IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Pre-Budget Submission 2021

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

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Covid 19 has brought the significant capacity deficits in our health system to the fore. Before Covid 19 decades of underinvestment have left our health system with enormous capacity constraints across the health system manifesting in Emergency Department overcrowding and unprecedented waiting lists for hospital appointments and procedures.

As we face into what is likely to be the most difficult winter yet, €600 million has been provide to the HSE to support the winter plan[1] to include:

- The opening of 483 additional acute beds (251 in Q4 2020 and 232 in Q1 2021) and an additional 89 sub-acute beds
- Reconfiguration of existing nursing home beds to intermediate community beds and intermediate rehabilitation outreach services
- 4.76 million additional home support hours
- Access to some private hospital capacity
- GP access to diagnostics
- Resourcing of community health networks and community interventions teams
- Expansion of community-based assessment hubs

While the additional resources are to be welcomed the IMO is concerned that, at just 3% of the annual health budget, €600million will do little to address the stark deficiencies facing the system. Physical distancing and infection prevention and control measures will see inpatient bed capacity reduced by the equivalent of 2,737 (25%) inpatient beds while up to 2,190 (20%) additional beds are required in preparation for a future surge. While the plan aims to keep many patients out of the hospital system where possible, the additional resources will be insufficient to cater for the 100,000 inpatient admissions that are likely to be displaced.

The health of our nation is key to our economic recovery, and in this year's budget we urgently need to invest in a fully functional health system:

- We urgently need to strengthen public health capacity. The expertise of Specialists in Public Health Specialist is vital for infection prevention and control, health intelligence, health services improvement and oversight of public health programmes such as cancer screening, immunisation programmes and tobacco control;
- We urgently need to invest in inpatient bed capacity to ensure that no patient is boarded for hours on a trolleys in a packed Emergency Departments while awaiting a hospital bed. , including temporary builds, a doubling of ICU capacity and capital finance for 5000 inpatient beds including stand-alone hospitals for elective care;
- We need to immediately increase the number of hospital consultants employed in the HSE to address the record numbers of patients on hospital waiting lists. It is unacceptable that that 840,000 people are on a waiting list for outpatient appointments, inpatient, day case or investigative procedures;
- Funding for GP access to diagnostics in the winter plan is welcome, but access is required on an on-going basis to support the shift of care into the community. We also need to build capacity with practice supports for both established and newly establishing GPs;

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[1] HSE, Winter Planning within the COVID 19 Pandemic October 2020 April 2021, Sept 2020 https://www.hse.ie/eng/services/publications/winter-planning-within-the-covid19-pandemic-october-2020-april-2021.pdf

- Additional intermediate beds, rehabilitation supports and additional home help hours provided for in the Winter Plan will help to reduce hospitalization of older patients this winter, however we have an ageing population and on-going resources are needed to ensure that older people can remain in their own homes for as long as possible.. Where nursing home care is required patients should have access to holistic care, including GP care that meets the complex needs of nursing home patients;
- We need to invest in eHealth infrastructure to support multi-disciplinary care and remote consultations where safe to do so;
- Finally prevention is the most cost effective way of reducing demand for healthcare, we must continue to resource school vaccination and our cancer screening programmes.

IMO Budget 2021 Recommendations

1. **Strengthen Public Health Capacity with:**

   - **Immediate awarding of consultant status to Specialists in Public Health Medicine (SPHMs) and the full implementation of the recommendations of the Crowe Horwath , the Scally report and the Report of the Covid 19 Nursing Homes Expert Panel;**

2. **Immediately invest in the expansion of acute bed capacity including:**

   - **Urgent expansion of physical capacity through investment in temporary builds;**
   - **Immediate financing of a programme of Investment in 5,000 additional public acute bed capacity including investment in stand-alone public hospitals for elective care;**
   - **Urgently double critical care capacity to 550 critical care beds;**
   - **Examine options to ensure that NTPF funding is used to the maximum benefit of patients and the taxpayer;**

3. **Address the shortage of Hospital Consultants**

   - **Urgently implement targeted measures to recruit and retain hospital consultants – The HSE is not an employer of choice and the Report of the Public Service Pay Commission, the HSE and the Government and many of our politicians recognise that the two-tier consultant pay issue is a major barrier to recruitment;**
   - **All SpRs who have finished training should be offered a temporary consultant locum post;**
   - **Increase the number of NCHD training posts to meet future demand;**

4. **Pro-actively support General Practice in the shift of care to the community setting**

   - **Resource diagnostic, radiology and laboratory departments on an on-going basis to allow GP timely access to investigations in the community;**
   - **Ensure Acute Medical Units (AMUs) and Acute Surgery Units (ASUs) are appropriately resourced with clear referral pathways for patients requiring urgent care;**
   - **Support GPs to employ additional GPs, practice nurses and other support staff;**
   - **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**

5. **Plan for the Health and Social Care needs of an ageing population with**

   - **Further resourcing of rehabilitative care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**

- **Ongoing investment in a holistic approach to care with input from a range of specialties including geriatricians and public health specialists**
- **Invest in a programme of GP care for nursing home patients that reflects the complexity of care required;**

6. Appropriately Resource Specialist Community Mental Health Services

- **Increase resources for specialist community mental health services to ensure teams are staffed with the full multidisciplinary compliment of staff as recommended in A Vision For Change.**

7. Invest in ehealth

- **Invest in electronic health records across hospitals and community health centres (systems must be able to communicate and allow imbedding of national summary patient records);**
- **Upgrade IT infrastructure, both hardware and software, to support safe remote-consultations and remote multi-disciplinary team-working;**
- **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.;**

8. Appropriately resource Prevention Programmes

- **Increase Community Medical staffing levels to maintain the quality and safety of child health and vaccination programmes, now that schools have reopened;**
- **Investment in diagnostics and treatment pathways are needed to support the full re-opening of life-saving cancer -screening programmes.**

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1. Strengthen Public Health Capacity

The Covid 19 pandemic has highlighted the vital role that our Specialists in Public Health Medicine (SPHMs) play in the prevention and control of infectious diseases. Since the beginning of the Pandemic, Specialists in Public Health Medicine (SPHMs) have been working long hours, 7/7 responding to thousands of outbreaks and helping to prevent the spread of Covid 19 to the wider population.

Specialists in Public Health Medicine by reason of their specialist training, experience and statutory responsibilities as well as their existing links with clinicians, community medicine, immunisation services. laboratories, international bodies, Department of Health etc. are uniquely qualified to play a pivotal role in the prevention and control of infectious diseases and management of pandemics. In addition to their statutory functions of infection prevention and control, Public Health Specialists carry out essential roles in health intelligence, health services improvement and disease prevention, providing expertise oversight of public health programmes such as cancer screening, immunisation programmes and tobacco control.

Currently there are just 67 SPHMs employed in Ireland compared to approximately 180-190 in Scotland and New Zealand where there are similar size populations. In addition over 50% of SPHMs are due to retire in the next 5 years with insufficient trainees to fill current posts let alone fulfil any expansion of our public health workforce to meet internationally recommended ratios or emergency pandemic workforce requirements.

In 2018, the Crowe Horwath Report on the Role, Training and Career Structures of Public Health Physicians, commissioned by the Dept of Health[2] made a number of recommendations on the future role and training of public health specialists in order to attract medical graduates to a career in public health medicine. The recommendations included the awarding of consultant status to Specialists in Public Health Medicine in line with their specialist training and experience. Both the Scally Inquiry into the CervicalCheck screening Programme (2018)[3] and the Report of the Covid 19 Nursing Homes Expert Panel (2020)[4] have recognised the role of Public Health Medicine and called for the full implementation of the Crowe Horwath report. Despite this Public Health Specialists across the country remain hugely frustrated and disappointed with the lack of progress on this issue.

The IMO is calling for:

- **Immediate granting of consultant status to Specialists in Public Health Medicine (SPHMs) and the full implementation of the recommendations of the Crowe Horwath , the Scally report and the Report of the Covid 19 Nursing Homes Expert Panel;**

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[2] Crowe Horwath, Final Report to the Department of Health on the Role, Training and Career Structures of Public Health Physicians, April 2018

[3] Scally G, Scoping Inquiry into the CervicalCheck Screening Programme, Final report April 2018

[4] COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 Report to the Minister for Health 2020

2. Immediately invest in the expansion of acute bed capacity

At 2.8 hospital beds per 1,000 population, Ireland has one of the lowest number of beds in the OECD and falls well below the OECD average of 3.7 beds per 1,000 population. At the same time our occupancy rates are the highest, averaging 95% in 2017. [5]

In 2018, the Health Service Capacity Review estimated that 1,260 acute beds were immediately required to bring bed occupancy levels to internationally recommended safe occupancy levels of 85%. The Review also recommended that by 2031, between 2,590 and 7,150 additional beds would be required depending on the level of reform. However, the ESRI project minimum bed requirements to be much higher with between 4000 and 6300 beds required across public and private hospitals of which 3200 to 5600 will be required in public hospitals.[6]

Covid 19 has added huge additional constraints on our acute bed capacity. However, the HSE estimate that social distancing and infection prevention and control (IPC) measures will reduce inpatient capacity by on average 25% and up to 50% in some specialties, while at the same time 15-20% spare capacity is required to ensure the system can respond to a future surge in Covid cases. [7] This means of approx. 10,950 inpatient beds available, physical distancing and IPC measures will see inpatient bed capacity reduced by the equivalent of 2,737 inpatient beds while 2,190 additional beds are required in preparation for a future surge. The winter plan will bring the number of additional beds to just 892 above pre-covid bed numbers.

At 5 beds per 100,000 Ireland has also among the lowest number of critical care beds in the OECD and falls well below the OECD average of 12 ICU beds per 100,000 population. In 2018, the Health Capacity Review recommended an increase in critical care beds from 237 (2016) to 430 in 2031 while in 2009 the "Towards Excellence in Critical Care-Prospectus Report" recommended that critical care bed numbers should increase to 579 by 2020.[8] Permanent critical care capacity has increased to 285 however we need to double the number of beds to bring Ireland in line with international ratios and to ensure 30% spare capacity is available in the event of a future surge.[9]

Purchasing care from the private sector through National Treatment Purchase Fund (NTPF) has long been heralded as solution to elective inpatient waiting lists. While NTPF cannot replace the urgent need to invest in acute bed capacity and medical manpower it can offer a short-term solution to our capacity crisis. Options should be explored to ensure that NTPF funding is used to the maximum

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[5] OECD, Beyond Containment: Health systems responses to COVID-19 in the OECD, April 2020

[6] Keegan C, Brick A, Walsh B, Bergin A, Eighan J, Wren M_A, How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030, t*he International Journal of Health Planning and Management*, 2018, pp. 1-14 **https://doi.org/10.1002/hpm.2673**

[7] HSE Service Continuity in a COVID Environment, HSE Submission to the Special Committee on COVID-19 Response, July 2020

[8] Prospectus, Towards Excellence in Critical Care, Review of Adult Critical Care services in the Republic of Ireland, Final Report, Submitted to the Health Service Executive September 2009

[9] Reilly, C. Critical care capacity must be permanently raised to 'normal levels' Medical Independent, 12/06/20 https://www.medicalindependent.ie/critical-care-capacity-must-be-permanently-raised-to-normal-levels-dr-motherway/

benefit of patients and the taxpayer using available spare capacity in both public and private hospitals. Options include

- Supporting GPs with direct access to diagnostics in the private sector
- Support consultant-led initiatives in our public hospitals to improve quality and access to care, using weekends and evening availability and staff remunerated at a rate commensurate with their supra-contractual commitment. This should be done though specific units established within the hospitals and in conjunction with hospital specialists and not through third parties.
- Issuing of tenders for whole care episodes to prevent the selection by private hospitals of low-, high-volume procedures and consequential fragmentation of patient care

The IMO is calling for:

- **Urgent expansion of physical capacity through investment in temporary builds;**
- **Immediate financing of a programme of Investment in 5,000 additional public acute bed capacity including investment in stand-alone public hospitals for elective care;**
- **Urgently double critical care capacity to 550 critical care beds;**
- **Examine options to ensure that NTPF funding is used to the maximum benefit of patients and the taxpayer;**

3. Address the shortage of Hospital Consultants

Waiting lists are at a record high. Since the end of February this year the number of patients on an NTPF waiting list for an outpatient appointment, inpatient / day case procedure or investigative scope have grown by over 63,000 and now stand at approximately 840,000. Outpatient waiting lists alone have grown by over 52,000 and now stand at over 610,000.[10] It is unacceptable that over 240,000 people are waiting over one year for an outpatient appointment and over 21,000 people are waiting over a year for an inpatient, day case procedure or investigative scope. We cannot hope to address hospital waiting lists unless we urgently address the shortage of hospital consultants in our health service.

With just 1.44 consultant specialists per 1,000 population Ireland has the lowest number of medical specialists in the EU. (EU average 2.48 per 1,000 population). [11] Currently 500 consultant posts in Ireland remain unfilled while approximately 1,600 consultants are required based on the NDTP stakeholder informed analysis of demand.[12] If we include requirements for Consultant Psychiatrists, as well as specialists in public health medicine the requirement for consultants is closer to 2,000. To meet the required consultant staffing levels over the next 10 years, the NDTP estimate that at least an additional 646 specialist training posts are required[13].

In addition, Covid 19 will continue to impact on staffing levels across our health system due to:

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[10] NTPF, Waiting lists 27/08/20 See www.ntpf.ie
[11] OECD Health Stats 2019
[12] HSE National Doctors Training & Planning (NDTP) Demand for medical Consultants and Specialists to 2028 and the Training Pipeline to meet Demand * A Higher level Stakeholder Informed Analysis. HSE, 2020
[13] Excludes training requirements for General Practice, Psychiatry, Public Health Medicine, Occupational Health Medicine

- deployment of staff to deal with a future surge in the virus
- reduction in the number of patients treated as a result of infection control measures
- the need to self-isolate or take sick leave if displaying symptoms or contracting the virus.

The HSE Winter Plan recognises the need for consultants and senior level decision makers to tackle growing waiting lists, however, no resources have been provided to address the crisis in recruitment and retention of hospital consultants . It has been well documented that poor working conditions in public hospitals is a major contributor to high levels of doctor migration.[14] [15] [16]Since the introduction of austerity measures more than a decade ago, hundreds of Irish trained doctors have emigrated to other English speaking countries in search of better pay and conditions. In 2018, the Report of the Public Sector Pay Commission[17] recognised pay disparity between consultants employed prior to and post October 2012 as a major contributing factor to difficulties in recruiting and retaining of hospital consultants across the HSE.

The IMO is calling on the Government to

- **Urgently implement targeted measures to recruit and retain hospital consultants – The HSE is not an employer of choice and the Report of the Public Service Pay Commission, the HSE and the Government recognise that the two-tier consultant pay issue is a major barrier to recruitment;**
- **In the meantime to retain their essential skills, all SpRs who have finished training should be offered a temporary consultant locum post;**
- **Increase the number of NCHD training posts to meet expected future demand;**

4. Pro-actively support General Practice in the shift of care to the community setting

The HSE response to Covid 19 requires an accelerated shift of care from the hospital setting to the community. GPs have a key role to play in the shift of care into the community and with appropriate resources can help to alleviate the increasing demand on the hospital system. €18m in the Winter Plan to support structured GP access to diagnostics will help GPs to appropriately manage patients in the community. However, resources are required to ensure that GPs have access to diagnostics, radiology and laboratory service requirements on an on-going basis. In addition, the appropriate resourcing of Acute Medical Units (AMUs) and Acute Surgery Units (ASUs) with clear referral pathways will ensure that GPs and can prioritize those with most urgent need for services, while at the same time relieving pressure on our Emergency Departments .

General Practice, however, is not without its own capacity issues. Ireland has a growing and ageing population and with increased age comes increased health need and a corresponding increased

[14] Medical Council of Ireland: Medical Workforce Intelligence Report. A Report on the 2018 Annual Registration and Voluntary Registration Withdrawal Surveys. Dublin: Medical Council of Ireland, 2019.

[15] Humphries N , Connell J , Negin J , Buchan J . Tracking the leavers: towards a better understanding of doctor migration from Ireland to Australia 2008-18. Hum Resour Health 2019;17:36.

[16]Humphries N , McAleese S , Matthews A , Brugha R . 'Emigration is a matter of self-preservation. The working conditions … are killing us slowly': qualitative insights into health professional emigration from Ireland. Hum Resour Health 2015;13:35.

[17] Public Sector Pay Commission, Report of the Public Sector Pay Commission, Recruitment and Retention Module 1, Aug 2018

utilisation of GP services. It is essential that we increase GP numbers and capacity to meet current and future demand for GP services.

The most recent analysis of medical workforce requirements [18] from the NDTP estimate that to roll out universal free GP care as per Sláintecare, an additional 1,660 GPs are required by 2028 and the number of GP trainee places would need to increase by 150%. These figures do not take into account GP emigration. A recent ICGP survey from 2019 found that 35% of current GP trainees are considering emigration while 9.7% of recent graduates are already abroad.[19]

If we are to retain newly qualified GPs in our system additional practice supports must be made available to both existing and newly establishing GPs. The recent agreement negotiated between the IMO, the HSE and the Department of Health has helped to stabilise General Practice after a decade of FEMPI cuts however further resources are needed to promote the development of General Practice on an on-going basis including additional supports to employ additional GPs and practice nurses and other practice staff.

For young GPs seeking to establish themselves in a new community, the initial investment costs in premises, equipment, IT systems, insurance etc. and are particularly prohibitive and supports are needed for this cohort of GPs.

The IMO is calling for additional supports for General Practice to assist the shift of care into the community:

- **Resource diagnostic, radiology and laboratory departments on an on-going basis to allow GP timely access to investigations in the community;**
- **Ensure Acute Medical Units (AMUs) and Acute Surgery Units (ASUs) are appropriately resourced with clear referral pathways for patients requiring urgent care;**
- **Support GPs to employ additional GPs, practice nurses and other support staff;**
- **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**

5. Plan for the Health and Social Care needs of an ageing population

At any one time, up to 650 patients, of whom the majority are over 65, can be delayed in hospital while waiting appropriate rehabilitative or long-term care. Their delayed transfer of care not only reduces access to hospital beds but also poses significant risks to older patients including a higher risk of contracting a healthcare associated infection and of deconditioning resulting in reduced mobility and higher dependence.

The IMO welcomes additional resources for older people in the HSE winter plan including 530 repurposed community beds, 631 rehabilitative places, 4.76million additional home care hours and resourcing for the expansion of community health networks and community intervention teams. The

[18] HSE National Doctors Training & Planning (NDTP) Demand for medical Consultants and Specialists to 2028 and the Training Pipeline to meet Demand * A Higher level Stakeholder Informed Analysis. HSE, 2020

[19] Collins C et al, 2019, "Finding a Future Path" Career Intentions of GP Trainees and Recent GP Graduates - Report of the 2019 Survey, ICGP https://www.icgp.ie/go/research/reports_statements/DF8CE555-7D66-4346-BBB05CAC93C59689.html

supports aim to reduce ED admissions and the number of bed days used by patients over 75 years and to reduce delayed transfers of care to 450.

While the additional resources are welcome, Ireland has an ageing population. Over the next 10 years the population over 65 years old is predicted to grow by 36% while the population over 85 years old will increase by over 50%[20]. While we are ageing healthily there is an urgent need to plan appropriately for the health and social care needs of our older citizens.

Even with investment in additional home care services there will still be a small percentage of older people that will require nursing home care. The tragic experience of Covid-19 among nursing home patients has highlighted the need to invest in a more holistic approach to care for nursing home patients. The IMO has welcomed the Report of the Covid 19 Nursing Homes Expert Panel[21] and calls for on-going investment in community support teams that input from a range of specialties including geriatricians and public health. To ensure continuity of care, the role of the GP as primary care giver to patients in Nursing Homes should remain in place. A programme of care for nursing home patients should be negotiated between the IMO, the Dept of Health, and the HSE that reflects the complexity and workload of care.

The IMO recommends:

- **Further resourcing of rehabilitative care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**
- **Ongoing investment in a holistic approach to care with input from a range of specialties including geriatricians and public health specialists**
- **Invest in a programme of GP care for nursing home patients that reflects the complexity of care required;**

6. Appropriately Resource Specialist Community Mental Health Services

Mental health services have long been the Cinderella service of our public healthcare system, receiving just 6% of overall health spending with no additional resources for specialist services provided in the HSE's winter plan.

While mental health teams are adapting to new pathways in care there are still significant deficits both in relation to the staffing of specialist community mental health teams and ICT infrastructure to support the shift of services to the community. A recent report published by HSE mental health division found that staffing levels at the end of 2019 in our Child and Adolescent mental health services were just 57.5% of the recommended levels in recommended in A Vison for Change, while staffing levels in Psychiatry of Later Life Teams and General Adult Community Mental Health team were 61% and 77.1% respectively compared to the AVFC recommendations.[22]

[20] www.cso.ie

[21] COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 Report to the Minister for Health, 2020

[22] HSE Mental Health Division Delivering Specialist Mental Health Services 2019 – June 2020

While there was an initial lull during lockdown, referrals and emergency presentations to mental health services are beginning to rise again with social isolation, domestic abuse and increased reliance on alcohol and drugs contributing to a range of mental health disorders including anxiety, depression and suicidal ideation. [23] As we head into the dark winter months and the potential for a second lock down isolated patients that rely on mental health services are particularly vulnerable. It is vital that are mental health services are not neglected and that funding for mental health services is prioritised in tandem with the rest of our health services.

The IMO recommends

- **Increase resources for specialist community mental health services to ensure teams are staffed with the full multidisciplinary compliment of staff as recommended in A Vision For Change.**

7. Invest in ehealth

Urgent investment in eHealth is required to support the HSE's Strategic Plan for the Continuity of Services, both In terms of the accelerated shift of care from hospital sites and into the community where possible, along with the provision for up to 50% of elective outpatient appointments to take place over phone or video call where safe to do so. Even prior to Covid 19, Sláintecare reforms required significant investment in eHealth to support integrated care. However, despite this, the development of eHealth has taken place in a piecemeal fashion and significant deficits exist.

While Electronic Healthcare Records have been piloted in some hospitals, many hospitals are still using paper-based notes systems as the main patient record as well as paper-based systems for tracking patient referrals, outpatient appointments etc. The use of paper-based records and the potential for vital charts and notes to be lost or mislaid increases the risk of error in clinical care, while difficulties in accessing paper-based health records between hospital sites and community services lead to long delays in Emergency Departments, duplication of tests or patients being treated with suboptimal information.

Outdated computer hardware and insecure software inhibits the safe deployment of telemedicine including teleconsultations with patients and teleconference meetings of multi-disciplinary teams.

In General Practice, the majority of GPs have recognised the value of eHealth and have invested significantly in practice management systems. Under the deal reached between the IMO and the HSE and the Department of Health in 2019, there was agreement to support GPs in the development of their practice systems and the roll-out of key ehealth initiatives over the next 4 years including:

- The Rollout of the Individual health identifiers (for which the legislation is already in place):
- Continued and expanded use of eReferrals;
- Co-operation with the specific agreed e Prescribing model
- Use of NImis for ordering of diagnostic imaging services;
- Use of the summary and shared care records system;
- Cooperation with the development and rollout of an integrated system management of immunisations;
- Continued and expanded use of Healthlink and Healthmail;
- Co-operation with the initial rollout of Medlis for the ordering of blood tests.

[23] College of Psychiatrists if Irekland, Survey of Consultant Psychiatrists shows increase of mental health referrals and relapse amongst those with mental illness following Covid-19 pandemic and subsequent restrictions. Press Statement 17 th June 2020

- Continued use of PCRS suite;

This co-operation is subject the HSE having the necessary developments in place and the continued honouring of the reversal of FEMPI process over the course of the agreement.

We urgently need to invest in ehealth to support integrated care

- **Invest in electronic health records across hospitals and community health centres (systems must be able to communicate and allow imbedding of national summary patient records);**
- **Upgrade IT infrastructure, both hardware and software, to support safe remote-consultations and remote multi-disciplinary team-working;**
- **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.;**

8. Appropriately resource Prevention programmes

Investment in prevention is one of the most cost effective ways of reduce future demand on our healthcare services and the IMO welcomes the agreement reached on the roll out of an extended flu vaccination programme this winter. However increased resources are to support other preventive programmes including our school immunisation programmes and our cancer screening programmes.

Community Medical doctors work mainly in areas of Child Health and Immunisation, however the number of doctors employed in community health has fallen over the last ten years despite increased demand due to population growth and implementation of the secondary school HPV, Tdap and MenC vaccination programmes. Some additional posts have been allocated this year for extension of HPV programme, but at the same time, vacant posts arising as a result of resignations or retirements cannot be filled . Catch up school immunisation programmes have taken place in a variety of temporary locations but social distancing requirements and slower throughput have continue to on staffing requirements.

Public confidence is returning in our cancer screening programmes which are slowly reopening on a phased basis. Our screening programmes can ensure that certain cancers are identified early, with better outcomes for patients and at reduced cost to the health system. However, Covid 19 has placed significant constraints on capacity to access diagnostic and cancer treatment pathways. It is unclear whether the €2m provided for in the Winter Plan will be sufficient to address the backlog.

The IMO recommends

- **Increase Community medical staffing levels to maintain the quality and safety of child health and vaccination programmes, now that schools have reopened;**
- **Investment in diagnostics and treatment pathways are needed to support the full re-establishment of life-saving cancer -screening programmes.**