Health Service Executive

Chief Executive Officer's Report

HSE Board Meeting
27 April 2022

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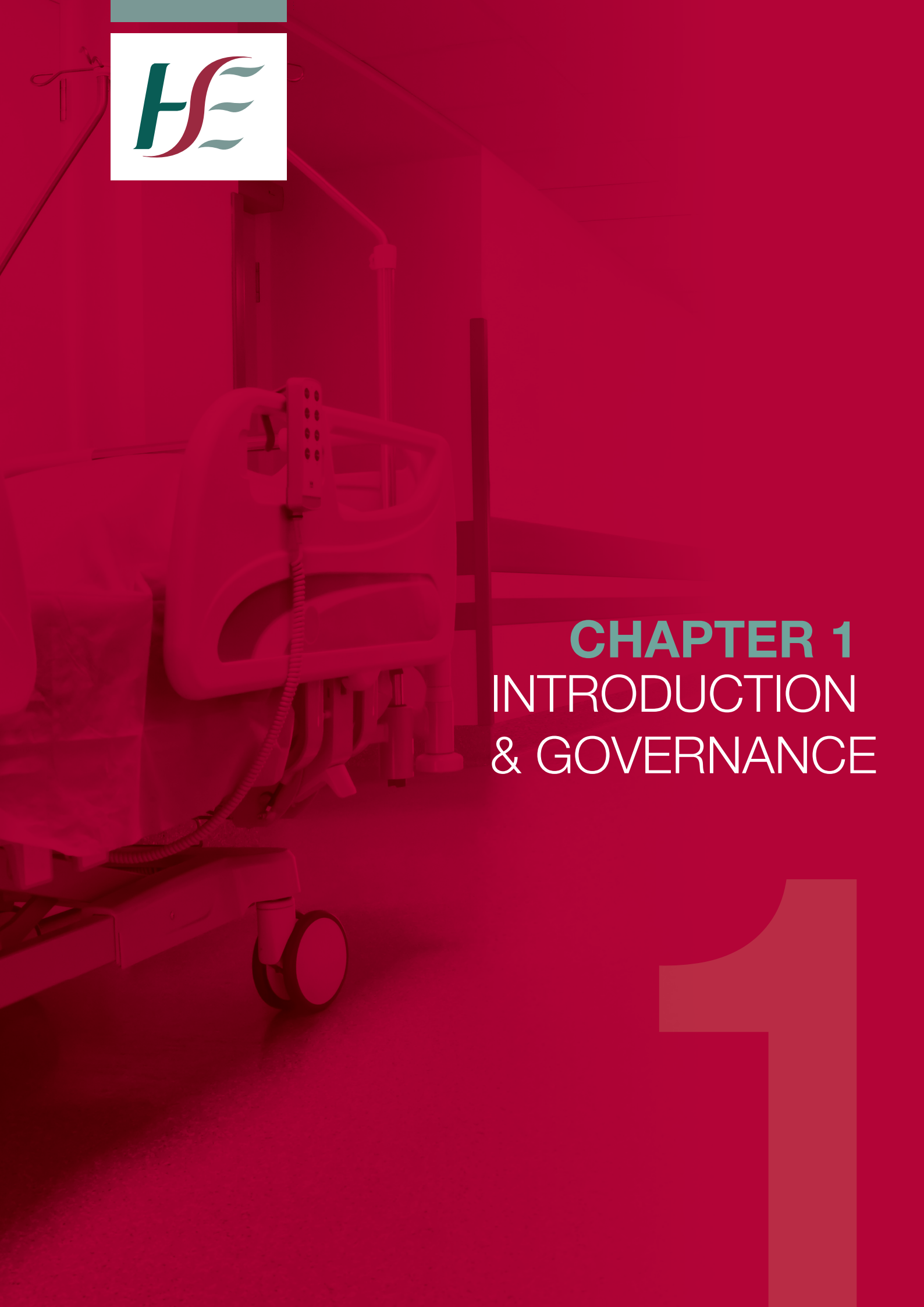

CHAPTER 1
INTRODUCTION & GOVERNANCE

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Holi Festival – Staff at Heuston South Quarter (HSQ) in Dublin, celebrate its diverse and multicultural team through Holi, the Hindu festival of colours.

INTRODUCTION

While March and early April saw an upward trajectory in the rates of COVID-19 infection the case numbers are now in decline. We welcome this with caution. Hospital settings had incurred a rapid increase in patient numbers, this in conjunction with record presentations at our emergency departments and high levels of staff acquiring COVID-19, led to perfect storm conditions that demanded severe but necessary action where scheduled care has had to be deprioritised in order to create capacity. The decline in April of staff numbers presenting with COVID-19 is also to be welcomed and the situation will continue to be monitored.

Having issued a communication to the hospital groups, requesting the prioritisation of COVID-19 patients and unscheduled care, this will remain continually under review as we manage these challenges. We are examining all options to mitigate the increased service pressure by availing of all resources available to us in the public, private and voluntary sector.

We continue our humanitarian efforts to support the tragic situation in Ukraine, both here in Ireland and also in delivering supplies directly to the Ukraine. The Oversight Group is carrying out fantastic co-ordinated work in planning and supporting in excess of 23,000 victims of the Ukrainian war who have arrived and continue to arrive in Ireland since the conflict began. It is anticipated that this number shall increase materially over the coming weeks, putting increased pressure on our health system that is already working at full capacity in most key areas.

As a national health service we are here to lend any support we can, to our fellow health professionals, as well as the innocent victims of war.

I and my EMT sincerely hope that the recent holiday weekends have given many staff a chance to refresh and recharge after some extremely challenge months which placed heavy demands on them.

1. GOVERNANCE

1.1 CHIEF OPERATIONS OFFICER'S ROLE

1.1.1 It is with regret that I have recently accepted the resignation of our Chief Operations Officer, Anne O'Connor, who will leave the organisation in June. However, I do feel that Anne's new role with VHI is a great opportunity for her to progress her career.

1.1.2 Anne has made an extraordinary contribution to the health service during her time with us, retaining an unwavering commitment to high quality and continuous improvement. My Executive Management Team and I, wish Anne well in her new appointment and in all her future endeavours.

1.1.3 We are commencing a recruitment process to search for a replacement COO. This person will lead all of our 100,000 plus operational staff, providing health and social services, in what will be a period of significant change.

1.1.4 As demonstrated so well by Anne, this leadership role has been vital in managing our growing and evolving health services, including the response to the Covid-19 pandemic, and the cyber-attack.

1.2 GOVERNMENT ANNOUNCEMENT ON REGIONAL HEALTH AREAS (RHAs)

1.2.1 The Government approved the setting up six Regional Health Areas (RHAs) within the HSE on 5th April last.

1.2.2 The design of the Regional Health Areas is planned to be completed in 2022. Each RHA will plan, manage, and provide integrated care for people closer to their homes.

1.2.3 2023 will see a phased introduction of the RHAs which will be fully operational in 2024.

1.2.4 RHAs will give greater accountability and governance in terms of finance and performance management, while also giving greater empowerment to front line staff and bring them closer to decision-making.

1.3 THEATRE CAPACITY REVIEW

1.3.1 I have recently engaged members of my Executive Management Team to review and assess the next steps needed to increase theatre capacity throughput and how this can be increased with meaningful changes to our current processes.

1.3.2 The HSE had, pre Covid-19, previously engaged with the RCSI on this matter. A detailed process review was completed which led to the reengineering of existing key actions and consequent increased efficiencies. Together with clinical input this resulted in a marked improvement in the output of the acute sites examined.

1.3.3 We are now revisiting this review with the leadership of RCSI, to update and extend this improvement initiative to a number of additional sites. I anticipate bringing the outcome of this to the Board in the coming months.

1.4 SOUTH KERRY CAMHS

I recently travelled to Killarney to meet with representatives of families whose children had been impacted by the harm caused in South Kerry CAMHS. I also met with the teams involved in this along with members of the Lookback Review team. An update on the committed actions is covered later in this report.

We continue to work closely with Minister Butler T.D. in this regard.

1.5 OMBUDSMAN FOR CHILDREN

1.5.1 I met with the Ombudsman for Children on issues relating to the Assessment of Need and the next steps required.

1.6 JOINT OIREACHTAS COMMITTEES

The following Committees were attended by my colleagues and/or I since the last Board meeting;

1.6.1

- Oireachtas Committee on the Irish Language, the Gaeltacht and the Irish Speaking Community, 30 March
- Joint Committee on Education, Further & Higher Education, Research, Innovation & Science, attended by Mr Michael Ryan, Mental Health Engagement & Recovery, 5 April
- Joint Committee on Health regarding Sláintecare, 6 April


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CHAPTER 2
FINANCE UPDATE

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2. FINANCE UPDATE – YTD FEBRUARY 2022

2.1 KEY MESSAGES

2.1.1 The draft revenue I&E financial position at the end of February 2022 shows a YTD deficit of €102.5m or 3.03%, with a significant element of this being driven by the direct impact of COVID-19, as reflected in the €105.5m adverse variance on the COVID-19 reported costs and (€3.0m) positive variance on core (Non-COVID-19) related costs. However, from an overall perspective it is expected that as this current surge comes to an end, our core (non COVID-19) activities will naturally increase and the impact of "delayed" care will also increase demand for core services.

2.1.2 The COVID-19 reported costs are essentially the incremental costs incurred in responding to COVID-19 which have been reported by the individual areas/divisions. However, it should be noted that this figure is not necessarily the total COVID-19 cost, as some COVID-19 related costs are embedded in core.

2.1.3 It is too early to begin to draw any detailed inferences as to what can be expected in financial terms for the full year, as only 2 months of data is available, coupled with the significant complexity related to the on-going pandemic generally, and the current surge specifically. As previously predicted, it should be noted that current rates of expenditure on COVID-19 would indicate that even with a levelling in COVID-19 cases and hence costs as the year progresses, the cost of responding to COVID-19 in 2022 is likely to be significantly higher than the specific COVID-19 funding provided of €697m (including access to core funding of €200m).

2.1.4 As part of the NSP process, an outlook/forecast for 2022 was prepared, which has since been reviewed based on January and February data. Initial views of this updated "2022 Opening Outlook/Forecast" suggest that the budget profile will require some adjustments, which will be processed for the March YTD reporting. In addition, full year forecasts will be prepared, which will be a bottom up exercise based on first three month actuals (Jan-Mar 22), with substantial divisional oversight. YTD March data will be visible at national level on the 22nd April, accordingly the consolidated full year forecast is expected to be available by Mid-May.

2.1.5 The HSE Capital Plan has Feb YTD expenditure of €64.0m against a YTD budget profile of €72.8m, leading to a positive variance against profile of (€8.8m) or 12.1%. Included in the February YTD surplus of (€8.8m), is a YTD surplus in

relation to the Children's Hospital of (€1.9m), (in addition to minor timing surpluses on other projects).

2.1.6 The average daily cash holdings to the end of March 2022 is €199.4m /3.3 days cash which is consistent with the €200m general cash holding guide agreed with the DoH. Based on cash utilisation to the end of March and expected requirements to the end of April we now expect the HSE to require a cash acceleration of €100m in May and June 2022 respectively. This indicates upward stress on cash requirements, consistent with the financial risks and issues flagged in the NSP 2022, particularly around COVID-19 related costs.

2.1.7 Meetings of the Health Budget Oversight Group (HBOG) continue to be convened monthly, ensuring that our external stakeholders (Department of Health (DoH)/ Department of Public Expenditure & Reform (DPER)) are briefed and updated on key issues related to the COVID-19 responses in addition to normal business topics such as vote expenditure returns and pay and staffing. In addition, the HSE & DoH have established a "Financial Reporting Working Group" to work collaboratively to improve both financial and management reporting requirements and deliverables going forward.

2.2 YTD FEBRUARY 2022 REVENUE INCOME & EXPENDITURE (CURRENT EXPENDITURE)

2.2.1 In December 2021, Omicron, a fifth variant of concern which is significantly more contagious than the Delta variant was identified, which led to another surge in cases. Therefore, January and February 2022 were exceptional months in terms of COVID-19 activity and expenditure, with high levels of hospital admissions relating to COVID-19, in addition to exceptionally high infection rates circulating in the community.

2.2.2 **COVID-19:** YTD costs of €380.3m against a budget of €274.8m leading to an adverse variance of €105.5m. Included in the COVID-19 costs of €380.3m, are the following:

- Testing & Tracing Programme costs of €176.8m
- COVID-19 Vaccination costs of €65.7m
- Private Hospitals costs of €20.9m
- Hospital and Community COVID-19 Responses of €116.9m (excl. Acutes Income deficit reported in core)

2.2.3 **Core:** YTD costs of €3,103m against a budget of €3,106m leading to a positive variance of (€3.0m).

- **Private Income**: YTD deficit of €24.0m which is mainly attributed to COVID-19 factors. Patients are exempted from charges if they have a COVID-19 diagnosis during the hospital stay. COVID-19 patient numbers were above 800 for most of January and above 600 for the most of February with the numbers in March increasing again considerably.

- **Pay Deficits**: YTD deficit in Acutes Pay of €21.6m which is related to the FEMPI restoration of premia payments (unfunded) and increased agency and overtime due to staff sick-leave.

- **Disability Services**: As flagged in the NSP, there is financial pressures within disability services in relation to residential places and emergency cases in 2022.

- **Budget Profiling**: YTD surpluses across community and other operations/services are primarily related to budget profiling. Budget profiles will be monitored and adjusted as appropriate as the year progresses, particularly as part of reviewing the 1st quarter results.

- **Pension & Demand Led Services**: a YTD deficit of €20.0m. Expenditure in these areas is driven primarily by eligibility, legislation, policy, demographic and economic factors, and accordingly, it is not amenable to normal management controls in terms of seeking to limit costs to a specific budget limit given the statutory and policy basis for the various schemes.

2.2.4 It should be noted that a total of €697.0m has been provided in the 2022 NSP, on a once off basis for COVID-19 response, of which €274.8m budget has been profiled YTD February 2022. The €697m comprises:

- €497m to cover COVID-19 responses, including but not limited to, vaccination, testing and tracing, personal protective equipment (PPE) and Hospital and Community COVID-19 Responses.

- €200m to cover acute and community scheduled care access (waiting lists and waiting times) including use of public and private hospitals.

2.2.5 There has been a significant level of important COVID-19 responses which have been put in place across our Hospital and Community Services, based on public health and infection prevention and control guidance, which are significant in operational scale and cost. Therefore, a clinically guided and operational led

review is underway to determine which COVID-19 costs need to be retained during 2022.

In terms of the cost of responding to COVID-19, costs may be categorised as follows:

- Cat. I - Mitigating pre-COVID-19 substandard conditions
- Cat. II - Improving patient flow, primarily, in COVID-19 context, to mitigate IPC risks
- Cat. III - Additional COVID-19 specific measures

2.3 OUTLOOK FOR 2022

2.3.1 As we enter the third financial year to be impacted by COVID-19, the ongoing uncertainty has contributed to a significant level of complexity and challenge in terms of managing ongoing financial issues and risks, which we will continue to address in so far as practicable during 2022. These financial issues and risks are identified in the Financial Management Framework chapter of the NSP2022.

2.3.2 As flagged in the NSP, the following areas have been identified as the key areas of risk, where it has not been possible to provide for in 2022 and which are beyond the normal level of financial risk that is typically managed in any given year

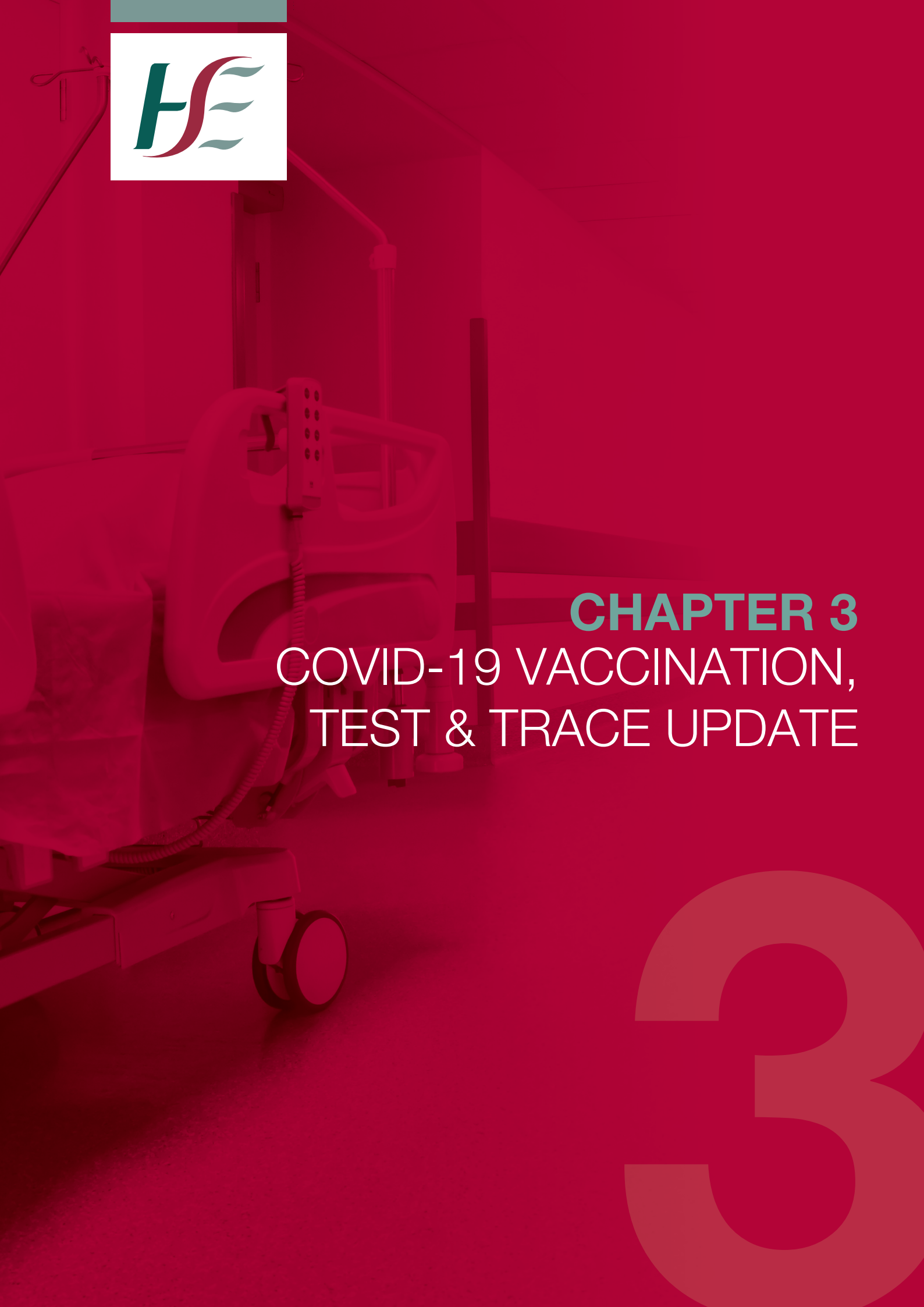
- COVID-19 – Overall likely costs including Long-COVID-19
- 1st July Financial Emergency Measures in the Public Interest (FEMPI) unwind provisions re twilight premia and overtime
- Savings target in respect of public community nursing home costs
- Private Income – material uncertainty, range of external factors, including COVID-19 impact
- Acute Hospitals – minimum additional forecasting / modelling risk of 2% of gross costs

Significant monitoring and engagement through internal governance structures, most notably the ARC and the HSE Board will be undertaken. In addition, engagement with external stakeholders including the DoH via the Health Budget Oversight Group (HBOG) process will be continued and enhanced until this risk has been sufficiently bottomed out and mitigated via any and all available options.

2.3.3 The NSP also flags the overall 2022 normal financial risk to be managed within our core operational service areas i.e. separate to pension and demand led areas, in the following areas:

- Acute Operations (including NAS)
- Community Operations (primarily disability services related to residential places and emergency cases)
- Support services

2.3.4 The quarterly forecasts will inform us on the emergence of the financial issues and risks above, with the first formal forecast for 2022, based on the first three months' actuals, being available by mid-May. This forecast will be a bottom-up forecast with substantial divisional oversight. These forecasts will be closely monitored with DoH colleagues and we will monitor these risks with DOH and DPER via the monthly HBOG meetings.



CHAPTER 3
COVID-19 VACCINATION, TEST & TRACE UPDATE

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3. COVID-19 VACCINATION/ TEST AND TRACE UPDATE

3.1 VACCINATION UPDATE

3.1.1 The COVID-19 Vaccination programme remains underway with the Primary & first Booster programme having delivered high overall uptake to date (Primary uptake of ca. 94.7% and first Booster Uptake of 76.3%), placing Ireland amongst the top performing EU countries.

3.1.2 Current uptake of the first Booster programme remains, however, generally low, particularly in the younger age groups (ca. 55.5% uptake for the 18-39 group and 61.6% in the 18-49 group). It is estimated that ca. 884k of the 12+ population remain eligible for first Booster vaccination. However, a higher uptake was achieved for the first Booster in the 60 and older cohort (97%), as well as with heath care workers (87.3%).

3.1.3 Continued focus will remain on uptake improvement initiatives for this group. This has most recently included direct engagement via HSELive to the immunocompromised group yet to receive a first Booster (of which 99k calls have been made), continuing access to vaccine administration locations (i.e. VCs, GPs etc.) and greater accessibility provided through self-scheduling option clinics in VCs.

3.1.4 On 5th April 2022, NIAC issued guidance reiterating the importance of completing the primary and first Booster course even after an infection (in unvaccinated people) and recommended the administration of a second Booster to the Immunocompromised and those 65 and older.

3.1.5 Operationalising this most recent NIAC guidance will be achieved in the context of planning for the future long term operating model for COVID-19 vaccination. A report on this model for COVID-19 vaccination was submitted to the Cabinet Sub-Committee on 31st March.

3.2 PLAN FOR SECOND BOOSTER

3.2.1 NIAC issued guidance recommending the administration of a second Booster to certain identified cohorts. Key elements of the HSE's plan to deliver this are:

- **Cohort Eligibility & Population** - Current in-scope population (i.e. over 65 year olds and over 12 year olds immunocompromised) is ca.742k of which ca 49k are immunocompromised (i.e. these are the number who have received their first Booster). Note that the total immunocompromised population is to be confirmed following identification of any new immunocompromised people.

- **Vaccine Administration Locations** - An all channel approach will be adopted meaning that all individuals within the >65 age group can be vaccinated through all vaccine administration channels (CVCs, GPs & Pharmacies). GPs will focus on >70s but will be accepted through all channels.
- **Vaccine Type and interval** - Those aged 12-29 years will receive the Comirnaty vaccine. Those aged 30 years and older can receive the Comirnaty or Spikevax vaccines. Spikevax will be the preferred vaccine to ensure utilisation and minimise vaccine expiry as far as possible. A second Booster vaccination can be given after a 4-month interval from previous vaccination or COVID positive case.
- **Start Date** - HSE Channels (Vaccination Centres, Mobile Vaccination Teams and Hospital based teams) and GPs will begin administration from 22 April. Participating Pharmacies will begin administration from 28 April (this later date is driven by required enabling ICT work).
- **Immunocompromised** - The Clinical guidance for identification of new immunocompromised patients will be distributed to Hospital Groups and GPs who will commence the identification and collation of population data. In parallel, the original immunocompromised cohort will start to receive text messages and be called for vaccination in line with their eligibility (expected early May). The ICT requirements to enable a second Booster for immunocompromised will be delivered early May.

3.2.2 The appendix attached outlines the 2nd Booster Programme in further detail.

3.3 FUTURE OPERATING MODEL

3.3.1 A final report on the Future Sustainable Long Term Model for COVID-19 vaccination was submitted to the Cabinet Sub-Committee on 31st March. The continued uncertainty around the future requirements has seen the Long Term Sustainable Operating Model developed based on a number of assumptions as part of scenario planning (e.g. timing, population scope, vaccination type, age cohort use and delivery allowing critical services in primary and acute care to operate).

3.3.2 The resulting recommended Long Term model will be primary care led with GPs and Pharmacies delivering a significant proportion of vaccines and the balance delivered directly through Vaccination Centres. This proximity led model will remove a potential barrier to high uptake and moves cost to "pay as you go" for the programme and is similar to the approach used nationally for seasonal influenza.

3.4 SUMMARY

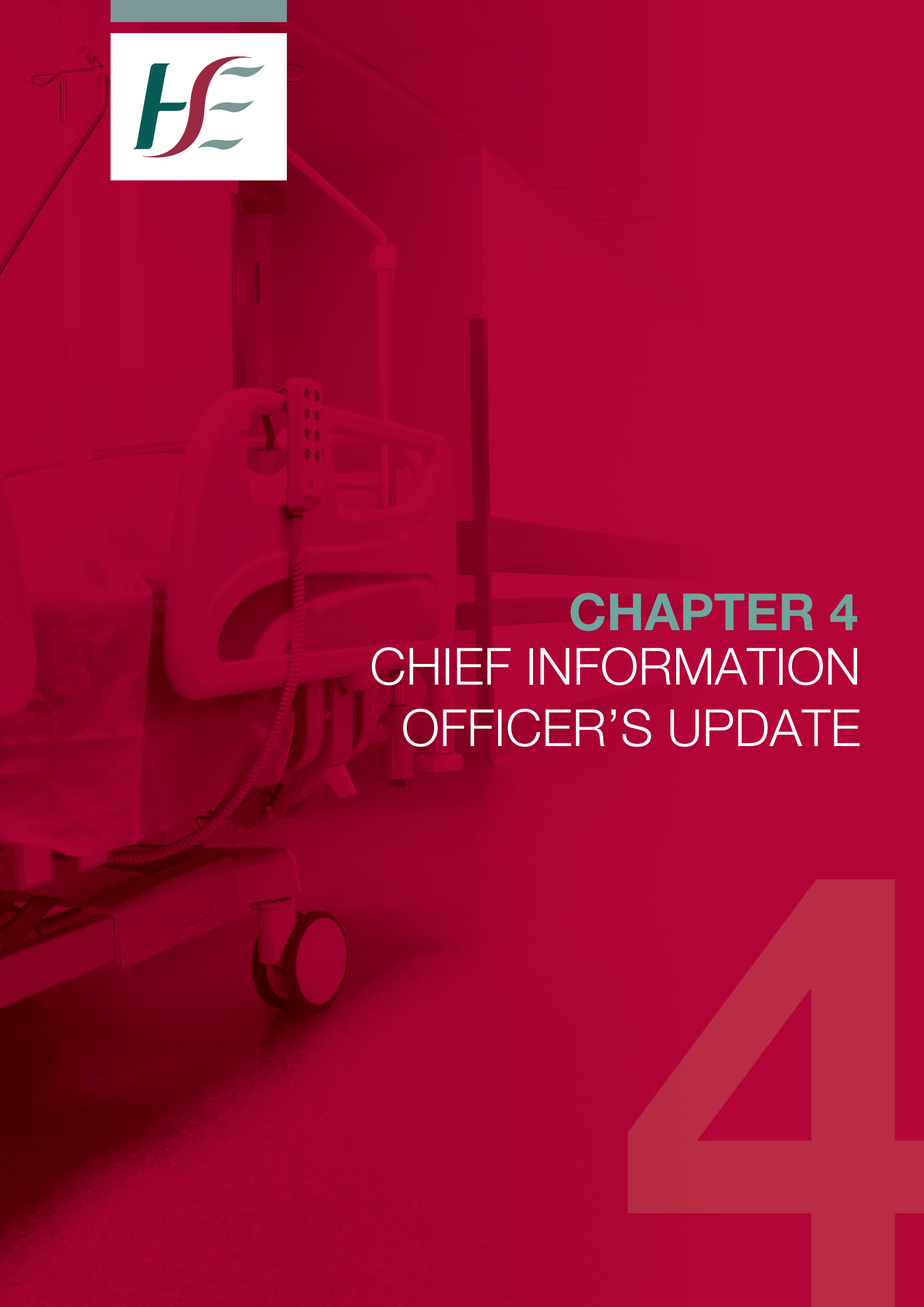
3.4.1 The COVID-19 Vaccination programme will shortly begin administration of the second Booster dose to eligible people that will increase the complexity of the programme which is currently seeking to transition to the new sustainable operating model. To enable this transition, immediate mobilisation is required to enable key deliverables of Flu Alignment, GP and Pharmacy Negotiations, Facility and Workforce Management, ICT Delivery, and Core team migration along with the investment decisions required for each. Detailed costings have been prepared to confirm the financial priorities and investment required for the vaccination programme in 2022 and into 2023.

3.5 CURRENT TEST & TRACE TRENDS

Overall demand and activity are reducing in line with public health testing advice and decreasing disease prevalence. All key indicators for week ending 21st April are showing marked decreases.

- Community referrals have decreased by 31.8% compared to the previous week with 16,787 community referrals. Community swabs undertaken have decreased by 33% compared to the previous week with 26,416 swabs. GP referrals have decreased by 45.6% compared to the previous week with 972 GP referrals.
- Laboratory tests have decreased by 23.8% compared to the previous week. 43,836 laboratory PCR tests were undertaken over the last 7 days versus 57,522 in the previous week.
- Overall, Antigen test kits booked have decreased by 56.9% in comparison to the previous week with 21,472 test kits booked over the last 7 days versus 49,846 in the previous week.
- There were 9,709 people notified of their detected Covid-19 test result in the last 7 days, a 38.8% decrease on last week. Of the cases who identified one or more close contacts, the average number of close contacts was 1.3.
- The progressive scaling back of services will continue to be undertaken in a planned way to maintain resilience within core systems and an ability to ramp up quickly should this be required.

There are several key issues that pose a risk to the scale-down of the Test and Trace programme, including the attrition of staff and subsequent knowledge loss of skilled-personnel and key contracted providers. In order to ensure a successful transition from the current mass testing model to the future GP-led clinical pathway, underpinned by enhanced Surveillance systems, a number of key financial and operational priorities have been identified which are currently being progressed with the relevant stakeholders.



CHAPTER 4
CHIEF INFORMATION OFFICER'S UPDATE

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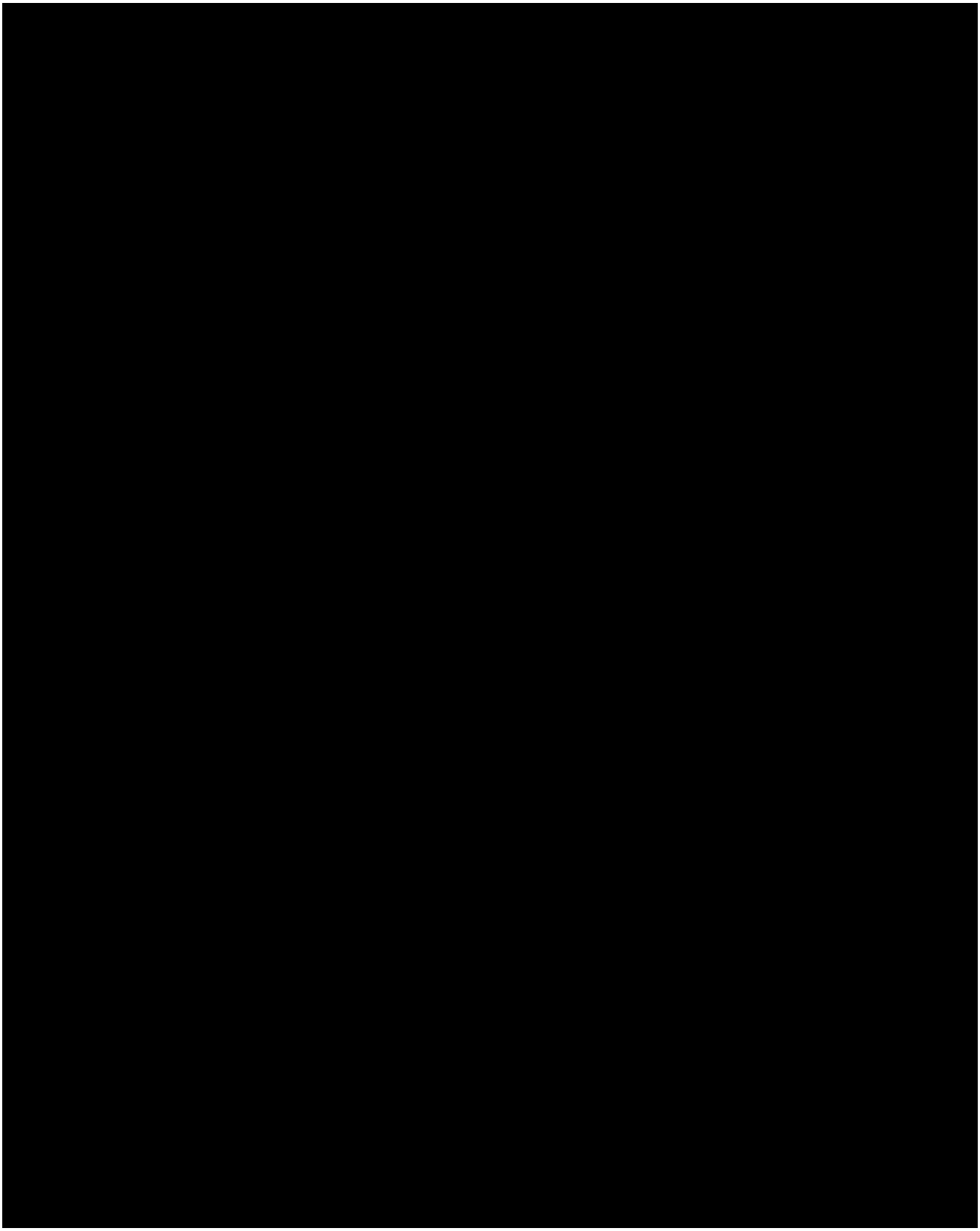

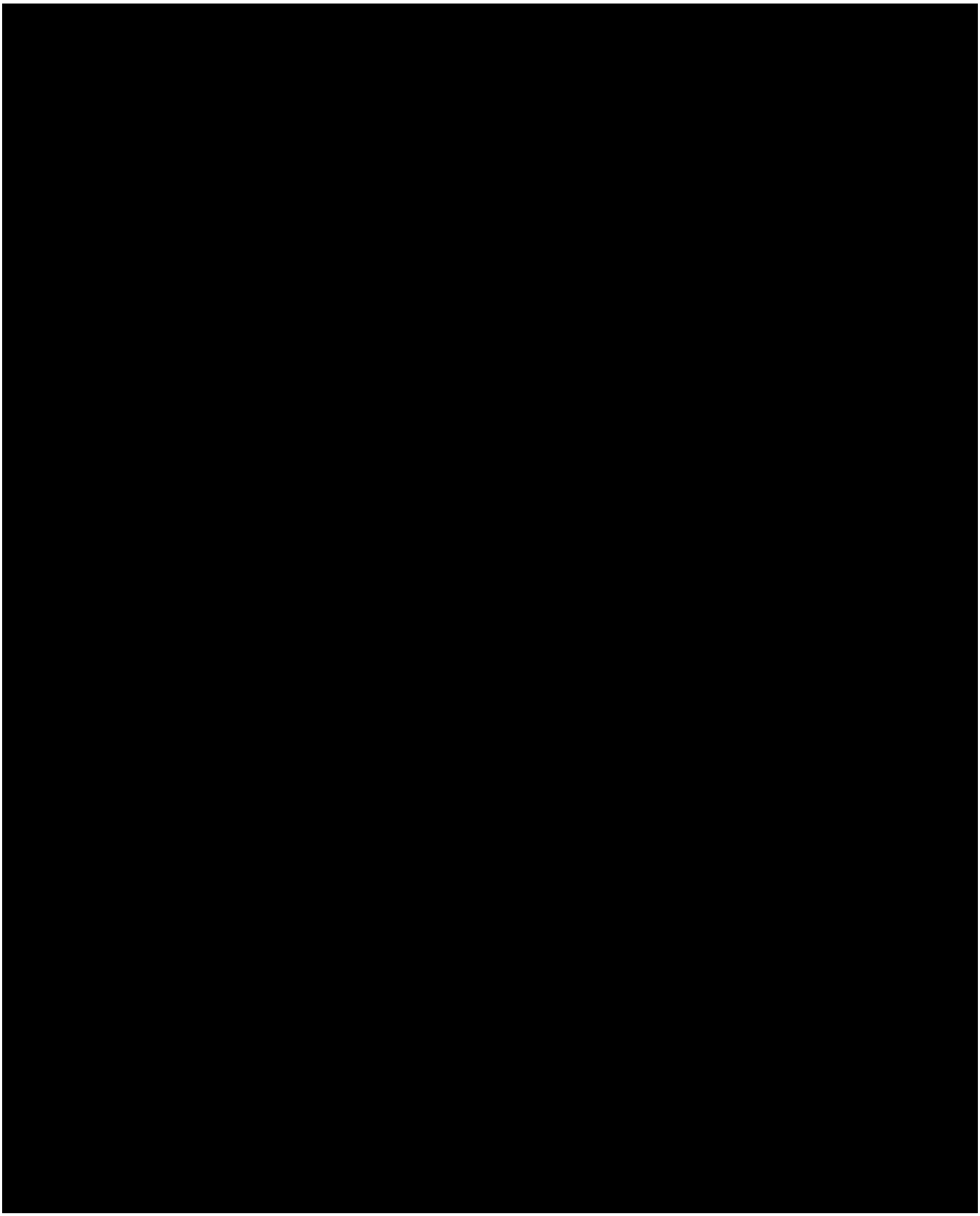

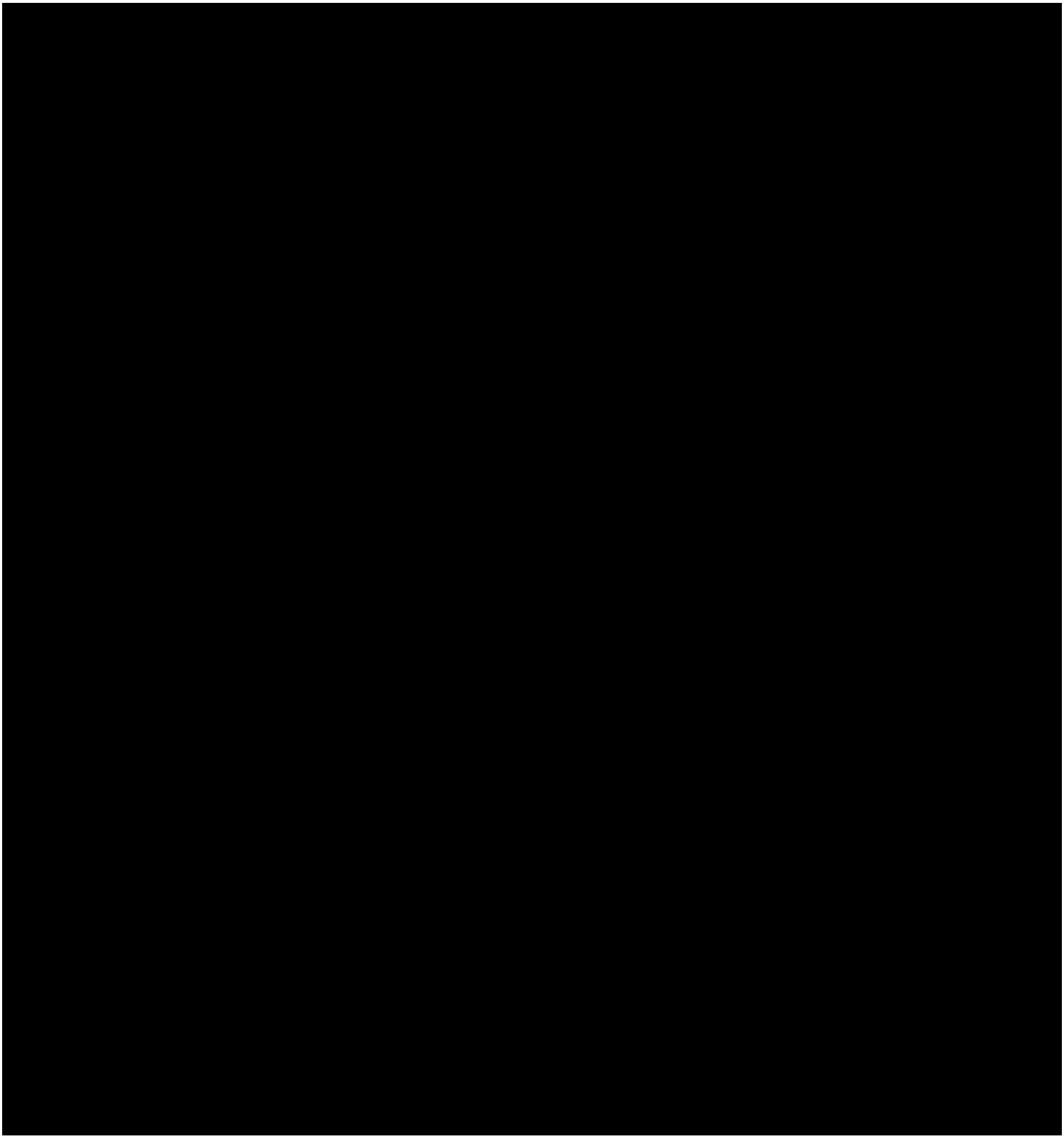

CHAPTER 5
INTEGRATED OPERATIONS

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5. INTEGRATED OPERATIONS

5.1 UPDATED ON SOUTH KERRY CAMHS ("MASKEY") REPORT IMPLEMENTATION

5.1.1 The National Oversight Group, co-chaired by the Chief Operations Officer and the Chief Clinical Officer, is tasked with overseeing, monitoring and reporting on the implementation of the Maskey Report. The Group has met four times to date and will continue to meet regularly to ensure timely progress is made on both national and local actions, as part of an overall integrated implementation framework. This implementation framework currently contains 63 actions arising from the 35 recommendations in the Report. Delivery of the majority of these actions has already commenced.

5.1.2 Updates in respect of the three CAMHS audit strands are set out below:

- The procurement process for the Audit of Compliance with CAMHS Operational Guidelines (2019) is underway with proposals expected at the end of April 2022. Following assessment and in line with procurement procedures, a provider will be identified as soon as possible thereafter. The successful provider will be requested to complete this audit within six months of appointment.
- Independently chaired by Dr Collette Halpin, an expert team has been established to conduct the audit of prescribing practice. This team also includes Dr Imelda Whyte, nominated by the College of Psychiatry, and Dr Suzanne McCarthy, Senior Lecturer in Clinical Pharmacy Practice, UCC. Administratively supported by the HSE's National Centre for Clinical Audit, the independent expert team is currently finalising the audit process, methodology and tools. The expert team expects to report Q4 2022.
- Engagement of an academic partner to conduct qualitative research into CAMHS experiences is at an advanced stage. The research methodology for this audit strand will require ethical approval and the process for securing same is underway. It is expected the research into the experiences of children and young people attending CAMHS, their families, referrers and other key stakeholders can be completed within six months from confirmation of ethical approval.

5.1.3 It is also worth noting that, in parallel with on-going efforts to implement the Maskey Report, over the past number of weeks, CAMHS teams have been actively engaged with and assisted Dr Susan Finnerty and the Mental Health Commission in conducting an independent review of CAMHS provision, as announced by the Commission in February of this year.

5.2 INDEPENDENT REVIEW ON UNSCHEDULED CARE/EMERGENCY DEPARTMENT PERFORMANCE

5.2.1 Unscheduled care is an integral part of the health system and part of a whole system and integrated approach in line with Sláintecare. Pressure within the unscheduled care system impacts both scheduled care and community services.

5.2.2 Following recent correspondence from and a meeting with the Minister in relation to unscheduled care a number of actions have been agreed, building on programmes of work already underway.

5.2.3 A 3-year USC Improvement & Change Programme is under development following the framework of the 5 Fundamentals of Unscheduled Care. However, an immediate piece of work to develop a short-term targeted response plan with a specific focus on the over-75 years cohort is underway.

5.2.4 Building on the experience of the implementation of the 5 Fundamentals Framework in SSWHG and CHO 4, the targeted response plan will follow the 5 Fundamentals Framework as outlined below;

- Leadership, Culture and Governance
- Patient Flow at Pre -Admission
- Patient Flow at Post -Admission
- Integrated Community and Hospital Services
- Using Information to support sustainable Performance Improvement

5.3 THE INDEPENDENT REVIEW OF UNSCHEDULED CARE PERFORMANCE

The Independent Review of Unscheduled Care Performance was commissioned by the HSE in 2019 to review performance across the nine hospitals that were under the greatest pressures in Winter 2018/2019. At that time, the aim of the review was to provide expert insight and recommendations that could help hospitals improve processes and procedures in delivering patient care. The review

conducted by an Independent Review Team between August and November 2019 provided thirty recommendations across the areas of; leadership and governance, operational processes and pathways pre and post admission, integrated working, data and business intelligence. The arrival of the COVID-19 pandemic in March 2020 required the HSE to respond to the extraordinary challenges posed and in doing so resulted in the implementation of structures and initiatives to address many of the issues and recommendations that were identified in the draft report.

The draft report from the review carried out in 2019 is outdated as a result of the pandemic and the significant investment that has taken place in our hospitals during that time. It has remained in draft format since January 2020 and close-out of the review process to include factual accuracy checks and response from the nine sites reviewed was never completed. Notwithstanding that the process was not completed, work is now underway with the sites to assess current status in the context of the draft report and more recent activity and performance. It is intended that this work will be incorporated into the 3 year USC Change and Improvement Plan.

5.4 UPDATE ON RECONFIGURATION Our Lady's Hospital Navan

5.4.1 You will be aware of the issues arising in relation to the planned reconfiguration of Our Lady's Hospital Navan (OLHN) to a Model 2 hospital, with a Model 2 Regional Orthopaedic unit as described in the Government Policy Document *Securing the Future of Smaller Hospitals – A Framework for Change (2013)*.

5.4.2 While it had been hoped that engagement on this matter during the Board's meeting with the Minister on the 2nd March 2022 would yield the promised meeting with Oireachtas members in order to progress the reconfiguration, this has not happened to date (14/04/22).

5.4.3 Given the issues of patient safety arising from the current operating model at OLHN which continue to be a concern, this matter has recently been escalated to the Chairman with a view to him writing to the Minister to progress this matter.

5.5 ASSISTED DECISION MAKING (CAPACITY) ACT 2015

5.5.1 The commencement of the Assisted Decision Making (Capacity) Act 2015 is due to take place in June 2022. While the HSE welcomes the 2015 Act and has undertaken a significant programme of work with our services to prepare staff for its commencement, the HSE has a number of concerns relating to certain aspects of it.

5.5.2 It is the HSE's view that, unless addressed, these have the very real potential to adversely impact the provision of care to a cohort of services users who are especially vulnerable and in need of safeguarding protections. Officials from the HSE and the DoH have been in communication about these issues for some time. While it is understood that work is ongoing to put in place legislative solutions for the issues arising, I have in recent weeks highlighted the HSE's principal concerns to the Secretary General. These are summarised below:

a) Wardship Applications post-22 April 2022

The HSE has been advised by the Wards of Court Office that it will not accept any new S15[1] Wardship applications after the 22nd April 2022. While it will still be possible to bring urgent Wardship applications from post the 22nd April 2022 until the planned commencement date of the ADM regime in June 2022, these applications will likely only be accepted by the Courts where there is a requirement to administer immediate and urgent treatment and/or secure a lawful basis for the detention of the incapacitated person. This will create a gap until commencement of the Act for adults who fall within the category of non-urgent applications.

b) Wards of Court subject to Detention Orders

Upon commencement of the Act in June 2022, Wards of Court who are currently subject to detention Orders (in facilities which are not approved centres) will have their placements reviewed, and where the Wardship Court determines that the detained Ward is not suffering from a mental disorder (as defined in the Mental Health Act 2001), the Court will have no option but to order the discharge of the person from detention.

c) The ADM Act and admission of persons without capacity to relevant facilities

The 2015 Act does not permit the Circuit court to make detention orders for those service users whose care needs necessitate the restriction of their liberty. The Wardship jurisdiction has been used safely and successfully to secure detention orders for this cohort of service user. That jurisdiction will be ended upon commencement of the Act, with no transitional provisions to facilitate an orderly move to the assisted decision making regime, and the HSE will be compelled to rely on an alternative (and less certain) legal basis such as 'Inherent Jurisdiction' to secure these orders. The lack of a clear legislative basis governing restraints on liberty, coupled with the fullest safeguards and protections for detained persons,

[1] S15 - Section 15 applications are typically initiated by the HSE to address safeguarding concerns. These would include, for example; where vulnerable service users lacking capacity are at risk of financial or other abuse; and, to assist the HSE by providing a basis for the transition of service users from acute hospital settings to more appropriate step down care facilities in circumstances where families are objecting to this transition.

places the HSE in a challenging position where there is significant uncertainty as to what care provisions will be legally permissible, if any, if the person subject to the detention order is discharged.

5.6 ASSESSMENT OF NEED (AON) – HIGH COURT JUDGEMENT ON STANDARD OPERATING PROCEDURE

5.6.1 The recent High Court judgement on the Standard Operating Procedure (SOP) for the Assessment of Need (AON) for Children in which Judge Phelan found that the SOP did not meet the requirements of the Act was a very significant judgement. It has major implications for how the HSE proceeds with AONs and the potential impact on intervention, especially in circumstances where there are already waiting lists for services for children. The judgement has to be considered in how we go forward.

5.6.2 It is important also to note that a further and important judgement by the Court of Appeal is imminent. This, along with the High Court judgement will be important to consider as the HSE develops a revised process and a plan for the approximately 10,000 Preliminary Team Assessments (PTAs) that have been completed to date.

5.6.3 A communication has been issued to the Community Health Organisations clarifying that the Preliminary Team Assessment (PTA) is not to be used as the AON.

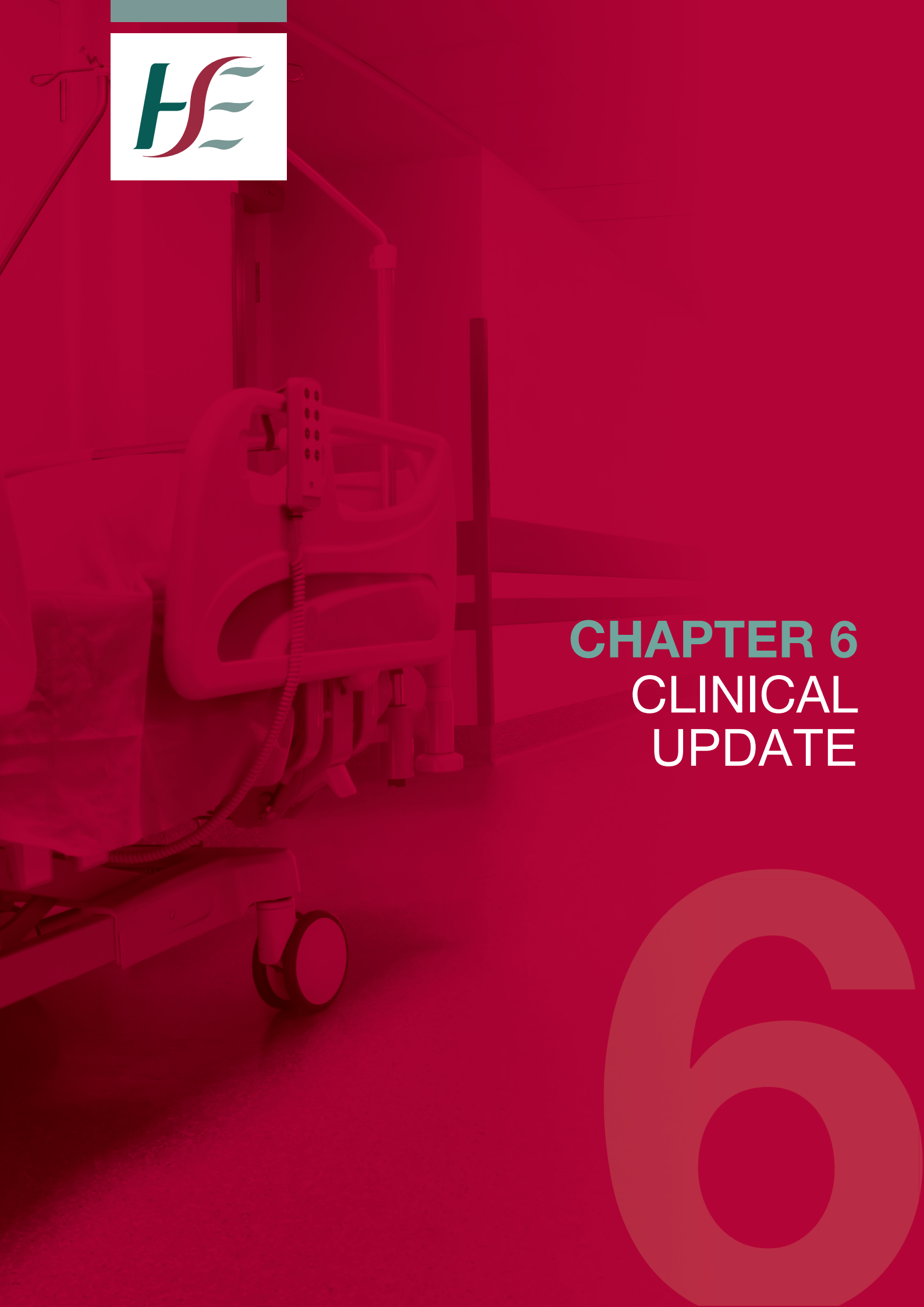
5.6.4 There are two strands of work being progressed currently:

- A working group to develop a logistical response to managing AONs has been established with a requirement to address the following:
  - Examination of available resources
  - Estimate of resources required for AON
  - Plan for new applications for AON
  - Plan to address those AONs who require further assessment after their PTA (2020/2021 applications)
  - Communication to families

- In addition, the National Clinical Programme for People with Disability is establishing a Task Group to issue Clinical Guidance on Disability Assessment and Assessment of Need. Within scope will be the pathway of accessing disability services (assessments and interventions), contact

interviews with parents, screening, AON and interventions by Children's Disability Network Teams/Primary Care/and CAMHs. A workshop will be convened on 20th and 21st April, with all major stakeholders to agree clinical guidance, which will be interim and due for revision three months after commencing.

5.6.5 Separately, we are also seeking to progress an initiative through the Sláintecare Access/Waiting List Initiative to address the current and the now increased waiting list for Assessment of Need.



CHAPTER 6
CLINICAL UPDATE

6

6. CLINICAL UPDATE

6.1 UPDATE ON PUBLIC HEALTH REFORM PROGRAMME

6.1.1 Public Health Reform continues to progress at pace. The first 5 Consultants in Public Health Medicine posts commenced on the 28th of March with the appointment of Area Directors of Public Health. The key priority for these strategic leadership posts is to establish the clear clinical, operational and corporate governance structures required to stand up the new Public Health Areas, aligned to the Regional Health Areas, ensuring a safe effective and responsive service is maintained throughout the transition. Communication is a critical success factor of all reform programmes and we have developed a communication strategy to ensure robust engagement and collaboration within Public Health and other stakeholders as we progress to the establishment of Public Health Areas.

6.1.2 This is a significant milestone in the reform programme and we have completed and submitted the year one review of progress outlining the delivery of reform to the Department of Health in line with the IR agreement. Consultant recruitment is progressing on target, subject to preferred candidates engaging in pre-employment clearances and progressing to appointment.

6.1.3 With the exception of the National Director of Public Health post, which is progressing to candidate offer stage, all other posts are expected to commence in line with the June 2022 timeline.

6.2 UPDATE ON NOVEL COVID-19 THERAPIES

6.2.1 Background

The HSE National COVID-19 Therapeutics Implementation Preparedness Working Group was established to develop preparedness plans for the operational roll-out and implementation of novel COVID-19 therapeutics. Following recommendations from the Therapeutics Advisory Group, three novel therapeutics were agreed upon and two of these have been the focus of the programme:

a) GSK Xevudy (Sotrovimab) and;

b) Pfizer's Paxlovid (ritonavir-booster nirmatrelvir)

6.2.2 Since the previous Board Paper, the Working Group has:

- Procured 2,016 doses of the order of the monoclonal antibody Sotrovimab and (as of 11 April 2022) 5,200 doses of the oral antiviral Paxlovid;

- Progressed the interim community pathway for Sotrovimab to become a fully operational permanent pathway, complete with electronic referrals;
- Worked with hospitals to coordinate stock control of the supplies of Sotrovimab and monitored the numbers of doses being administered weekly, to date there have been 679 doses of Sotrovimab distributed to hospitals;
- Engaged with hospitals to notify them of the newly available batch of Paxlovid doses;
- Developed GP Supports to enable a community pathway for Paxlovid to be put in place from mid-April onwards;
- Began the process for transitioning the programme into a 'Business as Usual' environment.

6.2.3 Supply**:**

- **Sotrovimab -** From February 2022, the second delivery of the monoclonal antibody Sotrovimab was available in Ireland bringing the total supply of Sotrovimab to 2,016 doses delivered to date. A community pathway was established for patients to access this intravenous therapeutic in hospitals via their GPs. As of the close of 08 April 2022, a total of 679 doses of Sotrovimab had been administered to patients across all Hospital Groups. Usage figures have declined since 28 March 2022 owing to information around efficacy of Sotrovimab in relation to COVID-19 variant BA.2 (refer to the 'Clinical Guidance' section below for further details).
- **Paxlovid -** Two distinct and separate contracting models are available to healthcare systems to access the oral antiviral Paxlovid; 1) a Bilateral Agreement (BA), and 2) the EU's Joint Procurement Agreement (JPA). A dual contracting approach was proposed which in the volume of 70,000 doses would be split between a BA and the JPA. The proposed ratios are as follows;
  - 20% of the volume (14,000 treatments) be allocated to the BA
  - 80% of the volume (56,000 treatments) be allocated to the JPA (once finalised)

  The programme has ordered the 14,000 doses of Paxlovid through a BA and 5,200 doses of this order were delivered and available to hospitals from 11 April 2022. The programme is engaging with GP's with a view to having the community pathway established for oral antivirals in over the coming days.

6.2.4 Operational Pathways

Pathways for in-patients and for community patients to access intravenous therapeutics are now established, Sotrovimab is currently available via this pathway. The CCO has engaged with the leads of all of the Hospital Groups in Ireland and no issues have been reported in these pathways. A number of hospitals have electronic referral pathways established, whilst others communicate directly with their local GPs.

A pathway for patients who may be eligible for oral anti-virals is due to be rolled out week-commencing 11 April 2022. It is envisaged that the GP community, with support, will prescribe oral agents. Oral therapy would be distributed through the existing community pharmacy network, including home delivery where appropriate. GP supports would include Therapeutics Advisory Group (TAG) clinical guidance, other online literature, webinars, support from community pharmacists, and support from National Medicines Information Centre (NMIC).

6.2.5 Clinical Guidance

The Therapeutics Advisory Group (TAG) continues to update their clinical guidance as appropriate as new information becomes available. Following a review of Paxlovid by NCPE in mid-March, the TAG's guidance was revised to include same. In addition, updates have been made to include guidance for paediatric and pregnant patients. The latest TAG guidance can be found here: hse-interim-guidance-for-the-pharmacological-management-of-patients-with-covid-19.pdf

6.2.6 Evidence

The evidence base for novel COVID-19 therapeutics is changing rapidly. In late March 2022 the FDA, USA, revised the emergency use authorisation of Sotrovimab removing its use in states where the BA.2 Omicron sub-variant accounted for more than 50% of cases, as new data suggests the drug is unlikely to be effective against this sub-variant. Given that this sub-variant is now reported to account for nearly 95% of cases in Ireland, this prompted TAG to review therapeutic guidance for the use of Sotrovimab in Ireland, and advise the CCO that an alert should be issued to all prescribers.

On 01 April 2022 the CCO wrote to GPs, Hospital Groups, and CHOs to advise all physicians and hospital pharmacists of the FDA update and the growing evidence for the reduced efficacy of Sotrovimab against BA.2 Omicron sub-variant.

The TAG continue to consider further novel therapeutics as they come on stream, they have requested rapid reviews from the National Centre for PharmacoEconomics (NCPE) for Merck's, Molnupiravir and Astra Zeneca's, Evusheld.

6.2.7 Technology

HealthLink has been enhanced to allow for electronic GP referrals direct to participating hospitals. Following user testing, this platform is now established and is being utilised in a number of locations. To date, at least 17% of patients who received Sotrovimab since the beginning of March 2022 were referred by GPs and this system supports those GPs and allows for a more efficient referral process. This eReferral system is available for all hospitals that chose to use the platform.

6.2.8 Budget

Approximately €69m has been approved for the COVID-19 Therapeutics Implementation programme and programme expenditure is continually reviewed. The majority of this budgeted expenditure is for monoclonal and antiviral novel therapeutics.

The estimated volumes are based on demand analysis and compared to order volumes for similar jurisdictions. The HSE received sanction from the Department of Health for up to €19.23m for the purchase of 4,032 doses of Sotrovimab and up to 14,000 individual courses of Paxlovid.

To date the full €19.23m sanctioned by the Department has been committed. In addition, some costs associated with the delivery, distribution and administration of the programme have also been incurred.

6.2.9 Communications

A communications campaign continues to operate to notify the population of the latest developments to the COVID-19 Therapeutics programme.

Links to published information can be found at:
https://www2.hse.ie/conditions/covid19/symptoms/treatments-for-covid-19/

6.2.10 Governance

The COVID-19 Therapeutics Implementation Preparedness Working Group was established to expedite the roll-out of new therapeutics through the development and implementation of operational pathways. To date operational pathways for both monoclonal therapies and oral anti-virals have been developed for both

inpatients and community patients. The programme has commenced engagement with the HSE Medicines Management Programme to enable the transition of the procurement of therapeutics to a 'Business as Usual' environment under the appropriate department.

6.3 THE NATIONAL SCREEENING SERVICE

6.3.1 The National Screening Service (NSS) continues to maintain screening services across all four programmes at reduced capacity in line with current safety measures.

6.3.2 BreastCheck

- BreastCheck completed 12,882* mammograms of women in the eligible population in February which is 29% above the target of 10,000. This was achieved despite continuing to be impacted by COVID staff absences and operating at reduced capacity.
- BreastCheck continues to manage the challenges associated with the ongoing radiology staff shortages and is exploring ways in which the service can increase capacity within a landscape of a finite number of radiologists. Reducing delayed invitations will be challenging in 2022 without recruitment of radiology staff.

6.3.3 CervicalCheck

- CervicalCheck has completed 27,907 screening tests in February which is 3% above the target of 27,000 and is a welcome return to normal activity levels;
- As a result of the Cyber-attack experienced in the Coombe Women's & Infant's University Hospital on 16th December, CervicalCheck continues to monitor this situation closely through a weekly SIMT meeting. There is currently no predicted date for laboratory services to resume while colposcopy referrals will revert to the Coombe clinic shortly.

6.3.4 BowelScreen

- BowelScreen screened 9,383* eligible participants in February which is 22% below the target of 12,000;

- In March BowelScreen issued 24,819* invitations. Invitations are closely monitored by the programme to match capacity within endoscopy units and maximise available colonoscopy appointments;

- Invitations and completed screening tests continue to be impacted by the surge in COVID infection rates in the community;

- BowelScreen colonoscopy sites are scheduling appointments at reduced capacity due to the number of COVID-19 cases and the impact on hospital capacity. Endoscopy services are not expected to operate at full capacity until at least May 2022;

- In March Mayo University Hospital became the 15th BowelScreen unit and commenced BowelScreen colonoscopies.

6.3.5 Diabetic RetinaScreen

- Diabetic RetinaScreen screened 8,806* participants in February which is 7% below target of 9,500;
- Some screening clinics continue to be impacted due to staff COVID related illness;
- The first full year of the 2-yearly screening pathway is now complete. Preliminary results are looking positive;
- The programme continues to invite participants to the new screening pathway.

6.3.6 CervicalCheck Programme Report 2017 – 2020

- The HSE's National Screening Service published the CervicalCheck Programme Report 2017-March 2020 on the 13th of April. The report covers the period from September 2017 to March 2020, to provide a statistical overview of the final years of Ireland's cytology-based population screening programme. It ends on 30 March 2020, when Ireland moved from cytology-led screening to be one of the first countries in the world to implement a primary HPV screening programme.

- In the reported period the national cervical screening programme offered repetitive cytology (smear) testing to the entire population of healthy women* in a specific age group (25–60 years).

- The report notes that since the programme began nationally in 2008 it has reduced the incidence of cervical cancer in Ireland by 2.8% per year. Its findings offer a data-led picture of the screening programme's operation. It details the programme's coverage and response times to women – indicating how many eligible women used the service and the interactions. Metrics concerning the numbers of cell changes and cancers detected through screening and the

functioning of the cervical screening system – laboratory, colposcopy, histology – are similarly detailed and measured against key performance indicators, where relevant.

- With the inclusion of comparative programme data from 2012-2017, the report also provides reference points with which to view the screening data from this period.

- Key facts from CervicalCheck Programme Report September 2017 to March 2020:
  - Over 650,000 screening tests taken, with 92% of tests returned as 'normal'
  - Over 33,000 abnormalities detected in women who came for screening
  - 293 cancers detected in women who came for screening.

- Many of the women who had abnormalities detected and treated following screening could have gone on to develop cervical cancer. Many of the women who had cancer detected via screening would not have had cancer found until they developed physical signs or symptoms of disease. It is known that 40% of all cervical cancers are diagnosed in women who have never had a screening test (cervical screening in cases of cervical cancer in Ireland 2008 – 2018, RCOG Independent Expert Panel Review).

- A key focus for the programme is to work on what barriers these women face in choosing to come for screening, and how we can help address them.

6.3.7 Interval Cancer Reports

All implementation groups continue to meet and progress their project plans and deliverables. The programme-specific groups continue to work with the NCRI/ NSS Strategic Planning Group to progress the calculation of interval cancer rates. The development of a standard operational procedure (SOP) to detail patient-requested review and disclosure process is underway.

An overall report of all research findings has been developed and is being refined by the group. Research in the areas of legal and health economics is ongoing. Members have reviewed the proposed additional amendment to the Patient Safety (Notifiable Patient Safety Incidents) Bill and will forward comment on its impact on screening.

6.3.8 Collaboration with International Agency for Research on Cancer

The NSS, DOH, and the International Agency for Research on Cancer (IARC), part of the World Health Organisation, have formed a collaboration to prepare strategic guidance on best practices related to cancer screening implementation. Three working groups along with a stakeholder advisory group have been established to progress the initiative. The first Stakeholder Advisory Group meeting took place in March. The collaboration is aligned to the Interval Cancer project.

6.3.9 National Cervical Screening Laboratory (NCSL)

The NCSL project is developing a new bespoke laboratory designed for use as a national 'Centre of Excellence' for cervical screening. Construction of the laboratory is due to complete in May 2022. The laboratory is due to be operational by the end the August 2022 following fit-out and commissioning. Construction is on track from a timeline and budget perspective. An action plan has been put in place for the procurement of priority equipment items. Workforce capacity remains the key limiting factor for full establishment of the laboratory.

6.3.10 Proposed amendment to the Patient Safety Bill by Minister for Health

The Patient Safety (Notifiable Patient Safety Incidents) Bill was presented for Committee Stage on 10-Mar-2022. The Minister for Health announced plans for additional amendment regarding screening services.

There are concerns that inclusion of disclosure of interval cancer to a Patient Safety Bill could imply that all interval cancers are incidents, contrary to the three Expert Reference Group Interval Cancer Reports (ERGICR), which recognised that interval cancers are an expected feature in organised screening programmes. In line with the recommendations, the implementation groups have committed to developing processes for patient requested reviews and programmatic anonymised audit in screening.

All screening programmes manage patient safety incidents or unexpected events in line with the HSE Incident Management Framework and the Open Disclosure Policy. There seems no justification to differentiate screening from non-screening clinical practice in a Patient Safety Bill. Clarification is being sought on what the additional amendment means for the screening service.

6.4 NATIONAL CANCER CONTROL PROGRAMME

6.4.1 Cancer services continue to operate near full capacity. Ongoing local difficulties are continuing related to staffing absences and acute capacity issues. Acute oncology nurses are now in place in all 26 hospitals that provide systemic anti-cancer therapy. This has significantly streamlined access to acute care for cancer

patients undergoing active cancer treatment. Having access to a dedicated specialist cancer nurse for assessment, management and an appropriate follow up pathway is helping to reduce reliance on ED for acute care. The National Cancer Information System went live in Kerry University Hospital on April 1st, bringing the number of hospitals now live on the system to six.

6.4.2 Ongoing access to private services remains essential and this need is likely to continue for some time, particularly in clearing backlogs for non-complex cancer care and ensuring timely cancer treatment. Staffing, recruitment and retention in cancer services continue to be challenged, as raised last month. Particular difficulties are being seen in relation to the availability of sufficient numbers of suitably trained staff to fill pharmacy, radiation therapist, radiation oncology, nursing and medical physics posts.

6.5 ADVANCED NURSE AND MIDWIFERY PRACTITIONERS

6.5.1 The CCO has commissioned a project to be led by the National Director of Clinical Programme Implementation & Professional Development, working with the Director of the Office of Nursing & Midwifery Services, liaising with a wide range of key stakeholders from across the system.

6.5.2 A key output of this work will be a consolidated and system wide view of demand for ANMPs over a multi-year time frame, aligned to strategic priorities & programme, education & training requirements along with a proposed approach to the prioritisation investment plan for required posts over the multi annual (e.g. five year) period ahead. This approach and plan will enable the organisation to best allocate senior, specialist nursing resource as best meets its needs ongoing. Also included in the work will be a proposed operational approach for governing the allocation and drawdown of posts within out annual funding cycles and approved, under the national service plan.

6.5.3 Creating a critical mass of Advanced Nurse and Midwife Practitioners (ANMPs) can contribute effectively and efficiently to addressing population health needs and has demonstrated improved patient experience, reduced waiting times and reduced admissions to hospitals. This work is envisaged to be completed by late May.

6.6 CLINICAL WORK ON UKRAINIAN CRISIS

6.6.1 A clinical workstream has been set up to respond to the needs of those fleeing the war in Ukraine, the overall response is being driven and led by Public Health. The workstream is governed/led by a subgroup of the existing CCO Clinical Advisory

Council, which reports to the CCO. This workstream and subgroup aims to provide clinical governance, clinical advice, clinical service designs (models of care, pathways) and clinical guidance to support the HSE to gear up the current healthcare delivery systems to meet the health and social care support needs of those fleeing Ukraine.

6.6.2 All matters regarding clinical/care pathways, clinical practice guidance (CPG) and related issues must be referred to the CCO to ensure clinical oversight. There is a GP lead being progressed through this governance forum and also the appointment of a TB clinical lead.

6.7 DEPARTMENT OF HEALTH WOMEN'S HEALTH ACTION PLAN

6.7.1 A Women's Health Taskforce (WHTF) was established by the DoH in September 2019 to improve women's health outcomes and experiences of healthcare.

6.7.2 In Budget 2021, a new dedicated **€5 million** Women's Health Fund was implemented in the DoH to implement a programme of priority actions arising from the work of the WHTF.

6.7.3 The National Women and Infants Health Programme (NWIHP) was successful is securing **€3.8 million (76%)** of funding to support a range of initiatives in Women's Health including ambulatory gynaecology, specialised endometriosis services, specialised complex menopause clinics, perinatal mental health, pelvic floor services, specialised paediatric and adolescent gynaecology services and ICGP training and educational supports.

6.7.4 In March 2022, the DoH published a Women's Health Action Plan specifically for 2022. This Action Plan captures much of the work underway already in the area of Women's Health or planned for 2022 in the HSE, however it does place additional emphasis and impetus in this area and provides an additional framework against which the HSE will be held accountable in terms of progress across the multiple areas and work programmes identified.

6.7.5 To underpin work in this area, the DoH has established additional executive management structures at Principal Officer level that will bring together relevant senior executive personnel who have specific briefs in the area of women's health.

6.7.6 Funding has been provided to support the establishment of a Women's Health Implementation Team within the NWIHP (3 WTE), which is being targeted at driving, co-ordinating and reporting in in the area of women's health in the HSE. This Team is currently being developed.

6.7.7 It is anticipated by the NWIHP that a network will need to be developed in the HSE which would mirror the additional executive structures that are now being established in the DoH as outlined above. This would enable collaboration, networking and information sharing in the area of women's health whilst not disrupting or undermining existing internal HSE reporting and accountability arrangements for specific work programmes.

6.7.8 In relation to the 2022 Women's Health Fund **(€5million)**, the NWIHP is already actively engaging with the DoH, seeking funding in the region of **€2.5 million** for a range of service developments including postnatal hubs, endometriosis and menopause specialist services.

CHAPTER 7
NATIONAL HR UPDATE

7

7. NATIONAL HUMAN RESOURCES UPDATE

7.1 LAUNCH OF 2022 HEALTH SERVICE EXCELLENCE AWARDS

7.1.1 The 2022 Health Service Excellence Awards launched on 24th March 2022 and the closing date for receipt of entries was 14th April 2022. This year there are 5 categories in the Awards;

- Improving Patient Experience
- Innovation in Service Delivery
- Excellence in Quality & Patient Safety
- Engaging Digital Solutions to provide a better service
- Right Care Right Place Right Time – Sláintecare Integration

7.1.2 The Health Service Excellence Awards is an opportunity to showcase and celebrate examples of the great work that happens every day across our health service. The awards also promote shared learning for other teams through our awards success stories.

https://www.hse.ie/eng/about/our-health-service/excellence-awards/health-service-excellence-awards-2022.html.

7.1.3 The Health Service Excellence Awards are looking for projects that are making a real and lasting difference to our health and social services. The projects could be:

- Improving access for patients;
- delivering a higher of quality care to patients, or;
- promoting pride among staff about our services.

7.1.4 This year, Sláintecare has aligned with the Excellence Awards and have sponsored the Right Care Right Place Right Time – Sláintecare Integration Award. The Awards are open to all staff (HSE and non-HSE) working in the public health system and any service provided directly to the public.

7.2 COVID COMMEMORATION

7.2.1 National HR and National Communications liaised with colleagues throughout the Services to ascertain ideas on how best to commemorate the efforts of staff in respect of their response to the pandemic. The most popular suggestion was tree-planting ceremonies taking place across major HSE sites (hospitals, hospices, nursing homes) on an agreed date. This was popular as it is inclusive, i.e. each region/major HSE would have its own ceremony which would be accessible to employees locally. It is also environmentally friendly.

7.2.2 Another popular suggestion was the creation of space for staff to meet outside, such as a bench or table, where staff can relax together. National HR and National Communications are proposing that we combine these ideas, with major HSE sites having tree planting ceremonies along with the creation of a staff bench with commemorative plaque which acknowledges the efforts of staff and outlines the significance of the tree, in late June.

7.3 BLENDED WORKING POLICY

7.3.1 The Civil Service Blended Working Policy Framework has been launched and the HSE are working towards developing an overarching policy for the public health service which reflects the principles in the Framework. This is scheduled to be completed by the end of Q2

7.3.2 The HSE policy will also apply to Section 38 organisations but each Section 38 employer will be responsible for determining which roles are suitable for blended working and putting in place arrangements to support the implementation of the policy within their organisation. The HSE policy will be developed in conjunction with the Right to Request Remote Working Bill 2021, which is still under review (it may be necessary to issue the HSE's policy prior to the enactment of legislation and review at a later date.)

7.3.3 The HSE Policy on Blended Working whilst reflecting the 5 general principles, should be appropriate for the health service and take account of the requirement for the vast majority of roles to be performed on-site at the employer's premises, at the service user's residence in community settings, etc. The ability to successfully meet the needs of the business while working remotely must be the foremost consideration for organisations in determining the suitability of blended working, as this is key to the approval of any blended working arrangement

7.4 HADDINGTON ROAD AGREEMENT HOURS

7.4.1 The 'Independent Body Examining Additional Working Hours (HRA) in the Public Service' was established under the Building Momentum public service agreement.

7.4.2 It was tasked with making recommendations to address the additional working time introduced for many civil and public servants under the 2013 Haddington Road Agreement. The Independent Body recommended that working time be restored to pre-Haddington Road agreement (HRA) levels.

7.4.3 Government accepted the recommendations contained in the report on 13th April. For the health sector, this will see the following reduction in weekly working hours from July 1st, 2022:

- Nursing and Midwifery: 1.5-hour reduction to 37.5 hours per week;
- Health and Social Care Professionals: 2-hour reduction to 35 hours per week;
- Management & Administrative: 2-hour reduction to 35 hours per week.

7.4.4 The number of health service staff impacted by the change is approx. 82,000 with an estimated loss of hours to the system of c. 8 million hours yearly.

7.4.5 Plans are underway to implement the recommendations across the HSE. In introducing the reduction in hours, for Nurses, Health and Social Care Professionals (HSCPs) and Management & Administrative staff every effort will be made not to impact service delivery to the general public.

7.5 2021 CONSULTANT APPLICATIONS ADVISORY COMMITTEE (CAAC) ANNUAL REPORT

7.5.1 The 2021 CAAC Annual Report is available at https://www.hse.ie/eng/staff/leadership-education-development/met/consultantapplications/rep1/caac-annual-report-2021.pdf

7.5.2 The purpose of CAAC is to provide independent and objective advice to the HSE on applications for consultants, and qualifications for consultant posts.

7.5.3 CAAC provides a significant opportunity for consultants to contribute their expertise and professional knowledge to the decision-making process for the development of consultant services throughout the country. It provides input from many parts of the Health Service, including Clinical Programme Leads who have a substantial input into the strategic direction of CAAC approvals

7.5.4 There was a 90% increase overall in Consultant posts recommended for approval (547 in 2021, an increase in 269). The largest increase was in the recommendation for approval of new posts which increased from 155 in 2020 to 409 in 2021 and is reflective of the additional investment received in the National Service Plan.

7.6 COVID-19 ABSENCE

7.6.1 COVID-19 has had a significant impact on health workforce absence. Figure 1 below shows the reported staff absence level since reporting on COVID-19 absence began in April 2020 to the latest report up to and including April 8th.

7.6.2 While the latest absence figure (from 2nd – 8th April 2022) is 4,270 **which is a decrease of 2,223** on the previous week, these figures still show significant staff absence levels across our health services due to COVID-19. The highest level reported in January 2021 was 6,763, compared to 10,343 in January 2022.

7.7 DIVERSITY INCLUSION & EQUALITY

7.7.1 International Women's Day 2022 was celebrated by the HSE via a video which was promoted via Twitter and HSE News at https://vimeo.com/684192714 and an article in Health Matters at the end of March 2022 with more information including more about the stories included in the video

7.7.2 The newly-reconvened Reach Out Network for HSE staff who are Lesbian, Gay, Bisexual, Transgender and Intersex has met twice this year already and is planning a major relaunch later in the year as well as a HSE presence at Pride 2022.

7.7.3 Equality-proofing of major HR policies and procedures commenced with reviews of the revised Dignity at Work policy and the HSE's recruitment processes.

7.8 CURRENT MILESTONE ROLLOUT OF NiSRP

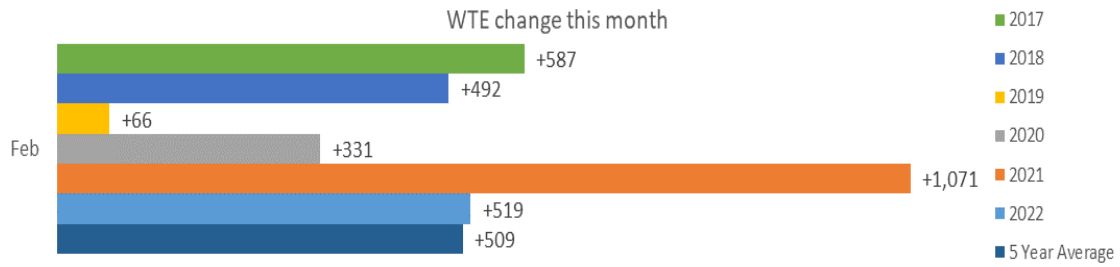
7.8.1 The NiSRP programme has successfully deployed Employee and Manager Self Service 'My HSE Self Service' to the HSE North West, HSE Midlands and HSE Mid-West with systems 'switch staggered' across January and February 2022. As these areas have been operating an integrated SAP staff records and payroll system since the implementation of PPARS, circa 2005, the NiSRP implementation was limited to the introduction of self-service only.

7.8.2 The My HSE Self Service portal was switched on for Tusla in February 2022.

7.9 HEALTH SECTOR WORKFORCE - FEBRUARY 2022

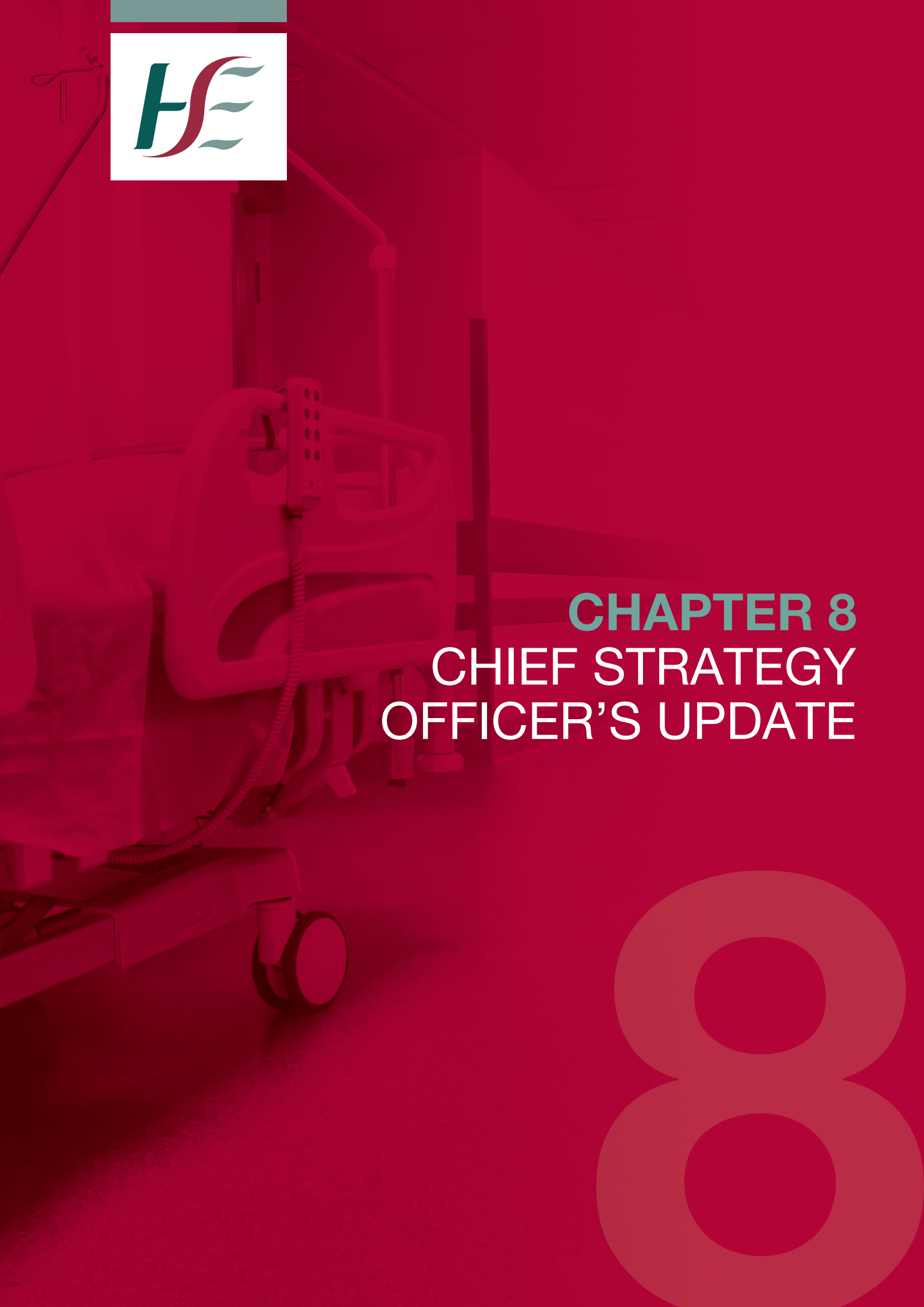
7.9.1 Employment levels at the end of February 2022, show there were **133,488 WTE** (equating to 152,570 personnel) directly employed in the provision of Health & Social Care Services by the HSE and the various Section 38 hospitals & agencies.

7.9.2 The change is ***+519 WTE*** *this month,* with employment levels continuing to show strong growth in-line with recent years (*the previous five-year average is +509 WTE*).



7.9.3 The overall increase since December 2019 now stands at **+ 13,671** WTE (+11.4%). The staff category with the greatest WTE increase is Nursing & Midwifery at **+3,999 WTE**, with *Staff Nurses & Midwives* also reporting the greatest WTE increase at **+2,065 WTE** followed by Health Care Assistants at **+1,988 WTE**.

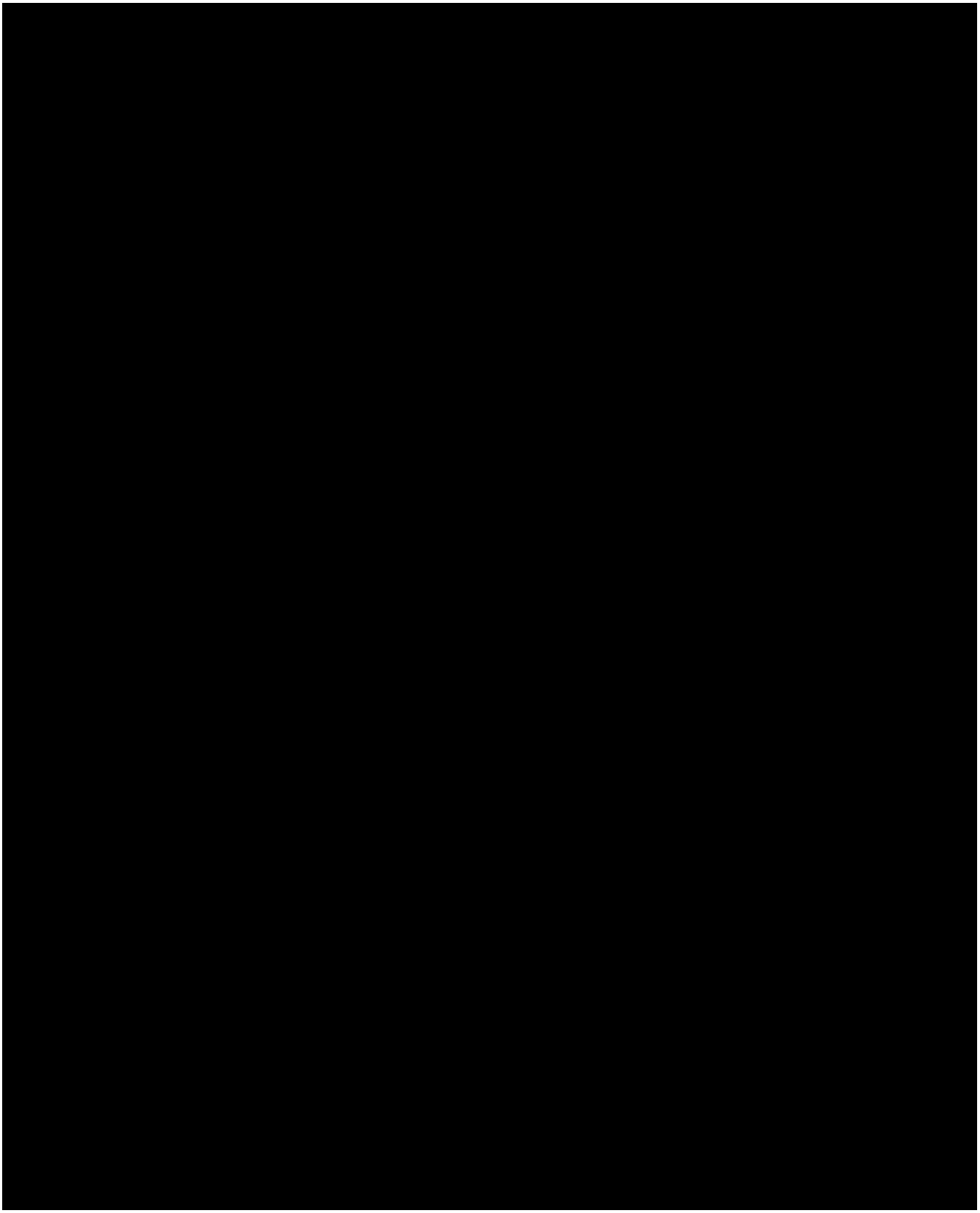
7.9.4 All staff categories over the period have shown significant growth with each category ranging from 6.6% in General Support to 16.6% in Management & Administration.



CHAPTER 8
CHIEF STRATEGY OFFICER'S UPDATE

8

8. CHIEF STRATEGY OFFICER



8.3 RISK MANAGEMENT

8.3.1 Board members are aware that significant work has been undertaken to strengthen the HSE's approach to managing risk. The process for identifying and managing corporate risks has been a priority area of focus, with the Board Committees playing a central role in overseeing both the risk process and individual risks. Other improvements include the development of the HSE's Risk Appetite statement and appointment of a Chief Risk Officer.

8.3.2 Following investment set out in the NSP 2021, the new HSE risk team is currently being established. The new Assistant National Director Enterprise Risk Management is expected to start by the end of June. Five of the seven Grade VIII risk posts allocated to EMT members risk teams have now been filled with the remaining two members expected to start in the next two months.

8.3.3 A workshop for the new risk team, focusing on the development of the HSE's Risk Management Programme was held on Wednesday 13 April. I had the opportunity to open the workshop and meet the new team. Other contributors included Colm Campbell, ARC member and John Moody who undertook the joint Board/ EMT review of risk management last year.

8.4 REGIONAL HEALTH AREAS

8.4.1 Board members are aware of the ongoing work in relation to the planning and implementation of Regional Health Areas. Following approval by Government, the Business Case was published earlier this month, setting out the policy direction, proposed work programme and associated timelines.

8.4.2 At the workshop held yesterday evening (26 April), Board members were provided with an overview of the work to date, in particular in relation to the objectives for the restructuring process and the various programmes of work to be taken forward in the coming months. The Board's input to and oversight of the process will continue to be crucial to the success of these arrangements moving forward.

8.5 SLÁINTECARE

8.5.1 As Board members are aware, HSE colleagues and I, together with the Secretary General and Departmental colleagues, are invited to attend the Joint Committee on Health meeting on a bi-monthly basis to provide members with updates in relation to the implementation of Sláintecare. The most recent meeting took place on 6 April at which the main focus of discussions was in relation to the introduction of Regional Health Areas.

8.5.2 Included within Board members' papers for today is the draft Sláintecare Action Plan for 2022 which sets out the key Sláintecare-related deliverables for both the HSE and the DoH for the remainder of this year. These deliverables are in line with the previously published Sláintecare Implementation Strategy & Action Plan 2021 – 2023.

8.5.3 Following final consideration by the Department and by the HSE Board, the Action Plan will be published.

8.6 NATIONAL MATERNITY HOSPITAL

8.6.1 Following approval by HSE Board, the final drafts of the Legal Framework documents and Constitution for the NMH DAC were considered and approved by the Boards of both Hospitals.

8.6.2 The draft Final Business Case, submitted in December 2021, remains under consideration by the DOH and their response is awaited.

8.6.3 HSE consent to the Transfer of Shares from the Religious Sisters of Charity to St. Vincent's Holdings CLG has been confirmed. St. Vincent's have stated their intention to complete this process as soon as possible. Related Governance and Legal matters have been resolved to the satisfaction of all parties.

8.7 HSE PROPERTY MANAGEMENT STRATEGY

8.7.1 The HSE is in the final stages of developing a Property Management Strategy which will set the strategic direction for the development of the Healthcare Estate in Ireland. The Strategy identifies a range of new approaches – including our approach to investing in existing Vs new facilities, our approach to prioritisation, our approach to design and manufacture, our approach to maximising value from data and technology, and how we build in flexibility and adaptability – with a view to transforming the existing estate and achieving net zero carbon no later than 2050.

8.7.2 The Strategy has been developed with inputs from across the HSE and the Department of Health, co-ordinated through a national Steering Group. The Strategy was recently considered by EMT and will be considered by ARC in the coming weeks prior to consideration by the full HSE Board. Thereafter, the Strategy will be used to take forward the preparation of a multi-year implementation plan.

8.8 HSE ANNUAL REPORT

8.8.1 As Board members are aware, the HSE's Annual Report 2021 has been prepared in the context of the continued prevalence of COVID-19, the impact of the cyberattack and the HSE's response to both during 2021. The penultimate draft Annual Report was reviewed by EMT at their meeting of 12 April 2022 and by the Performance and Delivery Committee at their meetings of 14 and 22 April 2022. The final draft has been circulated today for consideration and adoption prior to submission to Minister and subsequent publication, in line with legislative requirements.

8.9 MARCH STRATEGIC SCORECARD

8.9.1 The March strategic scorecard will be circulated for discussion at today's meeting.

CHAPTER 9
COMMUNICATIONS

9

9. COMMUNICATIONS

9.1 GENERAL UPDATE

9.1.1 The volume of press queries to the HSE in recent weeks has fallen back to close to pre-Covid levels. There was a spike in interest during March coinciding with the surge in Covid cases but this has reduced again now.

9.1.2 On 30th March, I attended the Oireachtas Committee on the Irish Language to outline the COVID-19 advice and vaccination programme videos produced to provide information for specific migrant communities where there was a lower uptake of the vaccine and /or high admissions to ICU. The videos in 12 languages are specifically targeted at migrant communities and, therefore, neither Irish nor English language videos are required.

9.1.3 A particular effort got underway within communications over the past month to try to promote and showcase projects and initiatives related to Sláintecare and 2022 National Service Plan initiatives. For example, we sought and secured coverage in the Sunday Independent and Sunday World showcasing the National Ambulance Service as a great place to work to coincide with a recruitment campaign; we secured good coverage of a HSE workplace diversity initiative; and

got a positive TV discussion on how innovative cancer treatments are improving outcomes for teenagers.

9.1.4 This project is in its early stages but the objective is to have a regular series of public stories about changes and improvements being made within the HSE arising both from additional funding and from innovation. Obviously the progress of this is dependent on pandemic communications demands continuing to remain at a highly reduced level.

9.1.5 Communications continues to support the vaccination programme with advertising and publishing messaging encouraging the immunocompromised and the over 65s to come forward for their next booster.

9.1.6 From the start of May, the HSE website will be providing all the COVID-19 and COVID-19 vaccination information available in Irish. Over time we will identify services that have budget to translate their public information into Irish and increase the amount of Irish language content.

CONCLUDING REMARKS

CONCLUDING REMARKS

- As COVID-19 numbers decline the EMT will continue to provide its complete support to the operational system to enable it to recover and re-set, especially recognising the huge pressures that staff have endured.

- The HSE Excellence Awards, launched last month, provides a national platform to showcase some of the drive, innovative approach and dedication to improvement that has been a feature of our colleagues' approach to providing services across the entire country. These efforts have been most prolific and prominent over the past two years. While it would not be possible to formally recognise all efforts worthy of awards we will continue to support and foster a can-do culture of empowerment, innovation, locally and nationally.

- However, the decline in COVID-19 cases will, hopefully, continue and provide much-needed time to focus on planning and implementation to progress the many key strategic developments underway. It is critical that we continue to promote the necessary maintenance of the COVID-19 behavioural changes to provide continued protection to the general public, our patients, service users and staff.

Paul Reid
Chief Executive Officer

APPENDICES

COVID-19 Vaccination Programme

Summary Plan for 2nd Booster Programme

14/04/2022

1. NIAC Guidance

On 5th April 2022, NIAC issued guidance (Appendix A) reiterating the importance of completing the primary and booster course even after an infection (in unvaccinated people) or a breakthrough infection post vaccination and recommending the administration of a second Booster to certain identified cohorts.

NIAC recommendations for the second Booster programme are:

- Delivered to the over 12 Immunocompromised and aged 65 and older population
- With an interval period of at least six months after the first booster was recommended although a minimum of 4 months can be used for operational reasons.
- Noting the post breakthrough infection interval of at least 6 months after the first booster or a minimum of 4 months which may be used for operational reasons (i.e. eligibility after COVID-19 infection)
- Comirnaty is to be used for those aged 12-29 years. Comirnaty/ Spikevax to be used for those aged 30 and older.
- If an mRNA vaccine is contraindicated or declined, consideration may be given to using a non mRNA vaccine as the second booster vaccine, following an individual benefit-risk assessment

2. CAG Guidance

The HSE's COVID-19 Vaccination Clinical Advisory Group (CAG) reconvened to provide guidance (Appendix B) on clinical issues pertaining to this NIAC Guidance. The CAG provided the following guidance:

- **Clinical Issue: Advice re interval between doses and post infection (4 or 6 months)** - it was agreed by CAG that it would be reasonable that the interval between first and second booster or post infection and second booster should be a minimum of 4 months.
- **Clinical Issue: Advice re definitions of "COVID infection" with regards to deferral of vaccination** - It was agreed by CAG that the definition should include COVID infection confirmed by PCR or antigen test, as self-reported by the patient.
- **Clinical Issue: Advice re immunocompromised definitions and pathway for review due to those immunocompromised at first booster being included** - It was agreed by CAG to proceed with table of only immunocompromised conditions taken from NIAC Chapter 5 as a guideline as this would support clinical judgement.

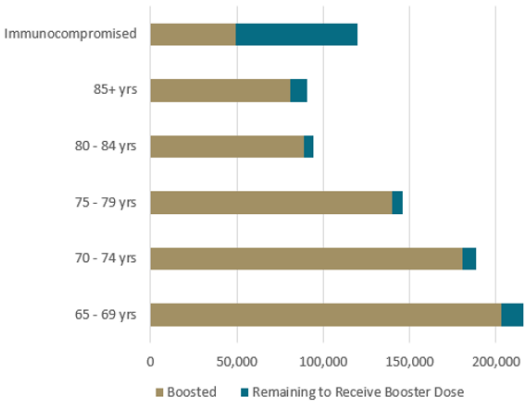
3. Key elements of 2nd Booster Plan

To operationalise this NIAC guidance and subsequent CAG guidance, the Vaccination Programme's Integrated Planning process developed a plan that was considered and accepted by the 13 April Vaccination Programme Working Group. Key elements of this programme are:

a. **Cohort Eligibility & Population -** In scope population (i.e. over 65 year olds and over 12 year olds Immunocompromised) is broken down in the table below by age group. Note that Immunocompromised population is to be confirmed following identification of any new immunocompromised.

65+ and Immunocompromised Cohort Sizes

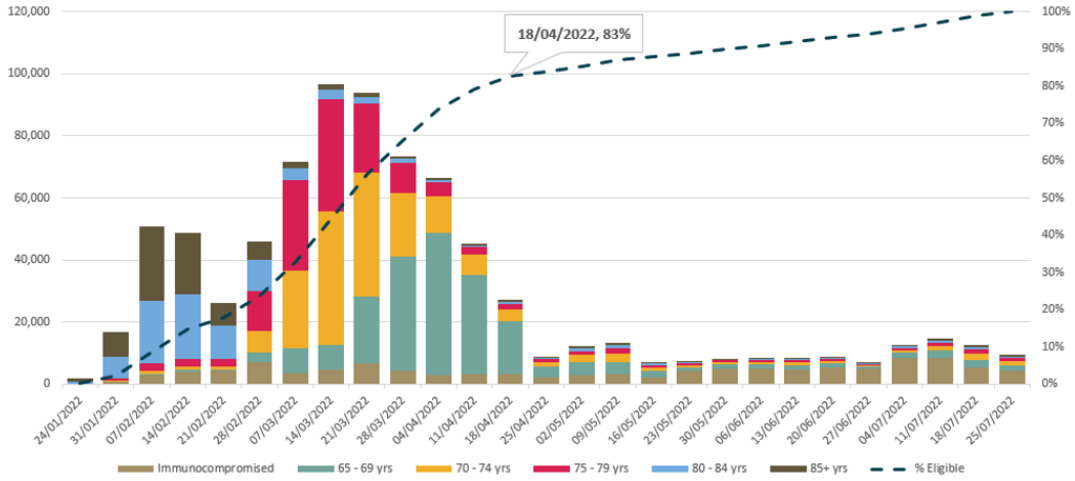
Cohort	(A) Fully Vaccinated	(B) Boosted	Remaining to Receive Booster Dose (A – B)
65 - 69 yrs	215,595	203,045	12,550
70 - 74 yrs	188,491	180,271	8,220
75 - 79 yrs	145,867	139,596	6,271
80 - 84 yrs	94,379	89,068	5,311
85+ yrs	90,446	81,042	9,404
IC	119,804*	49,401	70,403
Total	854,582	742,423	112,159



*Fully Vaccinated for Immunocompromised cohort is calculated based on the total who received an 'Immunocompromised' 3rd Dose

The expected eligibility profile for the 2nd Booster programme based on 4 months post date of vaccination or COVID infection is shown in the table below. Note that the majority of those becoming eligible from end May are Immunocompromised.

65+ and Immunocompromised Eligibility – 4 Months Post Additional Dose Date – Including Covid Cases



The above graph shows the eligibility profile for the 65+ and Immunocompromised cohorts based on 4 months post date of additional dose/ immunocompromised dose or date of Covid infection (whichever is later)

b. **Vaccine Administration Locations - An all channel approach will be adopted** meaning that all individuals within the >65 age group can be vaccinated through all vaccine administration channels (CVCs, GPs & Pharmacies). **GPs will focus on >70s but all in scope will be accepted** through all channels (GP, Pharmacies and CVCs).

c. **Vaccine Type and interval -** Those aged **12-29 years will receive Comirnaty**. Those aged **30 years and older can receive Comirnaty or Spikevax**. **Spikevax will be the preferred vaccine** to ensure utilisation and minimise vaccine expiry as far as possible. A second booster vaccination can be given after a **4 month interval from previous vaccination or COVID positive case**

d. **Start Date - HSE Channels (Vaccination Centres, Mobile Vaccination Teams and Hospital based teams) and GPs will begin administration from 22 April**. Participating **Pharmacies will begin administration from 28 April** (this later date is driven by required enabling ICT work). Pharmacies can continue to vaccinate 12-15 year olds in the intervening period.

e. **End Date - The target is for substantial completion of the in scope population by the beginning of June**. This target end date will support the implementation of the sustainable operating model and the alignment of **any Autumn COVID-19 vaccination programme with**

the Flu programme. There will be capacity in place in some vaccination centres and pharmacies over the summer months to support any "mop up" of the second Boosters required.

f. **Immunocompromised Plan -** Clinical guidance for identification of new Immunocompromised will be distributed to **Hospital Groups and GPs** who **will commence the identification and collation of population data**. In parallel, the **original immunocompromised cohort will start to receive text messages and be called for vaccination in line with their eligibility** (expected early May). The ICT requirements to enable a second Booster for immunocompromised will be delivered the week of 9th May. Following this the second booster programme for this cohort will commence.

4. Key enablers for rollout of second booster programme

a. **ICT -** Covax sprint 20 went live on 12-Apr enabling Booster 2s in GPs and CVCs. Pharmavax system changes to enable Booster 2 administration through Pharmacies will go live on 28 April. **Covax sprint 21 will go live in early May enabling Immunocompromised administration** (in line with their eligibility profile) and completing remaining changes required for Booster 2**.**

b. **Workforce -** VC workforce & GP/ pharmacy support confirmed. **Training and communications regarding ICT updates to be release in advance of 22 April commencement**

c. **Supply -** Update on GP portal with respect to ordering process to be in place prior to 22 April commencement

d. **Communications - Communications plan and key messages to be finalised** now that key elements of the plan have been agreed

5. Risks associated with Rollout

a. **Clarity of Messages -** Ongoing Primary & Booster programmes make the communication of clear messages to target populations challenging.

b. **Communication of Staggered Approach** - Initial administration will be through VCs & GPs (22 April) followed by Pharmacies (from 28 April).

c. **Communication of Immunocompromised Start** - Immunocompromised will begin early May with the date driven by collation of population data, further ICT changes and expected eligibility profile

d. **Continuing risk of low uptake** - Substantial completion of the 2nd Booster programme will be dependent on uptake which has been low since Jan despite a substantial group of people remaining eligible but not Boosted. Low or slow uptake for the 2nd Booster programme will potentially impact the target completion date of beginning Jun, the stock expiry issue and alignment with the Autumn flu programme

e. **Complexity of enabling ICT changes** - The complexity of ICT changes required to enable the administration through Pharmacies and Immunocompromised is such that there is

- a potential for the Pharmacy date of 28 April to be delayed
- significant risk of the Immunocompromised date of early May to be delayed

6. Appendix A - NIAC Guidance (05.04.2022)

RECOMMENDATIONS

These recommendations are made recognising the uncertainties regarding the trajectory of SARS-CoV-2 infections and on a precautionary basis to protect those most at risk of a severe outcome. They are based on current evidence and will be reviewed when more information becomes available. See the prior recommendations for primary and first booster vaccination.

1. Efforts to increase primary and first booster vaccination uptake should remain a public health priority. mRNA vaccines (Comirnaty and Spikevax) are the preferred vaccines for use in Ireland. • Those aged 12 years and older, including those pregnant or breastfeeding, should complete a primary course and receive a booster vaccine (total of three doses)
   • Those aged 5-11 years should complete a primary course (total of two doses) • Those with immunocompromise associated with a sub optimal response to vaccines at the time of their primary or booster vaccination:
      a) aged 12 years and older should complete a primary course, an additional dose and a booster vaccine (total of four doses)
      b) aged 5-11 years should complete a primary course and an additional dose (total of three vaccine doses)
2. Those who have a contraindication to or who decline a primary course or booster dose of an mRNA vaccine should be offered a non-mRNA vaccine.
3. Those who have had previous SARS-CoV-2 infection should complete their primary and booster vaccination to optimise their protection.

Second Booster Vaccine

1. To maintain high levels of immunity in those most at risk of severe disease, a second booster dose of an mRNA vaccine is recommended for the following:
   a) those aged 65 years and older
   b) those aged 12 years and older with immunocompromise associated with a sub optimal response to vaccines
2. The second booster vaccine is recommended at least six months after the first booster. A minimum interval of four months may be used for operational reasons.
   a) For those aged 12-29 years, Comirnaty (0.3ml/30 micrograms) should be given b) For those aged 30 years and older, Comirnaty (0.3ml/30 micrograms) or Spikevax (0.25ml/50 micrograms) should be given
3. For those who have had a breakthrough infection following a first booster vaccine, it is recommended to defer the second booster vaccine for six months following infection onset. A minimum interval of four months may be used for operational reasons.
4. If an mRNA vaccine is contraindicated or declined, consideration may be given to using a non mRNA vaccine as the second booster vaccine, following an individual benefit-risk assessment.

7. Appendix B - CAG Clinical Guidance on NIAC Guidance (08.04.2022)

Clinical Issue: Advice re interval between doses and post infection (4 or 6 months)

Clinical Advice: it was agreed by CAG that it would be reasonable that the interval between first and second booster or post infection and second booster should be minimum of 4 months. It was noted that this would support operational issues and align with planning and delivery of the flu campaign with COVID-19 vaccines in the Autunm.

Clinical Issue: Advice re definitions of "COVID infection" with regards to deferral of vaccination

Clinical Advice: It was agreed by CAG that the definition should include COVID infection confirmed by PCR or antigen test, as self-reported by the patient.
It is acknowledged that a key challenge is those who self-reported cases of infection cannot be linked to COVAX and that a separate forum is developing future testing criteria guidance, but it is expected that this guidance should not affect vaccination guidance for immunocompromised.

Clinical Issue: Advice re immunocompromised definitions and pathway for review due to those immunocompromised at first booster being included

Clinical Advice: It was agreed by CAG to proceed with table of only immunocompromised conditions taken from NIAC Chapter 5 as a guideline as this would support clinical judgement. This is set out in the appendix. The referral process should be made as easy as possible for new patients and vaccine should be available in all VAL's to support uptake.
Although outside the scope of this group, it was noted that a single clinical guidance on immunocompromised definitions would be beneficial for COVID-19 vaccination and administration of paxlovid. The CAG acknowledged that Liver and Neurology are included in paxlovid guidance but not included in NIAC guidance so not included in table (5a.2).

8. Appendix C - Supporting Data

65+ and Immunocompromised Cohort Sizes

Cohort	(A) Fully Vaccinated	(B) Boosted	Remaining to Receive Booster Dose (A – B)
65 - 69 yrs	215,595	203,045	12,550
70 - 74 yrs	188,491	180,271	8,220
75 - 79 yrs	145,867	139,596	6,271
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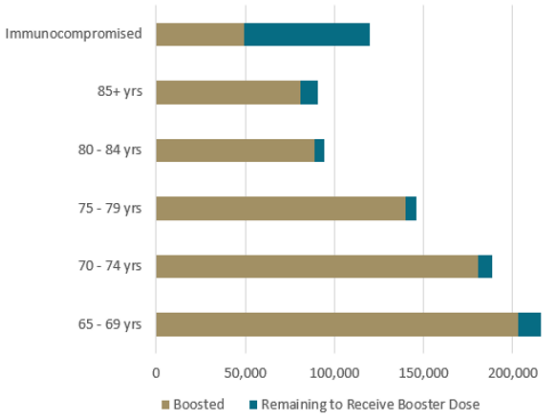
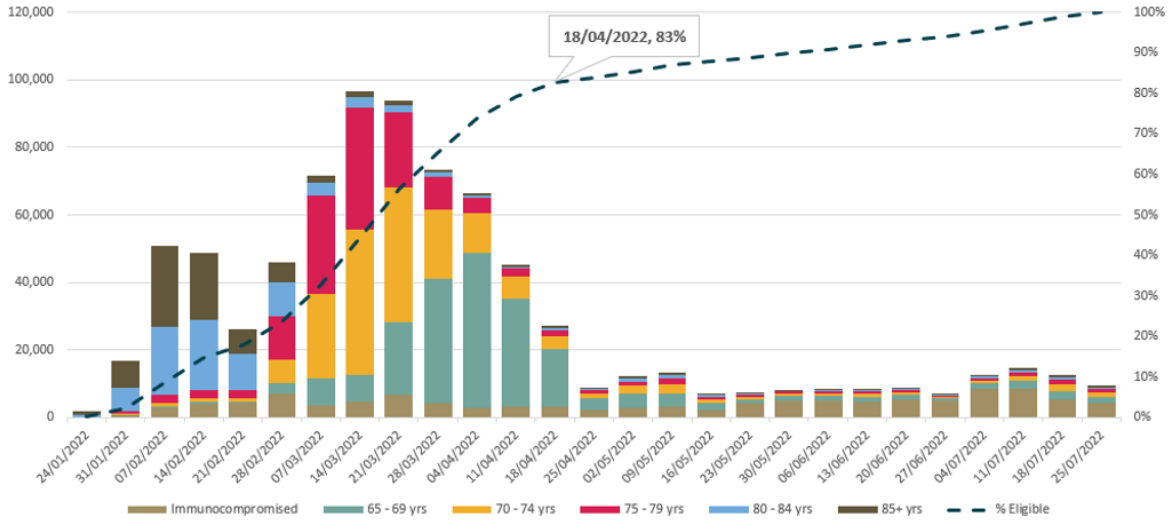


*Fully Vaccinated for Immunocompromised cohort is calculated based on the total who received an 'Immunocompromised' 3rd Dose

65+ and Immunocompromised Eligibility – 4 Months Post Additional Dose Date – Including Covid Cases



The above graph shows the eligibility profile for the 65+ and Immunocompromised cohorts based on 4 months post date of additional dose/ immunocompromised dose or date of Covid infection (whichever is later)

Immunocompromised Eligibility

An analysis was done to determine when immunocompromised people will become eligible to receive their first and second booster:

- Eligible for Booster 1: Those who received an immunocompromised dose but not a booster dose. The eligibility date of this group was calculated as the later date between 3 months after their immunocompromised dose or 3 months after their Covid positive test result.
- Eligible for Booster 2: Those who received an immunocompromised dose and a booster dose. The eligibility date of this group was calculated as the later date between 4 months after their booster dose or 4 months after their Covid positive test result