Health Service Executive

Chief Executive Officer's Report

HSE Board Meeting
25 February 2022

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CHAPTER 1

CEO INTRODUCTION

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1. INTRODUCTION

February has been a month in which we have experienced some success, but we are also contending with a number of significant challenges.

On a positive note, for the first time in many months, it is possible to express with more confidence that we have finally turned a corner in terms of our pandemic response.

Many of the changes and innovations made to how we deliver health and personal social services will be permanent. The EMT and I are now fully engaged the important task of ensuring that we rebuild our health service capacity, with these changes incorporated, as quickly and as safely as possible. Strong cooperation and good will is required between the statutory, voluntary, and the private sector, which I believe is still present in abundance in both acute and primary healthcare. It is important to our mutual success that we tackle the very significant backlogs that have developed because of the "stop-start" nature of services over the past two years.

We have a very big task ahead of us to try and rebuild trust with the young people who were badly let down by the failure to provide an adequate CAMHS Service, and more particularly the lack of adequate oversight in that service across multiple fronts. We owe a debt of gratitude to those who were guided by their ethical code to come forward and speak out.

There has been much publicity regarding the relationship between the Department of Health and the HSE on foot of recordings which were provided to the press. We are working with our colleagues in the Department to understand their concerns. As CEO I recognise and respect the role of the Department in relation to the HSE. For example, over the course of last year, we enjoyed respectful and cordial discussion as we worked together to define the contours of that relationship through the development of a draft Oversight Agreement. While we have been up front that about our concerns, the unity of our mission binds us together and ensures that the relationship between us remains strong.

I conclude this introduction by expressing my thanks the HSE's incredible staff for their enduring commitment. The best way in which to manifest my gratitude to you is by devoting the whole of my attention and that of my team to bringing into being the type of health service envisaged in Sláintecare.

CHAPTER 2

Governance

2

2. GOVERNANCE

2.1 ACCOUNTABILITY WITHIN THE HSE

2.1.1 I have prepared a short paper to update the Board in relation to both the progress and the issues that remain to be satisfactorily resolved in ensuring that we have an integrated system of accountability throughout the HSE.

2.1.2 As I have pointed out previously, there are a number of dimensions to accountability, or "pillars" as I referred them, of which there are (at least) five:

(a) Clear management organisation and processes;

(b) Performance management;

(c) Open disclosure;

(d) Professional regulation;

(e) Disciplinary procedures.

2.1.3 If these things are in place, are understood, and are functioning well, it is my view that we would see a significant improvement in how we as an organisation confront individual or collective error, whether it be of a clinical or managerial nature.

2.1.4 Getting accountability right and calibrating our approach to accountability at an organisational level is something which I have concluded needs further work and refinement. I look forward to debating this in more detail during the course of the Board meeting, and to the benefit of Board members' insights.

2.1.5 For the moment, what I have presented is an update on progress made across a number of the "pillars" referred to above, and the paper concludes with a discussion about some of the issues which require further management attention.

2.2 SLAINTECARE PROGRAMME BOARD MEETING

2.2.1 On February the 14th, the Sláintecare Programme board held its second meeting, combining key stakeholders from the HSE and the Department of Health.

2.2.2 The Board will be aware that that I co-chair the Programme Board with the Secretary General. However, I have been clear in all of my communications with the

Department and the Minister that in performing this function I am subject to the Board's oversight in its capacity as the HSE's governing body.

2.2.3 A key element under Sláintecare and also the NSP 2022, is concerned with addressing waiting lists and relieving the situation for individuals who are waiting for inordinately long periods of time to access the care that they need. Dedicated funding has been assigned to overall reduce achieve the outlined waiting times, as laid out in Sláintecare and the multi-year plan be an important part of arriving at a more enduring solution to this long-standing problem for our health services.

2.2.4 Enhanced Community Care (ECC) is also a key element of Sláintecare's objective of ensuring that people access "the right care, in the right place at the right time." Discussions were held on the strategic and operational plans of ECC and on our progress in relation to primary care centre development plans.

2.3 ANNUAL REPORT 2021

2.3.1 Preparation of the Annual Report is a legislative requirement under the Health Act, 2004 (Section 37) which requires the HSE Annual Report to be prepared and adopted no later than the 30 April each year on the performance of its functions during the preceding year. The Annual Report 2021 (AR 2021) is currently being drafted focusing on the HSE's emergence from COVID-19, key achievements during the year, and how resources have been used more generally. AR 2021 will report at a high-level on progress against key priorities included in NSP 2021 and there will also be strong messaging around climate and sustainability.

2.3.2 The Annual Report must be prepared and adopted, no later than the 30 April each year, and it must address (at least) the following matters:

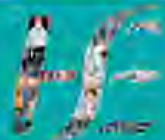
(a) a general statement of the health and personal social services provided during the preceding year by or on behalf of the HSE (whether provided in accordance with an agreement under section 8 or an arrangement under section 38) and of the activities undertaken by the Executive in that year,

(b) a report on the implementation of the corporate plan in the year,

(c) a report on the implementation of the service plan in the year,

(d) a report on the implementation of the capital plans in the year,

(e) an indication of the HSE's arrangements for implementing and maintaining adherence to its code of governance,



(f) the report required by section 55 (i.e. complaints), and

(g) such other information as the HSE considers appropriate or as the Minister may specify.

2.3.3 The drafting and co-ordination of the AR 2021 will be led by the National Director Strategy and Research, on behalf of the Chief Strategy Officer, linking in with relevant staff from across the HSE Centre. An update on the approach and timelines regarding preparation of the AR 2021 was provided to the Performance and Delivery Committee at their meetings in January and February 2022. Further meetings have been scheduled with EMT and P&D over the next two months before the final draft of the AR 2021 is brought back to the HSE Board for formal adoption on 27 April 2022

2.4 INTERNAL AUDIT

2.4.1 **Opinion of National Director of Internal Audit**

2.4.2 The National Director of Internal Audit (NDIA) has provided an overall annual audit opinion for 2021 of limited assurance in respect of the governance, risk management and internal control processes within the HSE. This assurance level is consistent with the NDIA 's annual audit opinions for 2019 and 2020.

2.4.3 In assessing the level of assurance that can be given, the NDIA's opinion is based on:

- all internal audit work completed during the course of the year
  - **145 reports, containing 890 recommendations.**
- results of any follow up exercises undertaken in respect of previous years' internal audit work
  - **16 follow-up audits**
- audit recommendations implementation progress made by business owners
  - **Implementation rates: 2021 – 64%, 2020 – 64%, 2019 – 92%**
- results of work of other review bodies where appropriate. Notably this has included:
  - **Conti cyber-attack on the HSE – Independent Post Incident Review: PWC December 2021**

- **Report for the HSE Board and Executive Management Team – Managing Corporate Risk: John Moody July 2021**

2.4.4 The NDIA's opinion is included in HSE's Statement of Internal Control and assists in informing this statement together with assurances provided by other areas e.g. Heads of Divisions (National Directors), the Risk Management function and other reviews that have been carried out during the year.

2.4.5 **Internal Audit Review of the Operations of HSE Standards and Recommended Practices for Post Mortem Examination Services**

2.4.6 Internal Audit's review of the operation of the HSE Standards and Recommended Practice for Post Mortem Examination Services across all public hospitals commenced on 11th November. The review focused on post mortem practices completed between 1 January 2018 and 31 October 2021 in the hospital mortuaries of all 25 hospitals where post mortems are carried out.

2.4.7 The audit reviewed compliance in this area on:

(a) The information provided to families;

(b) Securing relevant consent from families;

(c) The ultimate disposal of retained organs.

2.4.8 The audit has now been completed and the final report was issued on 18th February. There are a number of findings which will require management attention and on which I will further brief the Board on 25 February.

2.5 JOINT COMMITTEE ON HEALTH – SLÁINTECARE IMPLEMENTATION OVERSIGHT

2.5.1 On February the 16th the Joint Committee on Health convened in order to discuss Sláintecare; focusing principally on two key areas:

- The introduction of new regional health areas and matters arising and relating to regionalisation of the health service;
- The oversight structures for the implementation of Sláintecare.

2.5.2 The Secretary General, Mr Robert Watt noted in his opening address that the pandemic had taken up much management time in the preceding two years which slowed down many reform. Mirroring my own observations to the Committee he also pointed out that the COVID-19 response had necessarily accelerated many positive

aspects of the Sláintecare vision, including fast-tracking service innovation, new pathways of care and new ways of working.

2.5.3 The Committee was anxious to learn about the HSE's and the Departments plans to implement Sláintecare, and they asked a number of questions regarding the plans to implement Regional Health Areas with a view to ensuring that decision making in relation to healthcare is made as close as possible to the point of service delivery.

2.5.4 In my opening submission and in my address to the Committee I made reference to a number of innovations that were truly transformative during the pandemic response, and which are here to stay. For example, within Primary Care granting GPs direct access to radiology has reduced materially the demands on our hospitals. The e-Health and the roll out of the Chronic Disease Management Programme have also improved things materially for at least 430,000 people living which chronic diseases. There is now a great opportunity to galvanise the system and to build on the reforms already introduced.

2.5.5 The next Joint Committee on Health are due to meet on the 6th of April.

2.6 ASSISTED DECISION-MAKING (CAPACITY) ACT 2005

2.6.1 The Assisted Decision Making (Capacity) Act was signed into law on 31 December 2015. The Government has committed to full commencement by the end of June 2022. The Act provides for the reform of the law relating to persons who require or may require assistance in exercising their decision-making capacity, whether immediately or in the future. The Act applies to everyone over 18 and will have wide-ranging implications for all health and social care providers.

2.6.2 The reforms and benefits provided in the Act will require significant change in management support for staff and services to ensure successful implementation of these welcome reforms and to adequately deliver on the intended benefits. In preparation for commencement, the Act is undergoing some amendments which will not be complete until April 2022.

2.6.3 15 codes of practice were issued for public consultation by the Decision Support Service (the oversight body for the Act). Strategy and Research have been co-ordinating the HSE response in relation to this. It is expected the codes will not be finalised until at least May 2022. Key Reforms of the Act include:

- The Abolition of wards of court system for adults under the Lunacy Regulation (Ireland) Act 1871

- The Repeal of the Marriage of Lunatics Act 1871 (repealed 1 February 2021)
- Current adult wards of court to transition out of wardship within three years of commencement
- A statutory functional test of capacity; time-specific and issue-specific will now be required
- New statutory guiding principles on rights, decision making and autonomy
- New legally appointed decision makers to assist people with decision making – staff will need to interact and engage with these decision supporters in their day-to-day work
- Advance healthcare directives will have statutory power
- he establishment of Decision Support Service; the oversight body for the Act.

2.6.4 Work Done to Date

The HSE Office for Human Rights and Equality Policy, Strategy and Research with the support of the HSE Leadership Team, has been working with staff and services since early 2016 to support the implementation of the Act. This work includes:

The establishment of www.assisteddecisionmaking.ie to provide information on the Act and to host all of the resources that are developed.

- A Conference in 2016 with over 500 attendees, over 1200 via video link
- The establishment of the first ADM Steering Group and three working groups in May 2016 with an independent expert chair, Professor Deirdre Madden, UCC. This group had representation from across the HSE care groups, subject matter experts and service user representatives. This group was stood down in 2021 due to the change in focus of the work to implementation.
- Oversight and management of the Advance Healthcare Directives (AHD) Multi-Disciplinary working group on behalf of the Minister for Health, Simon Harris, T.D. Chaired by Professor Deirdre Madden. To progress implementation an AHD Sub-Group was established, chaired by Professor Mary Donnelly, School of Law, UCC. There was broad clinical, management and service user representation on this group.

- HSE development of three draft Codes of Practice submitted to the Decision Support Service as follows:

  (i) Code for Health and Social Care Professionals

  (ii) Code on the making of an Advance Healthcare Directive

  (iii) Code on the Designated Healthcare Representative

- Oversight and development of the Code of Practice for Health and Social Care Professionals on behalf of the Decision Support Service

- Support from the DDG Ops and Community Ops on the development of Guidance for HCW on Wardship (publication imminent) and support for the development of a revised National Consent Policy and supporting E-learning programme (launch imminent)

- Support from the Office of the CCO for the development of two suites of E-learning programmes (one on supported decision making- March 2022) and one on the 2015 Act (May 2022)

- Launch of HSE ADM Explainer Video in 2020 by Paul Reid, CEO and Minister Anne Rabbitte, T.D.

- Information and briefing sessions to staff delivered to over 15,000 staff across HSE and HSE funded services. These sessions have moved virtually since March 2020

- Three conferences in November 2019 examining what the Act means in health and social care practice with over 500 attendees. Presentations from these events are available online.

- Webinars in 2020 and 2021 on Supporting Decision-Making, Consent and the Act with over 14,000 people registering. These webinars were publicised using HSE Broadcasts.

- Collection of essays: The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections was launched by Paul Reid, CEO and Anne Rabbitte T.D. Minister for State in November 2021. This was publicised to staff via HSE Broadcast.

- Three-weekly meetings with the Inter-Departmental Steering Group who oversee the implementation of the Act, chaired by the Department of Children, Equality, Disability, Integration and Youth. Membership of the group includes the HSE, DCEDIY, the DoH, DoJ, Courts Service, the Office of the Wards of Court, MHC and the DSS.
- Strong links built with key government departments, agencies and stakeholders central to the implementation of the 2015 Act e.g. Department of Health, Mental Health Commission, National Disability Authority, HIQA, Department of Justice, Office of the Wards of Court, Department of Children, Equality, Disability, Integration and Youth.
- The HSE is the only delivery agency that has undertaken significant preparatory work for commencement and as such other agencies are seeking our advice and guidance including access to our resources.
- Publication of quarterly newsletters on preparatory work on commencement and revisions to the National Consent Policy. These newsletters are also available online.
- Monthly update meetings with the Office of Legal Services

2.6.5 Establishment of HSE ADM Implementation Steering Group

A HSE ADM Implementation Steering group chaired by Professor Mary Donnelly, School of Law, UCC and Professor Shaun O'Keeffe, Consultant Geriatrician, UCHG and a number of working groups were established in 2021 to prepare for commencement of the Act in June 2022.

2.6.6 Work to prepare for commencement in June 2022

An ADM Implementation Plan to support the HSE and HSE funded agencies to prepare for commencement of the Act is under way. Relevant internal and external stakeholders as outlined above are engaged. Responsibility for compliance will rest with the delivery system supported through the newly established Integrated Operations Working ADM Sub Group. The National Office for Human Rights and Equality Policy will continue to provide general and specialist guidance, training and resources on the 2015 Act before and after commencement. The ADM Implementation Plan will set out the following requirements for the delivery system to achieve compliance with the provisions of the 2015 Act:

- Governance
- Training and development
- Communications
- Documentation and Record keeping
- Monitoring and measuring implementation
- HR resourcing
- Risk
- Barriers and enablers to implementation
- Review

The Plan will require leadership support to ensure that the organisation fully engages with the operational requirements of the 2005 Act.

2.7 HEALTH (MISCELLANEOUS PROVISIONS) BILL 2022 INITIATED

2.7.1 The Minister of State at the Department of Health, Deputy Anne Rabbitte addressed the Dáil on the Health (Miscellaneous Provisions) Bill 2022 on 10 February 2022 following the following the Bill's publication on 8 February 2022.

2.7.2 The Minister outlined that the Bill will facilitate the transfer of specialist community-based disability services from the Minister for Health to the Minister for Children, Equality, Disability, Integration and Youth (CEDIY). She noted that broader disability equality policy is already the responsibility of the Minister for CEDIY following the transfer from the Minister for Justice in late 2020.

2.7.3 The Minister noted that the location of disability equality policy and specialist community-based disability services in a single Department will facilitate strategic policy development, including implementation of the United Nations Convention on the Rights of Persons with Disabilities, UNCRPD, which Ireland ratified in 2018, as well as the significant reforms envisioned under the *Transforming Lives* programme.

2.7.4 After the transfer of policy responsibilities takes place, the legislation makes clear that the governance arrangements will be that the HSE will retain service delivery responsibility and provide a framework for close co-operation between the Departments of Health and CEDIY. The Minister has said that this will ensure that

specialist community-based disability services benefit from, and are in line with, ongoing reform efforts including under Sláintecare.

2.7.5 As the HSE will continue to deliver the services, the transfer requires it to report to two Ministers for different elements of its functions. The Bill seeks to put in place a legislative basis to enable this and includes provisions on accountability arrangements for the HSE to the Minister of CEDIY under the Health Act 2004. This aims to ensure that both Ministers (Health and CEDIY) have the necessary authority in their respective areas of responsibility.

2.7.6 The legislation will *inter alia,* place an obligation on the HSE to prepare and submit a corporate plan to both ministers, and an approved service plan to include the Minister for CEDIY in relation to specialist community-based disability services.

2.7.7 In addition to the substantive objects of the Bill Section 41 will also remove the current requirement that the Chairperson of the Audit committee is appointed from amongst the external members only. The Board will in future have the prerogative to designate one of its members as the Chairperson.

2.7.8 Section 48 will amend Schedule 2 of the Principal Act (Health Act 2004 (as amended)) to delete the word "ordinary", thereby allowing for a quorum of 7 members of the Board (which may now include the Chair or Deputy Chair) who were heretofore precluded from being counted as part of a quorate Board).

2.7.9 **Objects of the Bill**

The legislation includes provisions in relation to revised corporate and accountability arrangements for the Executive under the Health Act 2004. This aims to ensure that both Ministers have the requisite authority and accountability in respect of the HSE (in their respective areas of responsibility). Some of these amendments include provision for the Minister for CEDIY powers in respect of:

- Issuing of directions to HSE
- Accountability of the HSE Board
- Corporate plan, service plan and capital plan
- CEO accountability re expenditure

- Expansion of Minister for Children, Equality, Disability, Integration and Youths powers in respect of investigations by the Health Information and Quality Authority under the Health Act 2007;

- Revised arrangements to provide for the coordination of sectoral plans by the Minister for Children, Equality, Disability, Integration and Youth under the Disability Act 2005; and

- Provisions relating to consultation, joint functions and cooperation between the Minister for Health and the Minister for Children, Equality, Disability, Integration and Youth.

2.7.10 A copy of the Health (Miscellaneous Provisions) Bill 2022 as initiated, the explanatory memorandum, and the Dáil debates concerning the Bill may be accessed at the following link.

CHAPTER 3

Finance Update

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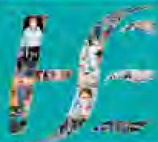


Rialtas na hÉireann
Government of Ireland

COVID-19
VACCINE
Public Health
Advice

If you have a weak immune system, your vaccine course is:

COVID-19 vaccine ☑

Additional dose ☑

Booster ☑

If you had COVID-19, wait three months before getting your booster.

3. FINANCE UPDATE

3.1 KEY MESSAGES

3.1.1 A previous draft paper entitled "Preliminary Finance Summary YTD Dec 2021" presented the pre-Annual Financial Statement (AFS) preliminary 2021 out turn position for Revenue Income & Expenditure (I&E), Capital I&E and Cash, was considered at the Executive Management Team (EMT) on February 8th, 2022, at the Audit and Risk Committee on February 10th, 2022.

3.1.2 This finance update report is focused on the Revenue I&E position and utilises the preliminary 0.7% / €140m adverse variance referenced in that previous draft paper. However, it should be noted that expenditure variances contained within that paper and this report are best estimates of the expected AFS 2021 year-end position which is subject to change. The final results will be determined once the final DOH Letter of Determination for 2021 has been received and the 2021 AFS and C&AG audit processes have been fully completed.

3.1.3 The HSE's very successful response to COVID-19 throughout 2021 has cost more than the specific COVID funding provided within the overall government estimates for 2021. Those government estimates were finalised in October 2020 and assumed, for example, Level 3 restrictions or better during 2021 and did not assume the roll out of our vaccination programme. Given the complex and evolving nature of the pandemic, and the difficulty in accurately predicting its course and the resultant costs, the Government set aside a significant central COVID contingency fund. This included €240m in relation to the health sector, of which €205m was understood to be available primarily in relation to costs associated with the test and tracing programme.

3.1.4 The general approach as operated by the Department of Public Expenditure (DPER), including via the Health Budget Oversight Group (HBOG), which HSE and the Department of Health also attend, was to:

(a) Monitor COVID and core costs (i.e. Non-COVID),

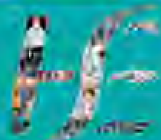
(b) Provide sanction, but not additional funding, for significant additional COVID costs as they became visible, for example in relation to the vaccination programme,

(c) Await visibility of year-end figures to determine whether additional unfunded COVID costs would be offset fully by savings in core (Non-COVID) service areas.

3.1.5 In summary terms COVID costs have come in c. €690m higher than the specific COVID funding provided to the HSE with c. €550m or c. 80% of this being offset by net once-off savings in core areas, leading to the preliminary €140m / 0.7% adverse variance referenced above (€690m-€550m = €140m).

3.1.6 Most of the savings relate to regrettable delays in our capacity to progress with developments, including recruitment of additional staff to permanently strengthen the health service. These delays were largely caused by our need to prioritise the overall effective response to the pandemic. Thankfully, the funding for these developments has been retained in 2022 and recruitment of the remaining new staff has been prioritised within our overall recruitment plans.

3.1.7 It is intended, on a once-off basis for 2021 only, to internally reallocate funding from areas of core savings to address in-year adverse variances in core services where relevant and thereafter to address in-year adverse variances caused by COVID responses. Given the €140m overall adverse variance, this internal reallocation



cannot address all COVID cost overruns, and will therefore prioritise front line services, including certain voluntary services, to ensure they are not impacted by the cash pressures that would inevitably arise if their COVID response costs were not funded. This internal re-allocation is the subject of engagement with DOH before being fully finalised.

3.1.8 The €140m / 0.7% adverse variance does not assume any allocation from the centrally held COVID contingency referenced above as DOH have advised that they did not seek or secure same, albeit it is noted that within the Test and Trace programme final estimated costs, driven by the exceptional volume of testing in the second half of 2021, are c. €275m above the level of funding initially provided by DOH for the programme (6.5m tests carried out, with 2.2m / 34% carried out in the last 3 months of the year). It is understood that DOH are considering alternative mechanisms to avoid HSE having a €140m 1st Charge on the available funding for services in 2022, and in this regard a final DOH Letter of Determination for 2021 is awaited.

3.2 PRELIMINARY FINANCIAL RESULTS

3.2.1 The draft revenue I&E financial position, including estimated AFS adjustments, shows a 2021 deficit of €140.6m or 0.7%, with a significant element of this being driven by the direct impacts of COVID-19, as reflected in the €689.1m adverse variance on COVID-19 related costs being offset by a (€548.5m) positive variance on core costs.

3.2.2 The €689.1m adverse variance on COVID-19 costs is predominately manifesting in areas such as Testing & Tracing c€275m, COVID-19 Vaccines c€330m and COVID-19 responses in Acute and Community settings.

3.2.3 The (€548.5m) positive variance in core is due savings related to delays in progressing new service developments and activity levels being lower as a result of COVID-19. This positive variance of (€548.5m) in core is the net figure after core deficits have been addressed, mainly an Acutes deficit of €108.5m, State Claims Agency deficit of €55.1m and small adverse variances across other divisions/services.

Had the Government contingency of €205m been available to HSE this would have equated to a surplus of (€64.4m) [€140.6m deficit + (€205m) budget contingency) which is within the previous range advised to the HSE Board on December 17th 2021[1].

[1] At the outset of the 2021 financial year, given the uncertainty around COVID-19 testing volumes, an additional €205m was set aside by Government which was to be held by DPER. The HSE have reinforced the requirement for this funding through documented correspondence,

3.3 FINAL INTERNAL FUNDING RE-ALLOCATION

3.3.1 The COVID-19 pandemic has led to unprecedented interruption to normal healthcare activity, with both community and acute settings affected. Not only have existing services been significantly impacted, but new services have had to be rapidly developed and deployed. Due to the primary impacting effect of COVID-19 in 2021 it was not practical to progress all developments in year, and while these will be progressed in 2022, the once- off savings in 2021 have been offset against core services in addition to unfunded but sanctioned expenditures in areas such as the Winter Flu campaign, COVID-19 Vaccines, Testing & Tracing and also COVID–19 costs in Acute and Community Services.

3.3.2 The **key principles** for the proposed re-allocation of funding is set out below.

(a) In the first instance, the HSE is required to use the funding provided to it for the purposes that it was provided. In the specific circumstances of the COVID-19 pandemic, such savings are available to address otherwise unfunded costs, including COVID related costs.

(b) Initially, once-off savings in core are being utilised to offset core adverse variances. This includes temporary once-off savings due to delayed developments and also savings due to COVID-19 related service interruptions. Due to the complexity of isolating COVID-19 costs, there is a degree of estimation and some COVID-19 costs may be reported in core.

(c) Thereafter COVID–19 funding has only been utilised to fund COVID-19 costs i.e., no COVID-19 funding was allocated towards non COVID-19 costs. This can be expressed as follows;

- Testing & tracing funding of €445m has been utilised to directly fund the costs of €680m (after and expected Vat adjustment) that relate to this programme.
- The COVID–19 Vaccine Programme funding of €200m has only been utilised to fund the cost of the administration and rollout of this vaccine

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and in engagements with DOH, in the latter half of 2021. This means that DOH would have to provide up to €140.6m via an alternative mechanism to avoid HSE starting 2022 with a revenue 1st charge.

programme including vaccine purchases. Total costs for the programme for the year are €330m.

- Access to Care funding has been utilised to fund COVID-19 costs related to the private hospital agreement plus other unfunded COVID–19 costs within hospital services.
- PPE COVID-19 funding has been used to cover PPE costs plus other unfunded COVID–19 costs.

3.4 2021 RESULTS – POST FUNDING RE-ALLOCATION

3.4.1 A core assumption in the general HSE financial management and planning process with services is that any excess costs incurred above budgets would be dealt with by the relevant statutory and voluntary organisations in the following year, unless exceptional reasons exist to justify an alternative approach in any specific instance. However, in 2020 and again in 2021, as a result of the challenges experienced due to COVID-19, a change in approach was agreed by exception, whereby in-year deficits would be temporarily addressed for these years. Table 1 below illustrates the effect of the proposed internal once-off only reallocation of 2021 funding on the health service's financial results. The resulting deficit of €140.6m, after reallocations, has year-end COVID driven deficit positions of €61.5m in Operations and €79.1m in Pension and Demand Led areas.

3.4.2 We have also prioritised voluntary S.38 providers in that context, linked to fact these organisations have to individually manage cash balances.

Table 1 – HSE Preliminary 2021 Financial Results (Including known AFS adjustments)

Service Area	COVID incl Income	CORE	Total
	€m	€m	€m
Acute Statutory	0.0	(0.5)	(0.4)
Acute Voluntary	0.0	0.0	0.0
Sub Total - Acute	***0.0***	***(0.5)***	***(0.4)***
National Ambulance Service	0.0	0.9	0.9
Total Acute Operations	**0.0**	**0.4**	**0.4**
Access to Care	(151.0)	-	(151.0)
Private Hospitals	151.0	-	151.0
Total Acute Operations, Private H & ATC	**0.1**	**0.4**	**0.4**
Community Statutory	178.3	(447.4)	(269.1)
Community Voluntary	7.9	(7.9)	0.0
Grand total Community	**186.2**	**(455.2)**	**(269.0)**
Total Operational Services - Other	**332.3**	**(1.8)**	**330.5**
Total Operational Services	**518.5**	**(457.0)**	**61.5**
Pensions & Demand Led	**170.6**	**(91.5)**	**79.1**
Grand Total HSE	**689.1**	**(548.5)**	**140.6**

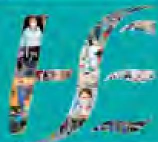
3.5 CONCLUSION

3.5.1 Pending the receipt of the final DOH 2021 Letter of Determination, and the conclusion of the AFS and C&AG Audit processes, this paper summarises the estimated Revenue I&E outturn position for 2021 which is an adverse variance of €140m / 0.7%, all of which is directly attributable to COVID related costs. It also proposes the once-off internal reallocation in 2021 only of savings to ensure front line services are not impacted by the cash pressures that would ensue if directly provided services, and certain voluntary services, were left with unfunded largely COVID driven deficits. This 2021 internal reallocation does not impact 2022 budgets. Thankfully we have been able to retain all of the 2021 development funding and we have prioritised the recruitment of the remaining 2021 additional staff within our overall 2022 recruitment plans, in order to permanently strengthen the health service.

CHAPTER 4

COVID-19 Vaccination/ Test and Trace Update

4



4. COVID-19 VACCINATION/ TEST AND TRACE UPDATE

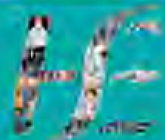
4.1 FUTURE OPERATION MODEL

4.1.1 I have provided the Board with a separate paper on progress on a future operating model for both Test and Trace and our Vaccination Programme.

4.1.2 The Test and Trace Programme has commenced a review of the National Test and Trace strategy, previously developed by the HSE, considering the current trends. Given the scale of the programme with c.3,000 staff, multiple partners and a nationwide infrastructure, it is important that any major changes in testing strategy, or changes to this complex infrastructure can be phased and considers any possible future requirement to flex upwards.

4.1.3 The approach for the Test and Trace future operating model is being developed and is progressing well, with input being received from across the HSE. Transition to this new testing model will need happen in agreed phases. It will be predicated on public health advice but will have to balance this with operational considerations and incorporate the ability to have a ramp-up protocol should this be required.

4.1.4 There are a number of 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, key contracted providers, all of which are directly related to the ramp-up requirement referred to above.

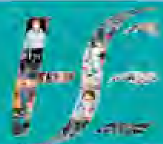
4.2 TRENDS

4.2.1 The key test and trace indicators over the last week show a downward trend in demand and positivity of 10.58% and 1.8% relative to the previous week with community swabs undertaken indicating a slight increase of 5%.

- Community referrals have decreased by 10.58% compared to the previous week with 68,543 community referrals, while community positivity has decreased from 48.7% to 46.9%.
- GP referrals have decreased by 10.4% compared to the previous week with 6,987 GP referrals.
- Community swabs undertaken have increased by 5% compared to the previous week with 78,511 swabs.
- Laboratory tests have decreased by 4.8% compared to the previous week. 112,159 laboratory PCR tests were undertaken over the last 7 days versus 117,771 in the previous week.
- Overall, Antigen test kits booked have decreased by 70% in comparison to the previous week with 118,818 test kits booked over the last 7 days versus 396,250 in the previous week. As deliveries are every two weeks for RCF, we expect to see fortnightly increases with the 'Other Programmes' figure.
- The average number of close contacts has decreased slightly this week at 2.5.
- There were 31,973 people notified of their detected Covid-19 test result in the last 7 days, with 73,499 people contact traced by the Contact Management Programme. These figures have decreased by 15% and 24%, respectively, in comparison to the same time-period last week.

4.3 PERFORMANCE

4.3.1 Performance remains strong for people getting a test with the median end-to-end T&T for a not-detected result in the Community at 1.0 day and for a detected result in the Community at 1.2 days.



4.4 INITIATIVES

- Serial Testing in Nursing Homes has been extended for a further two weeks. The extension will run from the 10th until the 24th of February.
- Since the launch of the Antigen Portal on Friday the 14th of January 2022, 166,450 positive antigen results have been reported.
- In total, there have been over 2,612,938 Antigen Test Kits dispatched and distributed for all our programmes.

CHAPTER 5
Chief Information Officer

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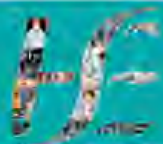


5. CHIEF INFORMATION OFFICER

5.1 GENERAL UPDATE

5.1.1 The Health Service has been experiencing sustained "phishing" campaigns against our users over the last number of weeks.

5.1.2 The National Cyber Security Centre and our own Cyber security personnel has been providing support and advice to the service throughout the HSE, including to individual voluntary sites.

5.1.3 The management of these phishing and any resulting potential cyber-attacks take a lot of time and our individual Security Operations Teams and ICT teams within the Health Service are giving this matter their fullest attention.

5.2 CYBER SECURITY

Interim arrangements have been established to operationalise a cyber-Security Operations Centre (SOC) with 24/7 enhanced security operations monitoring.

5.3 COVID AND VACCINATION PROGRAMMES

All COVID solutions required have been delivered including the COVAX solution. "Sprint 18" which was the one of the most substantial updates to the system's functionality successfully went live last week. This platform is operational across all vaccine facilities and locations. It is integrated with GP Practice Management systems, and the healthcare worker portal was also successfully deployed. The vaccination programme is being supported and maintained on an ongoing day-to-day basis.

5.4 OVERALL EHealth PROGRAMMES

In 2022, 49 programmes of work are receiving funding under the eHealth Capital Plan and National Service Plan. These programmes are made up of 877 individual projects in various project stages, each of which is underpinned by project plans and governed by project oversight groups ('boards'). More than 75% of programmes are proceeding to target (Green status), with the remaining quarter of programmes are in Red or Amber status.

5.5 IHI INTEGRATION INTO CORE SYSTEMS

Detailed planning has commenced for IHI & Eircode integration to Integrated Patient Management System (IPMS) in 5 of 13 instances, and all 4 accredited GP practice management systems.

5.6 UPRGRADE OF NATIONAL INTEGRATED MEDICAL IMAGING SYSTEM (NIMIS)

NIMIS 1.0 Client (Update to existing NIMIS SW Client) project Go Live completed in January. NIMIS 2.0 Upgrade - User Acceptance Testing commenced. NIMIS COVID BEAM solution go-live completed at Mercy University Hospital and Holles St.

5.7 INTEGRATED COMMUNITY CARE MANAGEMENT SYSTEMS (ICCMS).

ICCMS programme team has sought responses via formal "market soundings" process. This will inform the full business case and the statement of requirements for the procurement later this year.

5.8 SCHEDULED CARE eENABLERS.

Work has paused on business case and procurement of the larger Scheduled Care Transformation Programme is being re-scoped.

5.9 NSP STAFFING

5.9.1 2021- Recruitment plans were curtailed during 2021 due to the Cyber-attack. Since then, recruitment has resumed across all programmes; as of the end of January 47% of targeted roles were in place (169 of 358). This is a net increase of 12 WTEs from December

5.9.2 2021 - Recruitment is also moving forward for 2022 NSP roles, with campaigns underway and offers made; In January, none of the additional 138 targeted roles had been on boarded.

5.10 eHEALTH PROGRAMME SUMMARY (including status)

49 Total Capital Programmes

0 Completed Programmes

32 Programmes in Delivery Stage

7 Programmes in Procurement Stage

8 Programmes in Proposal Stage

2 Programmes in Pre-Mandate stage

eHealth National Service Plan Programmes				Project Count Within Programme				
Category	**Programme**	**Programme Stage**	**RAG Status**	**TOTAL**	**1. Proposal**	**2. Procurement**	**3. Delivery**	**4. Completed**
1. Foundational Infrastructure & Cyber Technology	1.1 Network & Communications Technologies	3. Delivery	Green	**165**	21	29	79	36
	1.2 Refresh Current Technology & Devices	3. Delivery	Green	**158**	22	18	81	37
	1.3 Single Identity	3. Delivery	Green	**4**	1	1	1	1
	1.4 Data Centre & Cloud Services	3. Delivery	Green	**42**	6	8	20	8
	1.5 Healthlink Cloud Migration	3. Delivery	Green	**0**				
	1.6 Cyber Security Technology	3. Delivery	Green	**29**	8	7	9	5
	1.7 New Technology	3. Delivery	Green	**19**	4	3	11	1
	1.8 IHI Infrastructure Refresh & Migration	3. Delivery	Green	**2**	1	0	0	1
	Subtotal			**419**	**63**	**66**	**201**	**89**
2. National Programmes	2.1 IHI Integration - Sustain Consumer Systems	3. Delivery	Green	**5**	3	1	0	1
	2.2 Integration and Interoperability	3. Delivery	Green	**3**	2	1	0	0
	2.3 Acute Floor Solution	3. Delivery	Red	**3**	1	1	0	1
	2.4 Critical Care ICT	3. Delivery	Amber	**17**	3	3	9	2
	2.5 Maternity and Newborn (MN-CMS)	3. Delivery	Green	**26**	3	4	10	9
	2.6 Medical Laboratories	3. Delivery	Green	**7**	1	0	4	2
	2.7 National Cancer Information System	3. Delivery	Green	**16**	4	1	7	4
	2.8 National Electronic Blood Track	3. Delivery	Green	**5**	0	0	5	0
	2.9 Medical Imaging (NIMIS & others)	3. Delivery	Green	**19**	4	6	7	2
	2.10 CHI ICT	3. Delivery	Green	**42**	7	22	9	4
	2.11 CHI EHR	1. Proposal	Amber	**1**	1	0	0	0
	2.12 CHI Crumlin-Temple St	3. Delivery	Green	**14**	2	8	2	2
	2.13 PAS IPMS	3. Delivery	Green	**18**	4	4	5	5
	2.14 ePharmacy	2. Procurement	Green	**4**	0	1	1	2
	2.15 EU Open NCP-SCR	3. Delivery	Green	**7**	3	1	1	2
	2.16 Chronic Disease Management (CDM)	3. Delivery	Green	**2**	0	0	2	0
	2.17 National Forensic Hospital	2. Procurement	Amber	**2**	0	1	0	1
	2.18 National Rehab Hospital	2. Procurement	Amber	**1**	0	0	1	0
	2.19 InterRAI Assessment Tool	3. Delivery	Green	**2**	0	0	1	1
	2.20 National Nursing Homes Support Scheme Replacement	2. Procurement	Green	**3**	2	1	0	0
	2.21 Small Solutions	3. Delivery	Green	**179**	90	16	49	24
	2.22 Nurse Task Force Management - Safe Nursing	3. Delivery	Green	**1**	0	0	1	0
	2.23 Integrated Financial Management	3. Delivery	Red	**19**	4	4	11	0
	2.24 National Estates System	3. Delivery	Green	**2**	0	1	1	0
	2.25 National Integrated Staff Records	3. Delivery	Red	**7**	1	3	3	0
	2.26 National Single Sign-on Solution	3. Delivery	Green	**2**	1	1	0	0
	Subtotal			**407**	**136**	**80**	**129**	**62**
3. HSE Transformation Priorities	3.1 Scheduled Care eEnablers	1. Proposal	Red	**8**	6	0	2	0
	3.2 Shared Care Record	1. Proposal	Green	**6**	2	0	1	3
	3.3 Integrated Community Case Management	1. Proposal	Green	**4**	3	0	0	1
	3.4 Telehealth	3. Delivery	Green	**11**	3	0	6	2
	3.5 Endoscopy	1. Proposal	Green	**0**				
	3.6 Cardiology	Pre-Mandate	Green	**1**	0	0	0	1
	3.7 SSW Inpatient Journey Solution	2. Procurement	Green	**1**	0	1	0	0
	3.8 Order Comms	2. Procurement	Red	**2**	0	2	0	0
	3.9 ePrescribing & NMPC	1. Proposal	Green	**3**	2	1	0	0
	3.10 Infectious Disease Register (CIDR)	Pre-Mandate	Green	**0**				
	3.11 Citizen Portal	3. Delivery	Green	**2**	0	0	1	1
	3.12 Immunisation	2. Procurement	Green	**8**	1	0	3	4
	3.13 Home Support Management System	1. Proposal	Amber	**1**	1	0	0	0
	3.14 Residential Care Management System	1. Proposal	Amber	**2**	1	1	0	0
	3.15 Health Performance and Visualisation Platform	3. Delivery	Green	**2**	1	0	1	0
	Subtotal			**51**	**20**	**5**	**14**	**12**
TOTAL eHEALTH				**877**	**219**	**151**	**344**	**163**

5.10.1 **Green Status (Programmes on track)**

(a) 37 of 49 programmes are on track to complete with minimal risk to targets

5.10.2 **Amber Status (Programmes at significant risk on missing targets)**

(a) Critical Care ICT – OLOH Drogheda CIS implementation delayed due to:

- Infrastructure: The ICCA servers required a full rebuild post cyber attack and have just come fully back online week of 14 Feb
- Resourcing: The System Admin was redeployed to clinical role during Covid, and has yet to be released back to the project, however this is expected to happen in Q2 2022.

(b) CHI EHR – Procurement timelines have been delayed in relation to mobilising infrastructure procurements; also programme has ongoing delays and challenges in attracting and recruiting the resources required for mobilisation.

(c) National Forensic Hospital system and National Rehab Hospital systems – Procurment is now completed and final contract is being targeted for completion by the end Q1 to complete.. The configuration of this mini electronic health record system will commence in Q2 2022.

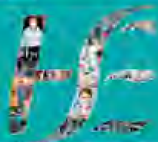
(d) Home Support Management System – Awaiting Community Digital Oversight Group decision around the approach for implementing a full case management system and how this is to be rolled out.

(e) Residential Care Management System – Awaiting Community Digital Oversight Group decision around the approach for implementing a full case management system and how this is to be rolled out.

5.10.3 **Red Status** (Programmes behind plan that will miss completion targets)

(a) Acute Floor Solution – Programme is paused due to Covid priorities; staff were redeployed to CCT and Vaccination systems. Programme to be restarted when staff return.

(b) Integrated Financial Management – A procurement to replace the system integrator is underway and is due to complete in Q3 2022. We have proposed an deployment approach in the procurement document which see maitain to



the greatest extent possible the orgional project timelines of having 80% of health expendiutre transacted through IFMS by Q1/Q2 2025, subject to validation by the incomming System integrator.

(c) **National Integrated Staff Records** – Further developments under this programme were paused due to Covid priorities; staff were redeployed to CCT and Vaccination systems. Programme to be restarted when staff return.

(d) **Scheduled Care eEnablers** – Overall Scheduled Care Transformation Programme is being rescoped, so business case for eEnablers is on hold.

(e) **Order Comms** – Programme is paused due to Covid priorities; staff were redeployed to CCT and Vaccination systems. Programme to be restarted when staff return.

CHAPTER 6

Integrated Operations

6

6. INTEGRATED OPERATIONS

6.1 SOUTH KERRY CAMHS REPORT (The Maskey Report) – HSE RESPONSE AND ACTIONS UNDERWAY

6.1.1 As the Board will be aware, the Report on the Look-Back Review into Child and Adolescent Mental Health Services (CAMHS) in the South Kerry CAMHS Service (the **'Maskey Report'**) was published Wednesday 26 January 2022. In advance of its publication, a briefing document was issued to the HSE Board and Safety and Quality Committee, alongside a framework for how the HSE will address recommendations contained in the Maskey Report.

6.1.2 The HSE has taken a range of actions to address report findings with further actions underway and planned to ensure full implementation of the 35 recommendations contained in the Maskey Report. This will include a range of reviews/audits of CAMHS announced by An Taoiseach Thursday 27 January 2022.

6.1.3 Jointly chaired by the HSEs Chief Operations Officer and Chief Clinical Officer, a National Oversight Group has been established to oversee, monitor and report on implementation of the Maskey Report to the Safety and Quality Committee. The National Oversight Group will include relevant senior clinical and operational management personnel within the HSE, as well as service user and family member representation. This group will oversee the implementation of the recommendations through the three programmes of work outlined below:

(a) Audit of compliance with CAMHs operational guidelines – as announced by An Taoiseach

(b) CAMHS qualitative experience study – including service users, families, staff, referrers

(c) Audit of prescribing practice - independently chaired review of medication practice focused on ADHD across all CAMHS teams.

6.1.4 The above work will also align and support as appropriate the other resulting reviews emerging from the Maskey Report findings and recommendations including the Mental Health Commission planned review of CAMHs services nationally and the indicated review of funding and spend in CAMHS nationally by the C&AG.

6.1.5 Within Cork Kerry CHO, the Chief Officer is standing up an Implementation Group to ensure timely delivery of local actions, including that key learnings are implemented within all CAMHS teams and across other relevant multi-disciplinary teams.

6.1.6 Cork Kerry CHO has implemented a number of immediate actions to ensure appropriate governance, clinical leadership and supervision within South Kerry CAMHS. The objective remains to secure a permanent consultant psychiatrist with interim measures put in place to ensure clinical governance and leadership for the South Kerry CAMHS Team. A Consultant Psychiatrist is on site two days per week with additional support provided remotely three days per week. In line with recommendations in the Maskey Report concerning telemedicine, a Consultant Adolescent Psychiatrist will provide three evening clinics per week remotely from Dublin, while a pilot involving Consultant staff from outside the EU (registered with the Irish Medical Council) is also underway.

6.1.7 A helpline was established in April 2021 to provide advice and support to families affected by the Look-Back Review and remains open from 8am to 8pm, 7 days a week. Through this helpline, families can access information, free counselling support and appointment scheduling with clinical support teams where needed

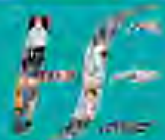
6.1.8 The HSE remains fully committed to hearing from and responding to concerns raised by our employees. Procedures are in place to facilitate employees to make protected disclosures in good faith where they have reasonable grounds that the health and welfare of service users may be put at risk.

6.1.9 I have recently written to Dr. Ankur Sharma to express my gratitude to him for having had the professional integrity and the strength of character to persist with his concerns and to insist that they be addressed.

6.1.10 At the present time we are engaging closely with the State Claims Agency and with the Office of the Attorney General in relation to the proposed compensation scheme, which An Taoiseach has confirmed will be a non-adversarial mediation process involving engagement with the representatives of the families and the children who were harmed.

6.2 NATIONAL PERFORMANCE OVERSIGHT GROUP (NPOG)

6.2.1 The National Performance Oversight Group (NPOG) meeting was held on the 2nd February 2022. The latest performance information relates to **December 2021**



inclusive of original or revised NSP2021 targets and service activity for relevant KPIs. It should be noted that RAG performance results per KPI are based on YTD data available relative to NSP2021 original/revised targets and are not recalibrated for data gaps. The December 2021 results need to be viewed in this context.

6.2.2 The key challenge across all services up to the end of December 2021 was the effect of the increase in COVID-19 cases and its impact on services. While our focus has been on the continued delivery of critical acute and community services, our single biggest challenge has been ensuring staffing of all critical services with high rates of absence to year-end.

6.2.3 Specifically, in relation to Acute and Community services, the following points should be noted:

6.2.4 **Acute Services**

6.2.4.1 Unscheduled Care

Emergency Attendances: ED attendances YTD 2021 were up 146,553 (13%) compared with 2020, but lower than 2019 by 5%. For the month of December, the total number of attendances was 15% higher than 2020 (14,405) but 5% lower than 2019. There are a number of factors contributing to the increase in ED attendances. These include: -

(a) The impact on access to GPs arising from their participation in vaccination programmes,

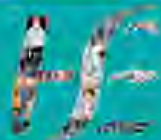
(b) Gradual return of patients to EDs as lockdown measures are eased and vaccination levels increase,

(c) Increased presentations linked to COVID-19.

6.2.4.2 Scheduled Care

Waiting Times: Scheduled care performance relative to revised NSP2021 targets is included in the Operational Services Report (OSR) and Performance Profile. Updates regarding numbers waiting include: -

(d) Inpatient Day Case: The number waiting over 6 months peaked in August 2020 at 45,193. It has since reduced by 16,532 (36.6%) to 28,661 at the end of December 2021 and is at its lowest point since March 2020.



(e) Colonoscopy/OGD: The number waiting over 6 months peaked in September 2020 at 15,892. It has since reduced by 5,400 (53.5%) to 8,503 at end of December 2021 and is at its lowest point since May 2020.

(f) Outpatient: The number waiting over 6 months peaked in September 2020 at 411,452. It has since reduced by 69,720 (16.9%) to 341,732 at the end of December 2021 and is at its lowest point since May 2020.

6.2.4.3 Access to Care Focus on Volumes Waiting:

In 2021 the HSE Access to Care Plan was approved. Targets were set in August 2021 to deliver improvements in total volumes waiting. The overall target for 2021 was to reduce our total numbers waiting across OPD, IPDC and Scopes by 38,000. As part of this plan the HSE put a procurement framework in place to allow Acute Services to purchase procedures from private providers.

These are procedures that the NTPF do not currently purchase. This Framework is now operational. In addition, hospitals are using the SafetyNet Arrangement with private hospitals to support continuity of emergency and elective services within the context of the Pandemic.

The Access to Care Plan is being supported by a combination of HSE core funding, optimising the resources within the access to care fund of €210m, Sláintecare redesign fund and NTPF funding of €130m. By the end of December 2021, we had exceeded that global target by 3,500 patients, with a total reduction target of 41,500 patients.

Table 1 below sets out performance at the end of December 2021. We performed very well in relation to Colonoscopy/OGD and Outpatients waiting lists. The ongoing challenges in relation to COVID-19 and Non COVID-19 presentations are having some impact on our ability to undertake elective work within our hospitals; as a result, we are relying upon significant outsourcing to private hospitals to support the delivery of these targets. We are also working closely with NTPF in this regard. Notwithstanding the sustained pressures on hospitals arising from the Omicron variant, the number on IPDC waiting list stabilised during December.

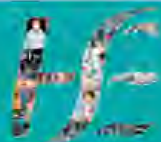


Table 1

WAITING LIST	Target *(to reduce volume waiting to)*	Actual	Actual Dec-21 vs Dec-21 target	
	Dec-21	Dec-21		
Inpatient Day Case	69,822	75,463	5,641	8.1%
Colonoscopy/OGD	33,128	27,145	-5,983	-18.1%
Outpatient	621,081	617,448	-3,633	-0.6%

6.2.4.4 Endoscopy

Urgent Colonoscopy: 385 new urgent colonoscopy breaches in December 2021, an increase from 323 in November 85% (328) of all breaches in December took place in the SAOLTA University HealthCare Group. The Group is implementing an improvement plan to address the ongoing breaches that includes the use of private sector capacity, mobile endoscopy units, and a dynamic purchasing agreement that enables the use of external resources in public hospitals, out of hours and at weekends. The Hospital Group has committed to delivering full compliance by Quarter 1 2022.

Routine Colonoscopy: Due to the renewed focus on tackling the total number of patients, by end of December 2021, the number of people on the Colonoscopy/OGD waiting list was 27,145. This is a decrease of 9.4% on the number waiting at the end of November 2021 (29,960) and 26.3% lower than the peak of 36,820 in February 2021. When compared with December 2020, there is a reduction of 5,394 or 16.6%.

6.2.5 **Cancer Services- Rapid Access Clinics**

6.2.5.1 Symptomatic Breast Services:

NCCP report an increase in referrals for all services, particularly Symptomatic Breast Services. This increase compounded by the existing backlogs, is having an impact on the performance against NSP KPIs at the Breast Cancer Clinics however the seasonal reduction in e-referrals observed in December is in line with usual expectation

Key challenges faced by Symptomatic Breast Services: Five hospitals met the target. Four of the hospitals were below the target of 95%. While the extraordinary challenges faced by hospitals in recent months arising from COVID-19 and the cyber-attack are acknowledged, given the importance of timely access for cancer patients, improvement plans have been requested in relation to Cork UH, Mater MUH, St James's Hospital and Galway University Hospital. These plans are currently under review by Acute Operations and the NCCP and engagements are planned with the relevant Groups to agree implementation requirements. The contributing factors to the non-compliance include:

(a) Significant and sustained growth in referrals.

(b) Challenges in accessing public and private diagnostic capacity because of competing demands from other services.

(c) Consultant manpower challenges at a number of sites.

6.2.5.2 Rapid Access Clinics for Lung Cancer:

Lung Cancer services are performing reasonably well at the eight hospitals. In December 2021 six hospitals were compliant. The NCCP is satisfied that patients are being seen within a reasonable timeframe.

6.2.5.3 Rapid Access Clinics for Prostate Cancer:

As a result of sustained focus and delivery of improvement plans four of the eight hospitals were fully compliant with the NSP target. Improvement plans have been received from the remaining two sites.

6.2.6 **Healthcare Associated Infections (HCAI)**

In December 2021 the rate of S. Aureus was 0.8, a reduction since November (rate of 1.0). The rate of *Clostridium Difficile* in hospitals in December 2021 was 2.3 (the same rate as November). There are established governance structure and arrangements for Antimicrobial Resistance and Infection Control.

6.2.7 **Community Services**

Notwithstanding the very challenging year in 2021 overall the performance of community services has been largely positive. At the time of writing (21st January 2022) it appears that the Omicron wave has peaked but it is still presenting challenges

across services with significant COVID-19 staff absences being reported across the system. There has been a downward trend in staff absence over the previous week but staffing absence remains a challenge for services.

The positive performance of Community Services has been in the face of very significant challenges in 2021, the emergence of the Delta variant in the earlier part of the year followed by the emergence of Omicron in December have impacted service delivery. This is in addition to the cyber-attack which had major adverse impacts for the onset in May across the summer and into the autumn.

Despite these challenges December has seen strong performance with some services delivering well ahead of National Service Plan targets for 2021, the following are examples of positive performance nationally:

(a) **CIT Referrals:** At end of December 2021, there were 71,128 CIT referrals year to date which is 18.7% ahead of the expected year to date activity of 59,919.

(b) **Physiotherapy Access within 52 weeks**: The national position at the end of December 2021 is 78.6% compared to the revised target of 80%. The number of clients waiting longer than 52 weeks has increased by +7.1% from 11,890 in November to 12,740 in December.

(c) **Access to Palliative Inpatient Beds:** The national YTD position is 98.4% of admissions to a specialist palliative care inpatient unit were admitted within 7 days of active referral, compared to the performance target of 98%.

(d) **Community Adult Mental Health Services:** 90.4% of referred patients were offered an appointment within 12 weeks in general adult mental health YTD December 2021 against a target of 90%.

(e) **Psychiatry of Old Age:** 96% of referred patients in Psychiatry of Old Age services were offered an appointment within 12 weeks YTD December 2021 against a target of 98%.

(f) **Disability:** A significant milestone in the reform of Children's Services in line with Progressing Children's Disability Services has now been achieved in 2021 with the reconfiguring of all 91 Children's Disability Networks (CDNs).

Additionally, most therapy services are exceeding targets for the numbers of patients seen in 2021. Examples here are Physiotherapy which is operating 4.1% beyond

target and Ophthalmology which is 9.1% ahead of target on the numbers of patients seen.

However, challenges remain in respect of waiting lists and notwithstanding the good performance in Physiotherapy, for example, in exceeding targets for access there has been an increase in the number of clients waiting longer than 52 weeks which has increased by 7.1% from 11,890 in November to 12,740 in December. Another example of waiting list challenges is Dietetics where the number of clients waiting longer than 52 weeks has increased by 4.5% from 11,872 in November to 12,406 in December.

6.2.7.4 Waiting List / Access to Care Initiative

It is a key priority of Community Services to help people to access the care and support that they need as soon as possible, and a Project Group has been established to oversee the Access to Care initiative. There are 2 initial waiting list initiatives underway where approval and resources have been secured – these are:

(a) Patients waiting for orthodontic treatment for more than 4 years and

(b) Children waiting for primary care psychology for more than 12 months.

Allocations of €5.5m and €4m respectively have been made to these initiatives in 2021 and these are continuing in 2022. Additionally, a submission has been made in January for an initiative to reduce numbers on the counselling waiting list and plans are at an advanced stage to address Child and Adolescent Mental Health (CAMHS) waiting lists.

6.2.7.5 Issues of Concern

In general terms the issues of strategic concern have not changed materially between this month and the previous month. See details hereunder: -

(c) The continuing impact of the pandemic on our workforce which will impact on our capacity to deliver on our KPI's for 2022. Staff have again responded to demands of the latest Omicron variant and many staff were infected or were close contacts.

(d) The impact of the 'roll back' of the Haddington Rd hours will be significant. At the November census there were 56,133 WTE's employed in the 9 CHO's. A two-hour reduction in the work week for these staff has an impact of over 112

thousand hours of staff time per week. This will have a significant adverse effect in the later part of 2022.

(e) Recruitment challenges remain and with a particular concern in respect of home support given our ageing population and our policy / intention to support citizens to lead healthy lives as long as possible at home. This also impacts on maintaining and developing home supports for people with disabilities.

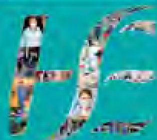
(f) The continued and increasing requirements arising from health & safety and regulation compliance is of considerable concern in the context of capacity for service continuity, service development and infrastructure being fit for purpose in the context of limited capital funding.

(g) Our ICT capacity in community is poor and needs urgent upgrade, it is not possible to run a modern efficient health service where many of the recording tools are paper based. This is a particular challenge in respect of the Waiting List / Access to Care initiative.

(h) Concern about unforeseen system risk, both the pandemic and the cyber-attack presented very significant challenges in 2021 and given the severe impact of Omicron from November and into January 2022 there is clearly the potential for other potentially more dangerous variants of COVID-19 emerging in 2022 in addition to the substantial requirement for planned service recovery in a safe and considered way.

6.2.8 **Nursing Home Expert Panel Review Implementation**

6.2.8.1 NPOG also considered a progress report on implementation of the Nursing Home Expert Panel Review. To date work has been completed on 62% of the recommendations for which the HSE has accountability. The table hereunder provides status overview by expert panel theme: -



.Table 1: Status Overview by Expert Panel Theme (Recommendations for which the HSE has accountability)	Complete	In Progress	External Dependency	Total
1. Public Health Measures	67%	33%		100%
2. Infection Prevention and Control (IPC)	100%			100%
3. Outbreak Management	100%			100%
4. Future admissions to Nursing Homes	100%			100%
5. Nursing Home Management	50%	50%		100%
6. Data Analysis	29%	71%		100%
7. Community Support Teams		100%		100%
8. Clinical – General Practitioner Lead roles		100%		100%
9. Nursing Home Staffing/Workforce	50%	50%		100%
10. Education-Discipline-Specific and Inter-disciplinary	50%	50%		100%
11. Palliative Care	67%	33%		100%
12. Visitors to Nursing Homes	100%			100%
13. Communication	100%			100%
14. Regulatory Recommendations	50%		50%	100%
15. A broader range of statutory care supports for Older People	17%	83%		100%
Grand Total	62%	37%	1%	100%

6.2.8.2 The key items delivered and implemented to date include:

(a) COVID Supports to Nursing Home providers via CRTs

(b) RCF Preparedness Plans (HSE as Registered service provider)

(c) Community IPC/AMS Strategy

(d) IPC Link Practitioner Programme

(e) IPC Training and Resources

(f) Nursing Home Serial Testing Programme

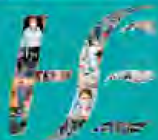
(g) Roles and Nursing Homes, Overview of roles of key stakeholders

6.2.9 The programme is now in the close-out phase with Implementation Steering Group structures due to stand down in Q1 2022 as work completes and transitions to business-as -usual activity, on the majority of the recommendations for which the HSE is accountable. Implementation of the report's recommendations is a key deliverable in the NSP2022 with relevant KPIs across all quadrants of performance are to be monitored. Significant progress has been implementing the Nursing Home Expert Panel Review Report to ensure staff, residents and management are appropriately supported to prevent, prepare for and manage future outbreaks of COVID-19 and other infectious diseases.

CHAPTER 7

Clinical Update

7



7. CLINICAL UPDATE

7.1 NATIONAL SCREENING SERVICE – UPDATED SCREENING

7.1.1 Breast Check

BreastCheck completed 127,288 mammograms of women in the eligible population in 2021 which is above the revised target by 17, 288 (15.7%). Radiology staffing levels are at a critical level in Ireland and within BreastCheck. The CCO has requested the CEO of the National Screening to look at a number of options and recommendations to mitigate and manage the risks.

7.1.2 Cervical Check

CervicalCheck has screened 318,486 women in 2021 which is 13.7% (38,486) above the target of 280,000.

7.1.3 BowelScreen

BowelScreen screened 91,529 eligible participants in 2021 which is 4.6% (4,029) above the revised target of 87,500.

7.1.4 Diabetic Retina Screen

Diabetic Retina Screen screened with a final grading result 93,356 participants in 2021 which is 3.7% (3,356) ahead of the revised annual target of 90,000. The 2-yearly screening pathway is now in place 10 months and is proving very successful. To date of those screened approximately 88% will remain on the 2-yearly pathway.

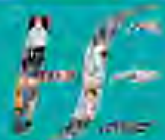
7.1.5 National Screening Targets

(a) At the beginning of the COVID pandemic screening services were paused. When the screening services resumed there was a reduction in the capacity for each of the programmes based on the following, Infection Prevention and Control Measures (IPC), physical distancing and client and staff safety.

(b) The **Breast Screening programme** reduced its capacity for the safety of clients and staff and some people's invitation for breast screening has been delayed by up to a year. The priority was to screen women who were symptomatic. If a woman was due to be screened in 2021, they are now being invited in 2022. The National Screening Service aims to return to screening women every 2 years as soon as possible. BreastCheck introduced a two-way texting system last year which improved attendances and maximised the available capacity, prior to the pandemic did not attend rates ran at 25%.

(c) When the **Bowel Screening service** resumed it needed to match the capacity available in the acute hospital system and therefore this was reduced. The target for the Diabetic retinopathy programmes reduced slightly.

(d) The targets for the four programmes have now reverted to their original targets for 2022 and BreastCheck will remain every two years and will be reviewed during 2022. The four programmes have all reached above their targets. The target for Cervical Check was 280,000 and reached 320.000, 14% above target. The other three programmes whilst targets were reduced, they have exceeded these.



7.2 NATIONAL CANCER CONTROL PROGRAMME

7.2.1 The past two years have been very difficult for people living with cancer, their families and those who provide their care. While the full impact of COVID-19 on cancer care and patient outcomes is not yet quantifiable, a report by the NCCP, NHQI, NEQI, NRQI, NCRI, RCPI and other partners[2], published in December 2021, has provided some initial analyses. This report estimated that 10-14% fewer cancers were diagnosed in 2020 compared to 2019 (pre-pandemic). This means that there is an expectation that the number of cancers diagnosed in 2021 and 2022 will be higher, in addition to cancer incidence rates arising from demographic factors. This will undoubtedly place additional pressure on a system that is already facing a challenging situation. However, the clinical outcome of these potential delayed presentations is, as yet, unknown.

7.2.2 While cancer services were prioritised throughout the pandemic, COVID-19, as well as the cyber-attack in 2021, have impacted on cancer services, resulting in backlogs in rapid access cancer clinics and delays in appointments and attendance. The response to the challenges posed by COVID-19 saw an acceleration in the implementation of novel approaches and innovations in the delivery of patient care. While the challenge is significant and is likely to take some time to address, a number of actions are being taken to mitigate the impact on patient care. These include the use of virtual clinics for some elements of care, which should be retained, where appropriate. Funding from the Government's Pandemic Plan was provided in 2021, and to a lesser extent in 2022, to support extended working hours, additional clinics, and access to diagnostics to address backlogs. The Safety Net agreement continues to be used to access private hospital capacity for elements of cancer services, such as radiology, diagnostic support (e.g. biopsies and endoscopies) and some cancer surgical activity.

7.2.3 The rapid development of clinical guidelines has supported services to operate more effectively and some new technologies adopted during the pandemic, such as Stereotactic Ablative Radiotherapy (SABR), have had the dual effect of improving patient experience and maximising capacity in hospitals. Improved GP access to diagnostics is also helping to mitigate the risk of delayed diagnosis. Many of the

[2] Cancer Care in Ireland in 2020: The impact of the COVID-19 pandemic", 2021. Faculty of Pathology, Royal College of Physicians of Ireland (RCPI), National Cancer Control Programme (NCCP), National Histopathology Quality Improvement (NHQI) Programme, National GI Endoscopy Quality Improvement (NEQI) Programme, National Radiology Quality Improvement (NRQI) Programme, DATA-CAN, the UK's Health Data Research Hub for Cancer Queen's University Belfast, Northern Ireland Cancer Registry (NICR), National Cancer Registry Ireland (NCRI).

innovations being implemented developed as a result of the continued collaborative efforts of front-line providers, supported by the NCCP.

7.2.4 The continued implementation and funding of the Cancer Strategy, which was supported by €20m additional funding in 2022, is essential to building the resilience of cancer services and to initiating new service developments.

7.2.5 Cancer services are currently operating near full capacity, with some ongoing local difficulties related to staffing absences. The key focus now is on continuing to address the backlogs and build future resilience in the system, as described above. Staffing remains the key risk to the continuity of safe cancer services. While there is improvement in staffing levels, services are experiencing pressure at a higher level than pre-COVID. Pandemic Plan funding is being targeted to address constraints and the NCCP continues to work with local providers to monitor service risks. New posts have been funded under the National Service Plan and services will be strengthened as recruitment completes.

7.3 ENHANCED COMMUNITY CARE PROGRAMME

7.3.1 Since the last board meeting the status of the key deliverables under the ECC programme are listed below, while the aim is that national rollout of the various measures will be achieved by end 2022;

(a) Community Health Networks (CHNS) - 51of 96 are now established.

(b) Community Specialist Teams (CSTs) for Older Persons – 15 of 30 are now established.

(c) Community Specialist Teams for Chronic Disease Management – 2 of 30 are now established.

(d) Community Intervention Teams –21 are now operational, with national coverage secured for the first time.

(e) Recruitment –over 1,000 WTE now on boarded with 400 WTE at advanced recruitment stage.

(f) Diagnostics – Over 140,000 scans of various modalities provided.

7.4 NATIONAL WOMEN & INFANTS HEALTH PROGRAMME

7.4.1 Interviews took place for the new Clinical Director of NWIHP and I am pleased to advise you that following a recent recruitment process, Dr Cliona Murphy is the incoming Clinical Director for the National Women and Infants Health Programme (NWIHP). Dr Murphy replaces Dr Peter McKenna who will stay on to lead the Obstetric Event Support Team OEST programme. I take this opportunity to thank Dr McKenna for his service as Clinical Director and to acknowledge the significant progress that has been made under his stewardship of NWIHP.

7.5 PUBLIC HEALTH REFORM PROGRAMME UPDATE

7.5.1 The Programme has made significant progress in driving Public Health Reform. Specifically, the Public Health Reform Programme has:

(a) Developed an implementation strategy and plan for Phase 1 of the reconfiguration of the current 10 Departments of Public Health into the six new Public Health Areas, aligned to Sláintecare areas;

(b) Progressed engagement with international expertise and strengthened engagement with the IMO;

(c) Scheduled a Public Health Virtual Engagement Event for 1st March, with invites sent to all in Public Health;

(d) Progressed a preferred option for an Outbreak / Case and Incident Management System.

(e) Agreed an updated approach to deliver a Public Health ICT Strategy focusing initially on ICT enablers for area reconfiguration, and then on the longer-term strategic plan;

(f) Commenced a process to create blueprint future area structures and to define the methodology for allocating resources within the Public Health Areas;

(g) Progressed campaigns for all 34 Phase 1 Consultant posts to support their onboarding by the end of June 2022, with the first appointments expected to commence in Q1 2022;

(h) The final recruitment campaigns were launched, to deliver the full 250 WTE permanent multidisciplinary resources aligned to the Public Health Workforce Plan.

7.6 COVID-19 THERAPEUTICS

7.6.1 Significant progress has been made by the COVID-19 Therapeutics Implementation Preparedness Working Group to support the roll out of the therapeutics recommended by the Therapeutics Advisory Group.

7.6.2 Since the previous update to the Board, the Working Group has:

(a) Progressed procurement of 1,008 doses of Sotrovimab IV and distributed stock to selected hospitals nationwide;

(b) Administered 68 Sotrovimab IV doses (as at 10.02.2022), 94% of which were administered to immunocompromised patients at risk of progressing to severe disease; 6% of which were administered to unvaccinated patients;

(c) Established an interim pathway for the highest priority patients to access Sotrovimab in a hospital setting as inpatients and community patients;

(d) Developed a business case for Stewardship and surveillance model and submitted to the Department of Health for funding;

(e) Proposed a contracting strategy for the procurement of Paxlovid – based on 20% of the supply coming through a Bilateral Agreement and 80% of the supply coming through the EU's Joint Procurement Agreement;

(f) Draft pathway for implementation Paxlovid antivirals developed with preference for community-based prescribing;

(g) Confirmed the date for the next batch of 1,008 doses of Sotrovimab to be delivered into the country during the month of February.

CHAPTER 8

National HR Update

8

8. NATIONAL HUMAN RESOURCES UPDATE

8.1 CONSULTANTS' CONTRACT

8.1.1 Discussions with the representative groups in relation to the introduction of a new Sláintecare Consultant Contract have yet to resume in 2022 although the Department and the HSE continue to engage on the matter.

8.2 STAFF SURVEYS PRIORITY

8.2.1 The overall HSE staff survey report was published in December and shared widely with individual service areas during December 2021. Following analysis of their dashboard reports each service will develop an action plan to address the survey findings.

8.2.2 The Staff Survey 2021 has identified a number of areas for action which will be prioritised nationally through the delivery of the NSP 2022 including:

(a) **Increasing the size of the workforce** to enable all existing roles to be supported and fulfilled.

(i) Key initiatives identified for the provision of expanded health services include increasing workforce capacity to support service development such as the Enhanced Community Care Programme, additional in-patient beds, in addition to the filling of existing replacement posts.

(ii) The single biggest challenge is availability in 2022 of health workforce supply largely influenced by the global workforce requirements to meet the needs of the pandemic. Nationally, the focus is on ensuring that the HSE has a whole of service approach to support internal and external resourcing.

(iii) The HSE continues to roll out the Recruitment Operating Model for the HSE which is building on recruitment capacity at Hospital Group, CHO and national level, through standardized processes and training, additional staffing and work is underway on a technology solution.

(iv) HR Shared Services is currently undergoing a major digital transformation of its recruitment services which is designed to maximize automation, improve capacity and the overall candidate experience.

(b) Enhancing the level of **career development and training** to increase retention of staff.

Scoping and planning regarding the development of a new Talent Management Framework and Strategy has commenced which will align with the People Strategy and HSE Corporate Plan. This will include a gap analysis and an action plan.

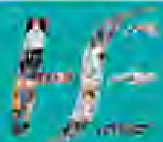
(i) As part of this work a Learning Needs Assessment Framework will be designed for use by the Services and initiatives will be undertaken arising from any gaps which emerge.

(ii) The design and delivery of appropriate learning strategies, plans, and interventions to further develop the leaders and management capability of HSE staff will continue, prioritising on-line and virtual channels, just in time micro-learning etc., together with providing one-to-one coaching and team coaching. We will strengthen our internal 1:1 coaching and team development frameworks.

(iii) Access will be increased to relevant talent interventions which support employee development aligned to HSE strategies and organisational priorities. This will be a cross organizational approach engaging occur in HR Capability and Culture, National Doctors Training and Planning, and Nursing and Midwives Planning and Development.

(iv) We will continue to build and enhance leadership and management development, capacity and capability through the Health Service Leadership Academy by delivering new cohorts of Leading Care I, II and III, in 2022 in accordance with Action 9.4.1 of Sláintecare. Subject to funding. In addition, we will further develop the HSE's online learning portal (HSeLanD) to ensure a more personalized learning environment with ongoing UX (user experience research) together with timely and accurate reporting on learner activity on HSeLanD.

(c) Addressing the **issues of culture** identified in the staff survey through engagement with staff, improved communications, and awareness of the policies and supports available to staff when needed.



Scoping and planning on the development of a staff Culture Framework has commenced which will set out existing assets, including work programmes, policies, supports and guidance.

(i) A planned gap analysis will lead to a robust action plan and related activities to enhance a high-performance culture. The new Culture Framework and related activities will provide guidance and support to staff and managers and will help improve culture in the organisation.

(ii) The Staff Culture Framework will work collaboratively with the Trust and Confidence project.

(iii) As part of our ongoing commitment to engage, consult and listen to staff feedback, the next HSE Staff Survey will be conducted during Q2/2023 to assess what has changed since the Q4 2021 survey and what improvements continue to be required.

(iv) We will champion the 'voice of the employee' in developing and delivering a joined-up approach to engagement programmes and this will include implementing the refreshed model of the Values in Action initiative.

(v) A new Diversity, Equality and Inclusion Framework will be developed and implemented.

(vi) Organisational effectiveness will be promoted by supporting teams and services to align their service priorities to the organisation's priorities. Organisational development interventions will also be provided to extend and develop high performance team working, adaptation and innovation, enhancing decision making and cross-service planning and collaboration.

(vii) We will support organisations and services to build on learnings from COVID-19 by encouraging the practice of regular review and reflection, fostering collective leadership within and across teams in the organisation.

8.3 GUIDANCE AND FAQS FOR PUBLIC SERVICE EMPLOYERS DURING COVID-19:

8.3.1 DPER published the updated FAQs on 3 Feb 2022 for Civil and Public Service staff – including Health Care Workers.

8.3.2 The FAQs have been prepared to assist employees and management to understand the process, rules and expectations associated with work arrangements during the

COVID-19 recovery period across the public service. This updated guidance provides clarity relating to:

(a) Revised guidance in relation to attendance in the work premises during COVID-19.

(b) Revised COVID-19 special leave with pay (SLWP) arrangements.

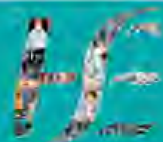
8.4 HSeLanD UPDATE ON ACTIVITY

8.4.1 HSeLanD continues to work with the services to respond to requests to develop e-learning programmes to meet both clinical and non-clinical training needs.

8.4.2 54 new programmes have been launched on HSeLanD during 2021 and 12 more are currently in preparation in conjunction with the Services.

8.4.3 New HSeLanD projects underway (or completed in January 2022)

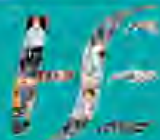
1	**ADM - Advance Care Planning**	**In progress**	**National Office for Human Rights and Equality Policy**
2	ADM - Functional Assessment of Capacity	In progress	National Office for Human Rights and Equality Policy
3	ADM - Supported Decision Making	In progress	National Office for Human Rights and Equality Policy
4	AMRIC Management Blood Body Fluid Spillages	Completed Jan 22	National HCAI/AMR Response & Implementation Team
5	AMRIC Management CDiff	In progress	National HCAI/AMR Response & Implementation Team



6	AMRIC Safe Management Care Equipment	In progress	National HCAI/AMR Response & Implementation Team
7	National Consent Policy	In progress	National Office for Human Rights and Equality Policy
8	Preceptorship in Practice	In progress	ONMSD
9	Redeployed Nurses to Critical Care	In progress	ONMSD
10	Reflective Practices	In progress	NHSCP
11	Social Inclusion NDRF	In progress	Social Inclusion
12	Supporting Patients with Medication Adherence	Completed Jan-22	TUH

8.4.4 Overall for 2021 there were 1.180mn programme completions. The top ten programme completions on HSeLanD for 2021 were as follows:

Rank	Course Title
1	AMRIC Hand Hygiene
2	An Introduction to Children First
3	Manual Handling and People Handling e-learning Theory Module
4	AMRIC Basics of Infection Prevention and Control
5	Safeguarding adults at risk of abuse
6	AMRIC Standard and Transmission Based Precautions
7	The Fundamentals of GDPR



8	AMRIC Aseptic Technique
9	Putting on and taking off PPE in community healthcare settings
10	AMRIC Personal Protective Equipment

8.4.5 Since 23rd March 2020 there have been 729,013 Covid-19 related programme completions.

8.4.6 Work continues regarding HSeLanD system enhancement to improve the user experience and reporting functionality and reliability.

8.5 DECEMBER 2021 STAFFING LEVELS

8.5.1 Employment levels at the end of December 2021, show there were **132,323** WTE which is an increase of **+1,059 WTEs** on the November figure.

(a) The largest increase was in **Management & Administrative** (+311 WTE) including +143 WTE Clerical (III & IV), +133 WTE Administrative/Supervisory (V to VII) and +35 WTE Management (VIII & above).

(b) **Patient & Client Care** showed the second highest growth with a **+223 WTE** increase. Health Care Assistants +163 WTE, Home Help +37 WTE, Care Other +22 WTE and Ambulance Staff +1 WTE.

(c) **Nursing & Midwifery** also increased by **+274 WTE** overall; including +327 WTE Staff Nurse/Staff Midwife (driven by the registration of new graduates), +44 WTE Nurse/Midwife Manager, +31 WTE Nurse/Midwife Specialists & AN/MP and +4 WTE Nursing/ Midwifery other.

(d) **Health & Social Care Professionals** increased by **+172 WTE** overall. There was a +57 WTE increase in Therapy Professions, +50 WTE H&SC other, +19 WTE in Pharmacy, +18 WTE Social Care, +10 WTE Health Science/ Diagnostics, +10 WTE Social Workers and +7 WTE Psychologists.

(e) **General Support** increased by **+42 WTE**; distributed as follows, +40 WTE Support (portering & catering) and +1 WTE Maintenance /Technical.

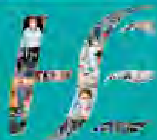
(f) **Medical & Dental** increased by **+37 WTE**; distributed as follows, +18 WTE Consultants, +12 WTE Medical/Dental, other, +6 WTE Registrars and SHO/Intern WTE remained the same from the previous month.

Staff Category /Group	WTE Dec 2019	WTE Dec 2020	WTE Nov 2021	WTE Dec 2021	WTE change since Nov 2021	WTE change since Dec 2020	% change since Dec 2020	WTE change since Dec 2019	% change since Dec 2019
Total Health Service	**119,817**	**126,174**	**131,265**	**132,323**	**+1,059**	**+6,149**	**+4.9%**	**+12,506**	**+10.4%**
Medical & Dental	**10,857**	**11,762**	**12,076**	**12,113**	**+37**	**+352**	**+3.0%**	**+1,256**	**+11.6%**
Consultants	3,250	3,458	3,590	**3,608**	+18	+150	+4.3%	+358	+11.0%
Registrars	3,679	3,876	4,098	**4,104**	+6	+229	+5.9%	+425	+11.6%
SHO/ Interns	3,116	3,594	3,586	**3,587**	+0	-8	-0.2%	+470	+15.1%
Medical/ Dental, other	812	833	802	**814**	+12	-19	-2.3%	+2	+0.3%
Nursing & Midwifery	**38,205**	**39,917**	**41,302**	**41,576**	**+274**	**+1,660**	**+4.2%**	**+3,372**	**+8.8%**
Nurse/ Midwife Manager	7,984	8,344	8,809	**8,852**	+44	+508	+6.1%	+868	+10.9%
Nurse/ Midwife Specialist & AN/MP	1,996	2,299	2,450	**2,481**	+31	+183	+8.0%	+485	+24.3%
Staff Nurse/ Staff Midwife	25,693	26,763	27,522	**27,850**	+327	+1,087	+4.1%	+2,157	+8.4%
Public Health Nurse	1,537	1,557	1,523	**1,523**	+0	-34	-2.2%	-14	-0.9%
Pre-registration Nurse/ Midwife Intern	*138*	*28*	*143*	*124*	*-19*	*+96*	*+339.9%*	*-14*	*-10.5%*
Pre-registration Nurse Intern (COVID-19)	*-*	*230*	*2*	*1*	*-1*	*-229*	*-99.4%*	*+1*	*-100.0%*
Post-registration Nurse/ Midwife Student	*293*	*258*	*283*	*277*	*-6*	*+19*	*+7.4%*	*-16*	*-5.6%*
Nursing/ Midwifery awaiting registration	*213*	*76*	*231*	*124*	*-107*	*+49*	*+64.2%*	*-88*	*-41.5%*
Nursing/ Midwifery Student	644	592	658	**526**	-132	-65	-11.0%	-118	-18.3%
Nursing/ Midwifery other	350	362	340	**344**	+4	-18	-5.0%	-6	-1.7%
Health & Social Care Professionals	**16,774**	**17,807**	**18,827**	**18,999**	**+172**	**+1,192**	**+6.7%**	**+2,225**	**+13.3%**
Therapy Professions	5,234	5,565	5,890	**5,947**	+57	+382	+6.9%	+713	+13.6%
Health Science/ Diagnostics	4,500	4,731	4,908	**4,918**	+10	+188	+4.0%	+418	+9.3%
Social Care	2,710	2,909	3,109	**3,127**	+18	+219	+7.5%	+417	+15.4%
Social Workers	1,165	1,238	1,286	**1,296**	+10	+58	+4.6%	+131	+11.3%
Psychologists	1,004	1,066	1,088	**1,095**	+7	+29	+2.7%	+91	+9.1%
Pharmacy	1,038	1,164	1,272	**1,292**	+19	+128	+11.0%	+254	+24.5%
H&SC, Other	1,123	1,134	1,273	**1,324**	+50	+189	+16.7%	+201	+17.9%
Management & Administrative	**18,846**	**19,829**	**21,271**	**21,583**	**+311**	**+1,754**	**+8.9%**	**+2,736**	**+14.5%**
Management (VIII & above)	1,842	1,969	2,181	**2,216**	+35	+246	+12.5%	+374	+20.3%
Administrative/ Supervisory (V to VII)	5,199	5,821	6,572	**6,705**	+133	+884	+15.2%	+1,506	+29.0%
Clerical (III & IV)	11,805	12,038	12,518	**12,661**	+143	+623	+5.2%	+856	+7.3%
General Support	**9,416**	**9,876**	**9,969**	**10,010**	**+42**	**+135**	**+1.4%**	**+594**	**+6.3%**
Support	8,234	8,676	8,773	**8,813**	+40	+137	+1.6%	+579	+7.0%
Maintenance/ Technical	1,182	1,200	1,196	**1,197**	+1	-3	-0.2%	+15	+1.3%
Patient & Client Care	**25,719**	**26,985**	**27,819**	**28,042**	**+223**	**+1,057**	**+3.9%**	**+2,323**	**+9.0%**
Health Care Assistants	17,396	18,554	19,162	**19,325**	+163	+772	+4.2%	+1,930	+11.1%
Home Help	3,569	3,543	3,509	**3,546**	+37	+2	+0.1%	-23	-0.7%
Ambulance Staff	1,828	1,877	1,934	**1,936**	+1	+59	+3.1%	+108	+5.9%
Care, other	2,926	3,011	3,214	**3,235**	+22	+225	+7.5%	+309	+10.6%

8.6 HEALTH SECTOR ABSENCE RATES

8.6.1 The reported absence rate for December 2021 stands at **7.9%.** This compares to 5.9% reported for the same month in 2020, however these figures notably include COVID-19 related absence for both periods. Excluding COVID-19 the current month's absence rate is **4.9%** compared to 4.25% in 2020.

8.6.2 This months' absence rate is higher than that reported for the previous month, reported at 7.7% (including COVID-19). Notwithstanding the fact that the overall



absence rate continues to be impacted by COVID-19 related absence, excluding COVID-19 absence, this months' absence rate is 4.9% which is 0.4% lower than the rate reported last month. It is important to note that this month's data, is occurring at a time of increased COVID-19 case reports.

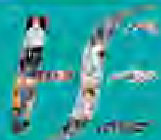
Benchmark Target	Nov-21	Certified Absence December 2021	Self-Certified Absence December 2021	COVID-19 December 2021	Dec-21	Full Year 2020	Year to date 2021
3.5%	7.7%	4.38%	0.55%	2.98%	7.9%	6.1%	6.1%

8.6.3 Health Sector absences week ended 11/2/2022

Combined Covid-19 Related Absence (Headcount) - COVID-19 & Cocooning

Table 1 — **Reporting Cycle 05/02/2022 - 11/02/2022**

Division	Medical & Dental	Nursing & Midwifery	Health & Social Care	Management & Administrative	General Support	Patient & Client Care	TOTAL COVID-19
Total Health Sector	226	1,618	700	427	410	915	4,296
Acute Hospital Services	183	1,100	364	275	284	244	2,450
Ambulance Services	-	-	-	-	-	65	65
Acute Services	183	1,100	364	275	284	309	2,515
Community Health & Wellbe	-	-	1	1	3	2	7
Mental Health	15	153	29	18	20	35	270
Primary Care	25	80	51	42	11	35	244
Disabilities	-	138	193	26	30	352	739
Older People	3	142	49	23	52	180	449
Social Care	3	280	242	49	82	532	1,188
Community Services	43	513	323	110	116	604	1,709
Health & Well-being	-	2	4	10	-	-	16
Corporate Functions	-	3	9	20	-	2	34
Health Business Service	-	-	-	12	10	-	22
HWB Corporate & National	-	5	13	42	10	2	72



8.7 UPDATE ON THE NEW RECRUITMENT MODEL:

8.7.1 The HSE has developed and approved a blue print for a new recruitment operating model which aims to meet the needs of the current global competitive market and the future requirements of Sláintecare. This includes maximizing recruitment capacity both locally and centrally and which will be under pinned by a quality assurance unit and appropriate digital enablers. This work is now in implementation phase.

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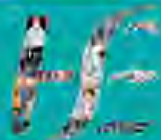
8.7.3 HR Shared Services is currently undergoing a major digital transformation of its recruitment services which is designed to maximize automation, improve capacity and the overall candidate experience. The initial phase of this transformation commenced in December with the launch of the NRS Helpdesk, which is providing both customers and candidates with live updates, at the end of January it is anticipated that the 'Job Order Gateway' will go-live, which provides an online solution for the initial steps in the recruitment process. This will be followed up by commencement of the implementation of the "end to end" recruitment solution.

8.8 COVID-19 RECOGNITION PAYMENT OF €1,000

8.8.1 The Department of Health are finalising arrangements to give effect to the Government announcement regarding the Covid Recognition Payment of €1,000, for those who worked on site in Covid exposed environments and were at an increased risk in a clinical setting.

8.9 SECTORAL BARGAINING

Some of the units are close to finality, there are a number of issues in some units due to less monies available than the totality of the claims. Discussions are ongoing but may have to be referred to the dispute resolution mechanism contained in Building Momentum.



8.10 HADDINGTON ROAD AGREEMENT – ADDITIONAL HOURS:

8.10.1 Building Momentum, a new Public Service Agreement for 2021 – 2022 made provision for an independent body to assess issues arising in relation to additional hours introduced in 2013 under the Haddington Road Agreement, and to make appropriate recommendations to be applied equitably across all affected grades, groups, categories and sectors.

8.10.2 The Additional Hours Body chaired by Kieran Mulvey, met with parties to this Agreement, including the HSE who met with the group on two occasions in 2021. It is expected that the Report by the group will be considered by Government in the coming weeks. Building Momentum makes provision for the roll-out of the body's recommendations to be initiated within the lifetime of this Agreement. Further, to enable commencement of the recommendations during 2022, on the publication of the Report, an envelope of €150m will be made available under this Agreement across all affected grades, groups, categories and sectors.

8.10.3 The Agreement also specifies in the context of the 2023 estimates, having regard to available resources, the parties to this Agreement will engage proactively in relation to such provisions as are necessary to roll out any remaining recommendations.

8.11 HSE DIGITAL ACADEMY:

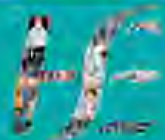
8.11.1 Scholarship Candidates for Masters in Digital Transformation decisions were finalised in November 2021 and 49 Student commenced the third instance of the HSE Digital Transformation Programme. The majority (44 of the class) are staff from the HSE and S38 agencies and the programme benefitted from many outstanding candidates with a broad variety of Healthcare backgrounds.

8.11.2 A Survey has issued to first Master's graduates by HSE Digital Academy for reporting on job utilization of learnings, career progression and project status. All HSE graduates have remained with the HSE.

8.12 **UPDATE ON ROLLOUT OF NISRP:**

8.12.1 NiSRP is a multi-year national transformation programme, which will integrate and modernise SAP staff records and Payroll systems and processes across the HSE. It will:

(a) Deliver a single Staff Records platform for national coverage of all people related data for the HSE.



(b) Deliver a single Payroll technical platform for all HSE employees

(c) Standardise associated Staff Records and Payroll processes nationally.

(d) Introduce on-line employee and manager self-service functionality and processes to allow all staff to request leave, submit travel/subsistence and other expense claims, change bank details, update certain personal information and carry out other common HR related tasks online

(e) Rationalise the multiple payroll processing centers and enable consolidation of staff records processing centers to an optimum number of sites. These objectives will provide:

(f) National coverage of all employee data - full oversight of people data to support management information and decision making

(g) Greater efficiencies for the organisation, allowing resources to be deployed where they are needed most

(h) Administrative agility and appropriate support function structural design

8.11.3 The programme is currently deploying Employee and Manager Self Service 'myhseselfservice' to the HSE North West, HSE Midlands and HSE Mid-West for "go-live" in quarter one 2022. As these areas have been operating an integrated SAP staff records and payroll system since the implementation of PPARS, circa 2005, so the NiSRP implementation is limited to the introduction of self-service only.

8.11.4 The NiSRP programme team continue to engage with staff in these areas to support the change implementation. A full training & engagement schedule has been created which allows for the requirements of all employees and managers, encompassing virtual and face to face requirements (Covid guidelines allowing).

8.11.5 **Future milestones -** The NiSRP Programme will deploy a fully integrated SAP HR & Payroll Solution with time entry and self-service functionality to HSE South in 2023. Engagement has commenced with Senior Management Teams across the Hospital Group, CHO and Corporate functions of the South alongside the formation of the South Implementation Oversight Group in 2021 which has been meeting on a monthly basis since September 2021. The introduction of the revised HRA hours if agreed may impact on the timelines for the South and this is currently being assessed in advance of any formal decision by Government.

CHAPTER 9

Chief Strategy Officer

9

9. CHIEF STRATEGY OFFICER

9.1 NATIONAL SERVICE PLAN 2022

9.1.1 As Board members are aware, the HSE National Service Plan 2022 (NSP 2022) and associated Plans were submitted to the Minister for approval on 23 November 2021, following adoption by the Board. A formal response was received from the Minister on 26 January 2022 advising that he had approved the NSP 2022 subject to a small number of amendments being made. In addition, a number of further amendments were suggested in separate correspondence dated 28 January 2022 from the Deputy Secretary General.

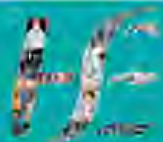
9.1.2 We sought to reflect, as far as possible, the amendments sought by the Minister / Department and an updated draft was considered and formally adopted by the HSE Board on 7 February 2022. The Chair of the HSE Board wrote to the Minister on 10 February enclosing the amended NSP 2022, an updated version of the 2022 Capital Plan (Building and Equipment) and the 2022 Workforce Resourcing Strategy which had also been slightly revised. The 2022 eHealth and ICT Capital Plan which was unchanged was also re-submitted.

9.1.3 We understand that the Minister has now approved the National Service Plan, which will be subject to review in the first quarter of 2022. The Minister will brief Government in relation to the NSP and the HSE will make arrangements for launching the NSP 2022 in the coming days.

9.2 SCHEDULED CARE REFORM / WAITING LIST REDUCTION PLAN

9.2.1 As Board members will recall, the Department of Health, working with the HSE and NTPF, published a 2021 Waiting List Action Plan in October 2021 focusing on the provision of additional procedures through public and private hospitals by the end of 2021 to arrest the growth of waiting lists and waiting times and, where possible, reduce them.

9.2.2 During the pandemic (December 2019 – August 2021), Outpatient Waiting Lists grew by 98k (18%) from 553k – 652k, and those waiting over 18 months grew by 90k (88%) from 103k – 193k. During the same time period, Inpatient/Day case Waiting Lists grew by 9k (14%) from 67k – 76k, and those waiting over 12 months grew by 11k (122%) from 9k – 20k. GI Scopes Waiting Lists grew by 10k (47%) from 22k – 32.6k, and those waiting over 12 months grew by 5k (432%) from 1k – 6k.



9.2.3 The impact of the 2021 plan was that, by the end of December, (compared to September 2021) the outpatient waiting list had decreased by 35k (-5%) with a 21% reduction in those waiting over 18 months. There was only a slight decrease in the Inpatient/Day Case waiting list due to the significant effect of the cancellation of elective surgeries due to COVID-19 and significant ED pressures; and there was a decrease of 5.4k (-17%) in the GI Scope Waiting list with a 31% reduction for those waiting over 12 months.

9.2.4 Over the past number of weeks, the HSE, DoH and NTPF have had ongoing engagement in relation to the development of a 2022 Waiting List Action Plan for the commitment of the €200m allocated to the HSE and €150m allocated to the NTPF in 2022. This engagement has resulted in the preparation of a 2022 Waiting List Action Plan which will be the first stage of a comprehensive multi-annual reform programme of work (2022 – 2026) to deliver sustained reductions in waiting lists numbers and waiting times.

9.2.5 The 2022 Waiting List Action Plan builds on the work done through the 2021 Waiting List Action Plan and incorporates investment requests from Hospital Groups, modernised pathways, Ministerial priorities and once off non-recurrent funding required to clear the backlog for specialities that do not have a recurrent gap. It also laid the foundations for several significant pieces of reform work, including the revision of waiting list management protocols, designing improved scheduled care pathways, introducing patient- centred booked arrangements and improving data collection and information. The 2022 Plan was shared with the Board at its special meeting on Friday, 18 February.

9.2.6 In relation to governance arrangements, the Waiting List Taskforce continue to meet regularly co-chaired by the Secretary General and myself. I also Chair weekly meetings with HSE colleagues.

9.3 ELECTIVE CARE CENTRES

9.3.1 The Minister announced in December 2021 the Government's approval of the Sláintecare National Elective Ambulatory Care Strategy for the development of standalone Elective Care Centre's in Cork, Galway, and Dublin. This Strategy aims to change the way in which day case, scheduled procedures, surgeries, scans, and outpatient services can be better arranged to ensure greater capacity in the future and help to address waiting lists.

9.3.2 The approved National Strategy notes that Elective Care Centres will focus on high volume, low complexity procedures, and a range of related diagnostic services and will provide coverage for 60-70% of the overall population. The elective care scope of service will be developed in two phases, commencing with day cases, diagnostics, and outpatients and then followed by consideration of in-patient treatment. Day procedures offered in the first phase will include Gastrointestinal, Gynaecology, Ophthalmology, and Orthopaedics.

9.3.3 Individual Preliminary Business Cases for each location have now been submitted to the Department of Health. Subject to favourable reviews by the Department of Health and by the Department of Public Expenditure and Review, these Preliminary Business Cases will be brought to Government for consideration and Gate 1 "Approval in Principle" decision.

9.3.4 The Government noted that, in progressing the Elective Care Centres, appropriate consideration will be given to other planned reform initiatives in the public healthcare system and to wider strategic capital investment considerations and proposals in Cork, Galway, and Dublin over the medium to longer term.

9.3.5 The Chief Strategy Officer and colleagues continue to liaise with the DoH in relation to developments on Elective Care Centres and communication recently issued to Hospital Groups providing a briefing on the position and way forward.

9.4 CONTI CYBER REVIEW

9.4.1 As Board members are aware, the PwC report of the independent review into the ransomware cyber-attack was accepted by the HSE in November 2021 and published in December 2021. Work has been continuing on the development of proposals for implementing the recommendations in the Conti PIR Report, including the establishment of an integrated Conti Post Incident Review Implementation Programme and associated governance arrangements. Key developments include:

(a) A Conti Review EMT Oversight Group has been established which meets every two weeks, chaired by me, to monitor progress across the programme.

(b) The HSE has engaged PwC for a period of four weeks as an extension to the Review process to prepare an initial, high-level plan of time critical actions and to advise on programme structures and reporting processes.

(c) A draft scope of the work has been developed for the preparation of a Request for Tender to be progressed through the Office for Government Procurement for more extensive, specialist, longer term support.

(d) The Office of the CIO has commenced work on developing the investment case required to implement the breadth of IT and cyber-transformation envisaged in the report. In developing the investment case, consideration is also being given to current funding and how this can support the overall objectives of the IT/ Cyber Transformation Programme.

(e) Draft job descriptions have been prepared for the Chief Technology & Transformation Officer and Chief Information Strategy Officer roles and are being progressed with DoH.

(f) Arrangements are being progressed to appoint an interim Chief Information and Strategy Officer.

9.4.2 The CSO was recently invited to present a briefing on lessons from the Conti Cyber-attack to the Government Task Force on Emergency Planning. The Task Force oversees and co-ordinates emergency planning at a national level. The CSO outlined that the HSE Board have sought to create a culture of openness particularly when major issues such as this arise, and provided an update to the Task Force on what we learned as an organisation following the attack. It was noted by the Task Force that it is important that this information and lessons learnt is shared appropriately with colleagues in other departments as it is relevant to a broad range of State and private sector entities.

9.5 NEW NATIONAL MATERNITY HOSPITAL

9.5.1 A paper on the proposed development of NMH on SVHG was presented to the Board for its meeting on the 26 November 2021. Board members will be aware that this paper focused in particular on issues relating to the proposed Legal Framework underpinning the new development, and the Draft Constitution of the new DAC that is to be established to run the service. In this regard the principal issues related to forfeiture provisions in the proposed lease, definition of NMH services to be provided in the new hospital, and the drafting of a new Constitution for the new DAC.

9.5.2 These and other points were reflected in the letter from the Chair to the Minister in December 2021. This letter also enclosed the draft final business case which was submitted to the Department for formal technical evaluation.

9.5.3 In the period since then there has been further formal communication with the two hospitals, and senior level engagement thereafter, with a view to resolving the remaining matters. The draft Constitution, prepared by the HSE legal team in line with direction given by the Board in November, has been agreed with the DoH and has been submitted to the two hospitals for their consideration and agreement. Their response to this document has been requested for 25 February 2022. The hospitals have been advised that the intention is to settle the Constitution at the same time as the legal framework documents, in line with Board direction.

9.5.4 The CSO has met with the Chair and other senior representatives of SVHG to discuss relevant matters including, in particular, forfeiture provisions under the lease and the transfer of shares form the Religious Sisters of Charity to the new St Vincent's Holding company. Further detailed discussions have taken place since and HSE representatives are seeking to conclude these matters as soon as possible.

9.5.5 The Department of Health are continuing their assessment of the Draft Final Business Case.

9.6 NEW CHILDREN'S HOSPITAL

9.6.1 As previously advised to the Board, construction of the New Children's Hospital continues to progress, but at a slower pace than is required under the contract. The National Paediatric Hospital Development Board report that the structure is up to roof level and the fit-out of internal elements is progressing throughout the building. Significant delays have been experienced in the delivery of the project, for reasons which include the impact of COVID-19 and issues with the contractor.

9.6.2 The 'substantial completion' date under the building contract is August 2022. As noted above, the Contractor's programme remains in delay, and the substantial completion date is now expected to extend into 2024, with some 6 months required thereafter to commission the new hospital and bring it into use. CHI advise that transitioning of services to the new facility should be planned outside of the winter months for safety and operational reasons.

9.6.3 As previously advised to the Board, a number of significant cost and funding pressures exist beyond the approved budget of €1.433bn, many of which are linked to the delay in the completion date, claims by the contractor, the impact of COVID-19, as well as other factors.

9.6.4 The process of engagement between the Development Board and BAM continues, with a view to obtaining certainty on cost and programme as a matter of priority. In this regard, NPHDB note that the Contractor has extended the temporary moratorium on claims processing, although claims continue to be submitted, with over 1,000 having been submitted to date.

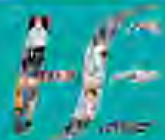
9.6.5 New Governance arrangements for the Programme were approved by Government in November 2021. These new arrangements do not change the statutory responsibilities of the key stakeholders. The revised arrangements are to support more integrated working between CHI and the NPHDB, and to focus on project delivery for the remainder of the Programme. Plans are underway for the new arrangements to be effective from April this year.

9.6.6 Under the new arrangements, the HSE CEO will formally give specific delegated authority to a HSE Lead Director who will be responsible for developing and implementing a 'Programme Assurance Plan' to be signed off by all principal stakeholders. The HSE Lead Director will periodically report to the National Oversight Group (to be Chaired by the Sec Gen, Department of Health) on oversight and co-ordination of the overall programme and will provide assurance on the programme schedule and budget. As part of the internal team in place to support the HSE Lead Director, an Assistant Lead Director has recently been selected and is due to start by the end of February. An external advisor (KPMG) has been appointed to provide a system of external review, support, advice, and a layer of independent assurance to the HSE Lead Director.

9.7 CAPITAL AND ESTATES

9.7.1 Some Board members will be aware that our colleague Jim Curran, National Director of Capital and Estates, is retiring. Jim started his career as an Army Cadet before joining the Eastern Regional Health Authority where he undertook various roles in the Technical Services Office before being assigned as Assistant National Director for Estates in the Dublin North East region.

9.7.2 Jim has been Head of Estates for over 10 years and most recently has been National Director for Capital and Estates. He has contributed to many major projects during his time in Estates and most recently led the response to COVID-19 in terms of securing additional facilities and the establishment of vaccination centres.



9.7.3 On behalf of the HSE, I would like to wish Jim all the best in his well-deserved retirement and thank him for his significant contribution to the health services over the past number of years.

9.8 DONATION OF SURPLUS PPE SUPPLIES TO COUNTRIES IN NEED

9.8.1 During 2021, as countries struggled to cope with the COVID-19 pandemic, the HSE donated medical equipment, PPE, drugs, vaccines and vaccine supplies to India, Nepal, Brazil, Zambia, Uganda and Lebanon. Towards the end of 2021, the HSE still had large stocks of surplus PPE which will not be used in Ireland within the expiry dates. This includes gowns, protective suits, surgical masks, face shields and goggles with a total book value of €5.5 million (1 January 2022). The Global Health Programme coordinates with HSE procurement to organise donations of PPE to countries in Africa in response to specific requests. This began in October 2021 with the shipping of two 40-foot containers to Zambia, funded by the Royal College of Physicians of Ireland.

9.8.2 The HSE Service Plan 2022 has committed to continuing to donate equipment and surplus PPE to less developed countries in response to COVID-19. The Global Health Programme will coordinate with HSE Procurement to make suitable arrangements with governmental and non-governmental organisations that will be responsible for the costs of collection, shipping and delivery of PPE to beneficiary countries in Africa. This presents an opportunity for the HSE to show solidarity with other countries and support Ireland's policy approach to address those 'furthest behind first' and achieve the UN Sustainable Development Goal 3 (SDG 3), which is better health and well-being for all. This item has been brought to the Audit and Risk Committee and is with the Board today for its consideration and/or approval.

9.9 REGIONAL HEALTH AREAS

9.9.1 The development of Regional Health Areas (RHAs) is a key priority as set out in the Letter of Determination, NSP2022 and the Programme for Government and is aligned with the overall aims and objectives of *Sláintecare*.

9.9.2 Board members will recall the feedback that was provided, following the November Board meeting, on the draft Business Case for the implementation of RHAs which showed that the preferred model is a 'HSE-Local Model' with six RHAs established replacing the Hospital Groups and CHOs.

9.9.3 The HSE continue to work with the DoH on identifying key enabling work streams in order to scope out the work of the programme and develop a comprehensive implementation plan. These work streams include Governance, Finance, Workforce and HR, Capital, and Communications and Culture.

9.9.4 Relevant HSE members continue to participate on the HSE Advisory Group which meet monthly and the RHA Implementation Team which meet fortnightly. Board members will be kept apprised of progress in this regard.

9.10 BOARD STRATEGIC SCORECARD 2022

9.10.1 The 2021 end of year performance across 21 Strategic Programmes and priorities was discussed at the January Board meeting.

9.10.2 Included as part of today's agenda is the first 2022 Scorecard populated with the January data. There are 22 Strategic Programmes and priority Scorecards for 2022 and these were again chosen for their relevance to the National Service Plan 2022 and Corporate Plan 2021-2024.

9.10.3 This year sees a Scorecard from 2021 in relation to IIS being removed and two additional scorecards being added in relation to Regional Health Areas and Climate Action and Sustainability.

9.10.4 This Scorecard reflects feedback from Board members at the December Board meeting, and more recently from the Department and the Minister. The full suite of scorecards has been circulated separately for discussion at today's meeting.

CHAPTER 10

Communications

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10. COMMUNICATIONS

10.1 GENERAL UPDATE

10.1.1 There has been a very substantial reduction in media interest in Covid related issues, although other communications activity such as information campaigns and direct contact with the public via HSE Live and social media still sees substantial Covid-related traffic.

10.2 MEDIA ENGAGEMENT

10.2.1 Last week saw a reduction in 56% in the volume of media queries handled compared to the same period in 2021, which came near the end of wave 3 of the pandemic. The falloff in media interest in Covid is clear, and the fall off in queries is also likely to be due to the existence of many new sources of information on Covid such as HPSC data, GeoHive data, and the daily operations dashboard and reports.

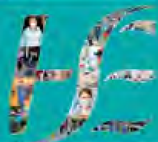
10.2.2 Nevertheless, press queries last week were 10% up on the same period in the last pre-Covid year, 2019. So despite the collapse in Covid related interaction with media, we have more interaction with media that in the last "normal" year. This is accounted for by queries on a very wide range of issues including waiting lists, trolleys, scoliosis, hospital charges and debt collection, eating disorders etc.

10.2.3 In the last few weeks we have dedicated a small team to working with communications and services colleagues throughout the HSE to proactively promote initiatives and programmes to the public. We are actively seeking out Sláintecare-related projects to highlight in the media so we can continue to build trust and confidence in the HSE.

10.3 DIRECT PUBLIC ENGAGEMENT

10.3.1 The number of calls and visits to COVID-19 and COVID-19 vaccination information continues to decrease from the all-time highs in December and January, when at one point they reached 14,000 calls per day. However, they still remain high, averaging 6,000 calls per day into HSELive and over 5 million visits to the COVID-19 and vaccination information on the website.

10.3.2 The National Disability Authority completed an accessibility audit of our website under the new programme of government monitoring of compliance with the EU Accessibility directive. Ours was one of six large public sector websites which were



audited so far. The HSE invested considerable time and resources in improving accessibility over the last 12 months, and this was reflected in a good audit outcome. In particular, the new elements of the HSE website had excellent levels of compliance, while the old HSE website had a number of issues. A remediation plan is in place and this will be implemented over time within resources available.

10.4 STAFF CYBER AWAREMENT CAMPAIGN

10.4.1 A new staff campaign on cyber awareness began on Tuesday, 8 February and ran for two weeks on all corporate internal communications channels. The campaign was being developed with OoCIO and it will be repeated several times during 2022, focusing on different elements of cyber-security.

10.4.2 In parallel with the information campaign OoCIO are running a series of simulated email phishing tests and a cyber-awareness training programme. Communications is supporting this with a dos and don'ts campaign on cyber safety.

10.5 COVID-19 VACCINE CAMPAIGN FOR PARENTS OF CHILDREN AGED 5 TO 11

10.5.1 In early February we began a public information campaign aimed at parents of children aged 5 – 11 in relation to vaccination. The campaign's tone is deliberately not directive or insistent.

10.5.2 Research results showed the importance of acknowledging that parents have concerns and questions. The campaign also acknowledges that parents need time to make their decision.

10.5.3 It points them to www.hse.ie for answers, addresses safety concerns and relies on parents' main motivators from our research – protection for the child and family.

10.5.4 The campaign is now live on TV, a wide range of local and national radio, outdoor poster advertising, digital display, video on demand and social media. Expert videos have been prepared in Irish, English and a range of other languages. An Irish language version of the TV ad will feature on TG4.

10.6 OTHER CAMPAIGNS

10.6.1 The Last Stop encourages smokers to QUIT for 28 days, making them 5 times more likely to quit for good. The programme includes a plan to help people give up, and tailored support along the way.

10.6.2 January is a traditionally a top performing month for QUIT plan sign ups, when smokers use the new year as a leaver to change their behaviour and improve their health.

10.6.3 QUIT was live in January on TV, video on demand, radio, digital audio and display. A new social media strategy and new display creative was introduced counter diminishing returns on these channels at the end of year two of this current campaign creative cycle and performed well.

10.6.4 The KPI for the campaign is activated QUIT plans. The campaign created 1,399 activated QUIT plans in January 2022, an increase of 30% on January 2021.

CHAPTER 11

Concluding Remarks

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11. CONCLUDING REMARKS

11.1 The COVID-19 pandemic has taught us many lessons. As we now embark on the task of rebuilding our health service, it is abundantly clear to me that this can only be done by investing in our staff. We must give priority to education, training, and development opportunities, which in turn offer the potential for both professional reward and career fulfilment. Most importantly, we must create both a care environment and a work environment that encourages retention of our incredible staff.

11.2 For that reason, we will continue do everything possible to meet the ambitious targets that have been set for recruitment in the current year, through sustained campaigns across the full range of available channels both in Ireland and abroad. The staff that we have shouldered a very significant burden during the pandemic, and it is only right that we should do everything possible to alleviate to support them by ensuring that there are adequate numbers employed at the front-line to sustain the high-quality work and care environment that we are all striving for.

11.3 As I have said on a number of occasions, and as the pandemic has shown, when we pull together our health service is a formidable force. We have shown time and again how quickly we can adapt and come together as one team united around shared challenges. The priority of my EMT over the coming months will be to ensure that we do everything in our power to support the operating system to get back on its feet as quickly as possible. The Government have shown their willingness to support us in doing that, as evidenced by the investment that has been made in the HSE again this year. We have been enabled financially to continue to leverage capacity from the private system to help us tackle the significant backlogs that we face in a number of areas. We are setting what I believe are realistic plans and targets for year-on-year improvements, and I am very confident about our capacity to make good progress.

11.4 I close my February CEO report by expressing optimism about the year ahead, and I look forward as always to engaging with the Board in its oversight of executive and operational performance during 2022.

Paul Reid

Paul Reid
Chief Executive Officer