficient evidence to support nurse-led care in the community. Arguments in favour of nurse-led services centre around perceived quality of care and patient satisfaction and propose a solution to the imminent shortage of GPs, however, there is no evidence to suggest that patient outcomes are improved or that care is more cost effective. A recent systematic review of evidence relating to autonomous advanced nurse practitioners found no evidence that health status, quality of life, hospitalisations or mortality are improved and that there was no evidence to justify the position that independent advanced nurse practitioners provide the same quality of care as medical doctors.[11]

The unpublished evidence review carried out on behalf of the Department of Health found no single overarching model of nursing and midwifery practice in the community that had been scientifically evaluated had emerged.[12] The review also found that there was insufficient evidence to inform the cost effectiveness of integrated models of nurse led care in the community and that further research was needed to underpin the development of future services. [13] Despite this, the Department of Health is proposing a vague model of nurse-led community health services that, rather than complementing GP care, will offer an alternative model of care that undermines continuity of care in General Practice and risks further fragmentation and duplication of care.

Acute Bed Capacity

With Ireland's ageing population and the growing incidence of chronic disease investment in GP care will improve outcomes for patients and reduce hospitalisations. Investment in General Practice will not solve the crisis in our Emergency Department but it will reduce the rate of increase in demand on the hospital system. It must be realised that an expanding and ageing population will create additional demand for hospital capacity.

[11] McCleery E, Christensen V, Peterson K, Humphrey L, Helfand M. Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses, VA-ESP Project #09-199; 2014.
[12] DOH, Development of a Community Nursing and Midwifery Response to an Integrated Model of Care, Consultation Document March 2017. pp9
[13] Ibid pp27

Just 10,643 public in-patient beds currently exist within the Irish health system, 1,480 less than a decade ago, when in-patient bed numbers stood at 12,123. While there has been some increase in the number of day-case beds since 2007 (1,545 to 2,150), this does not compensate for overall loss of beds to the system over the past ten years. All of this has occurred while the number of persons aged 65 years of age and older has increased by close to 158,000 people, or just over one-third. Bed occupancy rates published in 2016 found that bed occupancy in Ireland had risen to 97%, and sat an average of 104% in Model 4 hospitals. This far exceeds the recommended 85% bed occupancy, and is well above the identified 92.5% tipping point that has been shown to result in significantly higher patient mortality, due to rationing of resources and elevated stress levels. Additionally, this winter has been the worst yet in terms of emergency department over-crowding as a record average of 511 patients a day were cared for in beds, trolleys or chairs, on inpatient wards or units above the stated complement of that ward or unit in January 2017, an all-time high. Even at off-peak times, GPs are regularly requested to only refer emergency cases to local Emergency Departments and Medical Assessment Units, as there is no capacity to admit.

There is an urgent need to increase acute bed capacity to allow rapid admission from Emergency Departments for patients that require it. No hospital should operate at more than 85% occupancy to ensure patient safety and provide for seasonal surges in demand. In addition to bed numbers hospital planning requires an assessment of the diagnostics, radiology and laboratory service requirements in both the hospital and community setting as well as the human and financial resources required for the continuous and adequate delivery of those services. Hospital planning and investment projects also need to be future-proofed with additional capacity available as the population grows.

Excess capacity will also support infection control, allowing for deep cleaning of wards. While a greater number of single rooms are required both for isolation and to support end-of-life care.

Acute hospital care will need to adapt to demographic change and to rising rates of chronic conditions. For example, Emergency Departments will need to be in a position to provide services to more frail elderly patients with complex care needs. Hospital services will need to become more Dementia friendly while rising rates of obesity are likely to necessitate that bariatric facilities are more readily available.

Mental Health Services

There is currently a desperate need for long term supported accommodation for people with mental illness who have behavioural and care needs which makes them ineligible for housing within the non-statutory sector. While the move away from the “asylum model” of mental health care was a welcome policy direction however there will always remain a need for longer term placements. In our recovery model based mental health service this small group of patients who present with intractable problems are poorly served and often experience extended admissions in acute units which are not suited for their needs.

Such beds ideally should be provided in units which have a specialty focus (i.e. units dedicated to autistic spectrum disorders; cognitive impairment; early onset dementias; treatment resistant psychosis; and other debilitating conditions) follow best practice international guidelines and remain within the remit of the public health service to avoid patients being excluded by private providers narrowing referral criteria. The prospect of rehabilitation and recovery must be maintained and while some patients may need life-long housing, others may make a recovery after extended periods

of illness. With provision of such services this would lead to a more appropriate use of acute admission beds.

Urgent investment is needed in child and adolescent mental health facilities. As a result of ongoing deficits in child and adolescent mental health services young people continue to be admitted to adult psychiatric facilities inappropriate for their need. There are currently just 77 inpatient child and adolescent bed units available, a figure that falls far below the 100 units that were required "as a matter of urgency" in 2006. In 2016, 68 children and adolescents were admitted to adult psychiatric units in 2016 and a further 44 were admitted within the first five months this year[14] despite recommendations from the Mental Health Commission in 2009 that the practice should stop.

There is also a need for drug-specific detoxification units. One of the greatest deficits within our public health service has been the treatment of addiction. Currently there are no acute detoxification beds provided within the public health service specifically for alcohol; benzodiazepines and other non-opiate related addictions. Given the impact that addiction to these substances has made to homelessness and other social problems this is currently a national shame.

Currently most drug treatment sectors are located in the voluntary/charity sector however in order to be accepted for treatment the patient is required to be drug free. The step of becoming drug free (ie detoxification) is one the hardest on the journey to full recovery from addiction and many patients cannot achieve this by themselves. This has resulted in patients attempting to detoxify in acute psychiatric beds which is completely unsuitable for those wishing to detoxify and the patients with non-drug related mental illness. Any detoxification units would need to be designed upon international standards; have their own criteria for inspection and approval by the Mental Health Commission and may require a change in the Mental Health Act in order to be effective.

2. How can current capacity be more effectively used?

There exist no "magic bullets" that will rapidly increase healthcare capacity to the extent presently required. The Irish healthcare system suffers from decades of underfunding and in particular the last decade has seen significant financial, capital and manpower resources withdrawn from healthcare.

As aforementioned, one of the most effective ways of increasing future capacity within the health system and preventing unnecessary hospitalisations is to invest in the development of General Practice. However General Practice will not immediately resolve waiting lists or ED overcrowding.

Investment in Prevention

With just 1% of healthcare spending allocated to Health and Well-being, urgent investment is also needed in prevention. Prioritising disease prevention, health promotion and public health services has been highlighted by the World Health Organisation[15] as a key action to ensure the economic, social and environmental sustainability of healthcare systems.

[14] Mental Health Commission, Continued admission of children to adult mental health units "totally unacceptable" says Mental Health Commission, Press release 7 July 2017 downloaded from http://www.mhcirl.ie/File/PR_AR2017.pdf

[15] WHO, Environmentally Sustainable Health Systems: A Strategic Document , Copenhagen 2017

- With expertise in epidemiology, health economics, health information and planning, health protection and health improvement urgent investment is required to expand public health capacity.
- The Nurture and Healthy Childhood programmes currently in development need to be implemented and appropriately resourced to give all of our children the best possible healthy start and reduce as far as possible the incidence of preventable medical problems in children and young people.
- Immunisation is one of the most cost-effective interventions saving millions of people worldwide from illness, disability and premature death. Appropriate resources are needed to support national immunisation programmes and campaigns.

Investment in General Practice and Health and Well-being will curb future demand on the hospital system. In the meantime there are a number of measures that should be resourced in order to use current acute hospital capacity more effectively.

Reverse Bed Closures

As mentioned above, there are approximately 1,500 fewer inpatient beds available than in 2007. While a number of beds (approximately 10%) have been reopened since 2015, an immediate assessment and reinstatement of available beds is required accompanied by appropriate staffing and resources.

Addressing Delayed Discharges

It has been recently reported that more than 90,000 bed days have been lost in the hospital system so far this year because of delayed discharges according to figures released by the HSE.[16] Elderly people have the right to equal access and resourcing of health and social care services, however at any one time between 15% and 25% of hospital beds are occupied by patients awaiting discharge to appropriate long-term or convalescent care, including residential care, home care, rehabilitative or palliative care.

- Based on current demographics, the HSE[17] estimate that there is a current deficit of 1,460 long-stay beds and 2,653 short-stay beds which by 2022 will rise to a deficit of 5,910 long-stay beds and 3,600 short stay beds.
- Based on 2015 service levels, the HSE estimate that demand for admission specialist in-patient palliative care units would rise by 49 in 2017 and 189 by 2022 and demand for specialist community palliative care services would increase by 129 in 2017 and 496 by 2022.
- The HSE also estimate that an additional 1,565 people would require home help in 2017 amounting to 300,000 home help hours while demand for home care packages would rise by approximately 500. Despite existing inadequacies in home care provision, just 300 additional home care packages, and no additional home help hours, are being provided in 2017 above those provided in 2016, according to this year's HSE National Service Plan.

Only with appropriate provision of long-term care (residential and community), rehabilitative and palliative care as well as appropriate resourcing of extended care services in the community, a number of inpatient beds could be freed up within the acute hospital system.

[16] Radio Telefís Éireann, 90,000 hospital bed days lost over delayed discharges, 16 August 2017, available at: https://www.rte.ie/news/2017/0816/897737-hospital_beds/.
[17] HSE Planning for health, Trends and Priorities to Inform Health Service planning 2107

Implementing and Resourcing National Clinical Programmes

In recent years, a number of National Clinical Programmes have been established by the HSE in conjunction with the medical profession developing standardised care pathways, clinical guidelines and models of care in order to ensure the best outcomes for patients and the most effective use of resources for patients in a particular clinical area.

National clinical programmes and models of care such as the National Clinical Programme in Surgery and the National Model of Care for Trauma and Orthopaedic Surgery should be fully implemented and resourced.

Waiting lists for inpatient procedures primarily effect patients awaiting elective procedures. The Model of Care for Elective Surgery, if fully implemented and resourced will improve access, quality and cost by reducing waiting times, abolishing cancellations, optimising day surgery and average length of stay , standardising care, optimising theatre resources. Since 2016 the Government have allocated €40million to the National Treatment Purchase Fund (NTPF) to purchase care from the private sector while simultaneously budgetary constraints are leading to rolling theatre closures and cancellation of theatre procedures in the first place.

The reinstatement of the National Treatment Purchase Fund (NTPF) is not sufficient to reduce waiting lists in the long term as the private sector does not sufficiently cater for frail or complex patients. Funding for the NTPF should be diverted to support the Model of Care for Elective Surgery.

Investment in Electronic Healthcare records

Information and communications technology is widely considered a key tool for supporting integrated health care systems, facilitating the "seamless" transfer of patients between clinical settings and enhancing patient safety and quality of care, by reducing repetition and errors in diagnostics and treatments. The collection of data also allows for the advancement of medical knowledge, management of disease and health service planning, however the quality of such data is Ireland is often poor or incomplete. Plans are currently underway to introduce individual health identifiers for patients in Ireland by 2018, and to develop electronic health records for all patients in Ireland, however, the HSE has identified a lack of finance as the most significant barrier to eHealth.[18] Initiatives such as these can aid the provision of integrated care for patients, and thus improve health service efficiency, but are fraught with data collection and privacy challenges. A cost of between €647m and €875m has been estimated for the roll-out of Electronic Health Records over a five year period, and budgetary provision and commitment must be made to ensuring the timely implementation of this initiative, in the interest of improving integrated patient care.[19] Investment is required to ensure that electronic Health Records and critical IT infrastructure in healthcare are adequately protected, including from cyber-attacks with may come from within or outside the jurisdiction, as was the case during the recent cyber-attacks levelled against the United Kingdom's National Health Service.

[18] Health Service Executive, *EHR Strategic Business Case*, Office of the Chief Information Officer, Dublin, February 2016, at [25].
[19] S. Harris, Dáil Éireann Written Answers, Department of Health - Electronic Health Records, 31 May 2017.

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

Incentives for Investment and Development of Infrastructure in General Practice

- **Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report)** [20]

Infrastructure in General Practice is poorly developed In the majority of cases the General Practitioner provides their own facilities, in all cases they are responsible for employing staff, for overheads and other costs. While there are supports in place for practices the vast majority of the developments in General Practice, be they through services or facilities have been as a result of General Practitioners taking investing and taking the risk upon themselves and their practices to make improvements. Indecon carried out an analysis of potential measures to encourage the provision of primary care facilities and recommended a multi-faceted approach involving HSE-leased or built premises, GP-led centres and incentives for GPs to invest in premises and equipment. Targeted incentives would ensure the development of facilities would be GP-led and could significantly reduce exchequer costs and enhance health outcomes. The report also recommended that when developing HSE centres that the HSE should consult with GPs and consider existing and planned GP investments.

Investment in Acute Bed Capacity

- **Capital funding must be provided to increase acute bed capacity to meet current and future demand. Bed capacity should be based on 85% occupancy rates to ensure patient safety and provide for seasonal surges in demand. Hospital planning and investment projects will need to be future-proofed with additional capacity available as the population grows.**
- **In addition to bed numbers hospital planning must also include an assessment of diagnostics, radiology and laboratory service requirements in both the hospital and community setting as well as the human and financial resources required for the continuous and adequate delivery of services.**
- **A greater number of single rooms are required to support both end-of-life care and infection control.**
- **Emergency Departments and Acute Hospitals will also need upgrading to cater for elderly frail patients and patients with complex needs.**

Investment in Long-term and Rehabilitative Care

- **Urgent capital investment is needed in appropriate long-term residential and rehabilitative care to ensure elderly patient do not remain in hospital longer than is necessary.**

Address Deficits in Mental Health Services

Government investment is needed to address deficits in mental health services including:

[20] Indecon International Economic Consultants 2015 Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities , Dublin 2015

- **Investment in supported accommodation for people with long term mental illness.**
- **the provision of 100 Child and Adolescent Mental Health in-patient units in line with the recommendations of A Vision for Change.**
- **Investment in acute alcohol and illicit drug detoxification units for those who wish to choose detoxification as part of their recovery.**

Investment in Information and Communication Technology

- **The Government must provide ring fenced funding to support the roll-out of a secure national system of electronic health records.**