Health Service Executive

Chief Executive Officer's Report

HSE Board Meeting
25 March 2022

CHAPTER 1

CEO INTRODUCTION

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Dr Steevens' Hospital in the blue and yellow of the Ukrainian flag as a symbol of solidarity and nationhood

7. INTRODUCTION

On the same day as the last Board meeting the Minister launched the 2022 Waiting List Action Plan. The National Service Plan was approved the following week, on 1 March. There is much to do in order to achieve the targets set out on both documents. The Waiting List Action Plan details how the HSE, the Department and the National Treatment Purchase Fund will ensure that an even higher number, 1.7m are treated and removed from our waiting lists.

Over the course of February, we have seen a near complete unwinding of the emergency measures put in place as part of the national COVID-19 response. This underscores a growing confidence that despite the resurgence in infections we can manage COVID-19 as an endemic disease. However, we continue to emphasise in our public messaging the importance of making sensible personal choices. We only have to look at the numbers of COVID-19 positive patients in our hospitals which stood at 1,034 on 17 March. This level of infection, coupled with the usual seasonal challenges, is resulting in significant pressure on our services.

The WHO's goal is to substantially increase population immunity globally to protect people everywhere from disease, protect the health system, fully restart economies, restore the health of society, and lower the risk of new variants. The HSE will make a donation of over 1m COVID-19 vaccines to support this goal. We are delighted to have the ability and surplus capacity to make this contribution.

On 18 March we marked a National Day of Remembrance with an additional bank holiday. This was in recognition of the efforts of the public, volunteers and all workers throughout the pandemic. On this day we took the opportunity to remember all those who lost their lives over the past two years.

Finally, I know that colleagues right across the HSE have felt compelled, as I do, to express our horror about the senseless war that has been waged against Ukraine. There are many Ukrainians living in our community. Many Ukrainians are also our colleagues, and they are assured of our solidarity and support during this exceptionally difficult time.

CHAPTER 2

Governance

2. GOVERNANCE

2.1 TRANSFER OF FUNCTIONS IN RESPECT OF DISABILITY SERVICES FROM the DEPARTMENT OF HEALTH TO the DEPARTMENT OF CHILDREN, EQUALITY, DISABILITY, INTEGRATION AND YOUTH (DCEDIY)

2.1.1 I recently met with the Secretary General of DCEIDY to support and advance discussions regarding the transfer of Disability Services to DCEDIY.

2.1.2 All parties were positive about the impending transfer while noting that certain challenges need to be addressed. We will need to make provision for the dual reporting lines given that the HSE will now be accountable to two Departments of State. My discussions centred on potential reporting structures and on structuring our corporate documentation to meet the requirements of both Departments whenever possible.

2.1.3 Our discussions also emphasised the differences between the transfer of Departmental ***functions*** and the transfer of ***services***, which is not what is happening. By way of illustration it was agreed that this is not the same as the establishment of the Child and Family Agency (Tusla) which resulted in services transferring out of the HSE and into a new state body. All parties are clear that Disability Services continue to be the primary responsibility of the HSE from a service delivery perspective.

2.1.4 We also set out a number of agreed key priorities that require attention in the short to medium term;

(a) Project to complete the transfer to DCEDIY;

(b) Post transfer oversight & assurance;

(c) Inclusion in the estimates and NSP 2023;

(d) Develop and complete appropriate policies.

2.1.5 The Board will be aware that the transfer will have implications for its governance role, which will be dealt with by way of amending legislation. I will also keep the Board fully briefed about my ongoing discussions with the Department.

2.2 NATIONAL COMMEMORATIVE EVENT - 18 MARCH 2022

2.2.1 Earlier in the year the Government announced an additional one-off bank holiday on 18 March 2022, to be marked by all our citizens and people living in this country as a day of remembrance for those who lost their lives during the COVID-19 pandemic. The day also serves as a fitting recognition of the many workers across a range of sectors of the Irish economy who worked tirelessly and at risk throughout this period.

2.2.2 The Tánaiste said the additional holiday in 2022 would "recognise and say thank you" to volunteers, the Irish people and to all workers who helped in the fight against COVID-19.

2.2.3 We are delighted to recognise all of our workers and those of our partner organisations and I hope that the day (or the day's leave to be granted in lieu for those of us who were working) was enjoyed by one and all.

2.3 REGIONAL HEALTH AREA (RHA) IMPLEMENTATION WORKSHOP

2.3.1 The HSE and the Department meet on 3 March with a view to making progress on the formation of RHAs, which Minister Donnelly has identified as a key priority for 2022.

2.3.2 RHAs will enable better oversight and evaluation of costs and health outcome benefits, whilst ensuring the alignment and integration of hospital and community services at a regional level, based on defined populations and local needs.

2.3.3 RHAs will require careful and assured implementation to ensure that an appropriate governance architecture is put in place and to ensure that the transition to the new structures is achieved as seamlessly as possible.

2.3.4 The scope and scale of the work to be completed is substantial and so the focus was on the formation of agreed work streams, in addition to scoping the various milestones by which progress will be monitored.

2.4 PUBLIC ACCOUNTS COMMITTEE – MENTAL HEALTH GOVERNANCE AND CLINICAL OVERSIGHT

2.4.1 On 10 March a meeting of the Public Accounts Committee took place, focusing on expenditure on mental health services, with a particular focus on CAMHS expenditure. The Committee also table the Owenacurra Centre, in Midleton, Co. Cork for discussion.

2.4.2 The HSE furnished the committee with detailed cost breakdown on mental health services, including associated governance and oversight arrangements. We also provided a briefing on the Owenacurra centre, including an overview of costs and the basis for the decision that Owenacurra had to close.

2.4.3 As had been anticipated the Committee were particularly anxious to discuss the South Kerry CAMHS controversy and to hear about the HSE's response to the Maskey Report. In reply to questioning from Committee Members I acknowledged that the Maskey Report highlighted a range of failures, including the fact that the service was not operating in accordance with the operating procedures that were developed for CAMHS in 2019, the complete lack of clinical oversight, and poor governance standards in general.

2.4.4 The Chief Operations Office outlined that there are three strands to the work which is now being undertaken on foot of the Maskey Report. The first strand is to undertake a patient experience study. The second strand will be a review of compliance with the operational guidance given what was highlighted in the Maskey Report. The third strand relates to prescribing practices with a particular focus on ADHD prescribing. As Dr Maskey set out in his report, the majority of issues in South Kerry CAMHS arose in respect of ADHD prescribing. We also acknowledged at the PAC that the Minister of State wants the HSE to look at the broader prescribing practices and we are in the process of finalising our proposed approach to that.

2.4.5 I informed the Committee that this past decade has seen substantial investment made in Mental Health Services, with further developments planned in line with national strategy. We also outlined the many challenges that we are confronting, including workforce challenges, with staff in the earlier stages of their professional careers opting to explore employment opportunities abroad.

2.4.6 In highlighting these challenges, it was also noted that Mental Health Services continue to develop and modernise, and there has been a progressive move away from institutional to community care settings. This has been made possible due continued investment, a strong policy framework, and the support of successive Governments.

2.5 BOARD STRATEGIC PAPERS / PRIORITIES

2.5.1 The Board will be aware that one of the major themes arising from recent development processes led by Bernie Gray of *Better Boards* has been the inclusion of a strategic discussion item at the monthly Board meeting. The discussion is usually presented by the responsible person on the HSE's Executive Management Team and has a close connection to one or more of the objectives or enablers within the HSE's Corporate Plan. By the end of the March Board meeting we will have completed a full cycle of presentations touching on most areas of the Corporate Plan.

2.5.2 I am conscious from my discussions with the Chairman and with other Board members that some of these discussion items have been better received than others. Those that tended to be the most useful were those that remained faithful to the structure we had agreed, and lent themselves to a good strategic discussion focussing on the following:

- What is the role of the Board in the strategic matter at hand?
- What are the key actions that should be reserved to the board in relation to the strategic matter at hand?
- What are the key actions that should be delegated to the CEO and his EMT?
- How will the Board be assured by the executive about the process of implementation of the strategic matter at hand, going forward?

2.5.3 My Executive Management Team and I spent some time recently debating how we might improve this important element of our engagement with the Board, as such discussions are important the Board in discharging its role as the HSE's governing authority.

2.5.4 We agreed that it was important for EMT members to have sufficient preparation time so that papers are considered; not rushed and are drafted to the standards that the Board rightly expect. Following some initial discussion with the Chairman, and subject to any changes proposed at today's Board meeting, I am proposing the following schedule of strategic discussion items, all of which are important to the achievement of the ambitions set out in our Corporate Plan:

Month	Corporate Plan Commitments	Focus	EMT Lead(s)*
April 2022	*Ensure our organisation structure is fit for purpose*	**RHAs**	CSO
May 2022	*Continue to invest in eHealth infrastructure and security to deliver patient outcomes and protect information.*	**e-Health**	CIO
June 2022	*Improve scheduled care to enable more timely access and reduce the number of people waiting for services*	**Waiting Lists**	CSO
July 2022	*Increase capacity by elective only care centres, funding more hospital beds and using resources more effectively*	**Elective Care Hospitals**	CSO
September 2022	*Improve risk management and internal controls*	**Integrated Financial Management & Procurement System, National Integrated Staff Records & Pay Programme.**	CFO
October 2022	*Accessing the right care, at the right time, in the right place with people feeling empowered, listened to, and safe ["Our Aims" – Corporate Plan]*	**Universal Healthcare**	CSO
November 2022	*Develop an accountable organisation*	**Productivity/Outcomes**	National HR
December 2022	*Develop a strategic workforce plan, informing our recruitment and retention*	**Workforce Planning**	National HR

Note: Although lead EMT members have been assigned to each focus area, many will require the input of more than one EMT member, or indeed the full EMT.

2.5.5 I am in the Board's hands as to whether it considers these to be matters which it considers appropriate and/or instructive from a governance perspective, and/or whether the Board is content with the order in which we propose to bring the papers before you between April and December 2022.

CHAPTER 3

Finance Update

3. FINANCE UPDATE - January 2022 & 2021 Year End Results

3.1 Key Messages

3.1.1 The draft revenue I&E financial position at the end of January 2022 shows an YTD deficit of €70.3m or 4.0%, with a significant element of this being driven by the direct impact of COVID-19, as reflected in the €48.2m adverse variance on COVID-19 related costs and €22.1m adverse variance on core (Non-COVID 19) related costs. Costs reported as COVID-19 related costs are essentially the incremental costs incurred in responding to COVID-19.

3.1.2 It is too early to begin to draw any inferences as to what can be expected in financial terms for 2022, as only one month of data is available, coupled with the significant complexity related to the on-going pandemic generally, and the current surge specifically. However, from an overall perspective it is expected that as this current surge comes to an end, our core (non COVID-19) activities will naturally increase and the impact of "delayed" care will also increase demand for core services.

3.1.3 Initial views of an updated "2022 Opening Outlook/Forecast" are underway, based on engagement with services. Full year forecasts will be prepared, which will be a bottom-up exercise based on first three-month actuals, with substantial divisional oversight.

3.1.4 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 below the estimated Revenue & Capital I&E outturn position for 2021. The separate paper to the Board for the adoption of the AFS 2021 shows an adverse variance of €156.7m / 0.8%, all of which is directly attributable to COVID-19 related costs.

3.2 January 2022 Revenue Income & Expenditure (Current Expenditure)

3.2.1 In December 2021, a fifth variant of concern, Omicron, was identified which was significantly more contagious than the Delta variant, which led to another surge in cases. Therefore, January 2022 was an exceptional month in terms of COVID-19 activity and expenditure, with high levels of hospital admissions relating to COVID-19, in addition to exceptionally high rate of community transmission.

3.2.2 January YTD COVID-19 costs of €209.1m against a budget of €160.9m leading to an adverse variance of €48.2m. Included in the COVID-19 costs of €209m, are the following:

- Testing & Tracing Programme costs of €116.8m
- COVID-19 Vaccination costs of €34.3m
- Private Hospitals costs of €11.2m
- Hospital and Community COVID-19 Responses of €48m (excl. Acutes Income deficit reported in core)

3.2.3 It should be noted that a total of €697m has been provided in the 2022 NSP, on a once off basis for COVID-19 response, of which €160.9m budget has been profiled YTD January 2022.

- €497m to cover COVID-19 responses, including but not limited to, vaccination, testing and tracing, personal protective equipment (PPE) and Hospital and Community COVID-19 Responses.
- €200m to cover acute and community scheduled care access (waiting lists and waiting times) including use of public and private hospitals.

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

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

3.2.5 Of the YTD Core deficit of €22.1m, €43.4m is in acute operations, €4.1m in disability services and €14.2m in state claims agency with offsetting surpluses in other operations/services of (€33.9m) and pensions/demand leds of (€5.7m).

3.2.6 Of the Acutes operations YTD deficit of €43.4m, €15.7m of this deficit is in income which is attributed to COVID-19 factors. Private patient billing has been challenging in January, with COVID-19 patient numbers above 800 for most of the month, peaking at 1,063 on 10th January. Patients are exempted from charges if they have a COVID-19 diagnosis during the hospital stay.

3.3 Outlook for 2022

3.3.1 As we enter the third financial year to be impacted by COVID-19, the ongoing uncertainty has contributed to a significant level of complexity and challenge in terms

of managing ongoing financial issues and risks, which we will continue to address in so far as practicable during 2022. These financial issues and risks are identified in the Financial Management Framework chapter of the NSP2022.

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

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

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

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

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

3.3.4 The quarterly forecasts will inform us on the emerging of the financial issues and risks above, with the first formal forecast for 2022, based on the first three months' actuals, being available by mid-May. These forecasts will be closely monitored with DoH colleagues and we will monitor these risks with DoH and DPER via the monthly Health Budget Oversight Group (HBOG) meetings.

3.4 Year End 2021 Revenue Income & Expenditure (Current Expenditure)

3.4.1 At the end of 2021, the draft revenue I&E financial position, including AFS adjustments, shows a 2021 deficit of €156.7m or 0.8%, which is presented in the separate paper to the Board on the adoption of the AFS 2021. A significant element of the €156.7m deficit is being driven by the direct impacts of COVID-19 surges, as reflected in the €739.3m adverse variance on COVID-19 related costs being offset by a (€582.7m) positive variance on core costs. The time related savings in core services, which are due to activity levels being lower as a result of COVID-19 and regrettable delays in our capacity to progress with developments, are available in-year to offset against COVID–19 costs.

3.4.2 The cost of responding to COVID-19 in 2021 of €2.4bn are significantly higher than the specific COVID-19 funding provided of €1.6bn, resulting in the €739.3m deficit. The COVID-19 costs of €2.4bn include the following three specific COVID-19 expenditure items:

- Testing & Tracing Programme costs of €719m;
- Vaccinations costs of €530m;
- PPE costs of €360m;
- Other pay and non-pay costs incurred across the acute and community services which were categorised as directly attributable to COVID-19 expenditure.

3.5 2021 Capital I&E

3.5.1 The construction and ICT capital programme has expenditure of €1,015m in 2021. Initial indications were a deficit position in the combined capital programmes. When all income sources including non DoH income are fully taken into account, the combined capital programmes have a de facto balanced position for 2022, showing a small surplus for the year of €0.5m.

3.6 2021 Cash Position

3.6.1 The HSE's cash holdings has been an area that DPER and DOH had placed significant focus on in 2021. The HSE would typically hold on average 3-4 days' cash during the year. However, the final December cash drawdown from the exchequer was based on estimated year-end cash requirements with the HSE's final cash holding for 2021

being €608m (10 days' cash). This maximum cash holding was agreed between DoH and DPER prior to the 2021 year-end. Therefore, there was a cash surrender to the exchequer of €293m in 2021 which is inclusive of a €267m surrender relating to the 2020 financial year. The accounting treatment of these transactions has been informed by the notification and documentation of these adjustments, by the DoH and is reflected in the 2021 draft AFS. The liquidity position will continue to be closely monitored to ensure that liabilities can be discharged when they fall due.

CHAPTER 4

Vaccination / Testing & Tracing Update

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4. COVID-19 VACCINATION/ TEST AND TRACE UPDATE

4.1 VACCINATION UPDATE

4.1.1 The ongoing delivery of the Primary and Booster programme to date has delivered a high overall uptake (Primary uptake of ca. 94.6% and Booster Uptake of 73.8%) placing Ireland amongst top performing EU countries according to the European Centre for Disease Prevention and Control.

4.1.2 Planning is well advanced for the Future Sustainable Long Term Model for COVID-19 vaccination. Given the continued uncertainty around the future requirements, this operating model has been developed based on a number of assumptions as part of scenario planning (e.g. timing, population scope, vaccination type, age cohort use and delivery allowing critical services in primary and acute care to operate).

4.1.3 The emerging view is that the sustainable model will not rely on fixed vaccination centres in every county as proximity / uptake are key principles for the development of the long term model implying more use of local access points such as primary care. Further refinement of the approach will continue over the coming weeks.

4.1.4 Many countries internationally are looking to deliver fourth doses to certain cohorts. Israel, Denmark, Germany, UK, Sweden, Netherlands, and Chile have all commenced or are planning to deliver fourth doses more broadly to also include healthcare workers and the elderly.

4.1.5 No guidance is yet available on the clinical requirement for a fourth dose in Ireland making associated planning and decision making challenging and likely requiring the HSE to commit resources and spending to be ready for a range of potential scenarios. The Transition period (i.e. period between closure of the current Booster phase and the move into a long term sustainable model) will be mainly focused on planning and preparing for the Sustainable model, the HSE must remain ready for the possibility that fourth doses will be required to be administered.

4.1.6 Boosters to the 12-15 age group commenced on 5 March with ca. 9k administered through Vaccination Centres to date from an estimated population of ca.202k.

4.1.7 Booster uptake remains generally low, particularly in the younger age groups (ca. 53.5% uptake for the 18-39 group and 60.1% in the 18-49 group).

4.1.8 It is estimated that ca. 700k of the 16+ population remain eligible for Booster vaccination with an estimated ca. 200k who are currently ineligible due to having had COVID in the last 3 months. There is a potential for an increase in demand driven by these COVID infected individuals becoming eligible over the end Mar/ April period.

4.1.9 Continued focus will remain on uptake improvement initiatives which have most recently included direct engagement via HSE live to the Immunocompromised group yet to receive a Booster and targeted clinics with greater accessibility to 5-11 year olds through self-scheduling clinics in VCs.

4.1.10 As part of a wider HSE planning process to address the health and support needs of Ukrainian refugees entering Ireland, plans are in development to meet their urgent vaccination requirements. There will be a particular focus on the delivery of COVID-19 vaccination services as in general, this population cohort is under vaccinated. There will however be other urgent vaccinations required (e.g. Flu and childhood immunisations). A working group has been appointed by HSE COO who will look at

wider Ukrainian refugee health needs with the COVID-19 vaccination programme supporting this group.

4.1.11 Three Vaccination Centres have been extended for the coming months to support the current programme and the transition to the longer term more sustainable model (Limerick Scoil Carmel extend to end Q4, Galway Racecourse extend to end Q4, Fairyhouse - extended to Q3).

CHAPTER 5
Chief Information Officer

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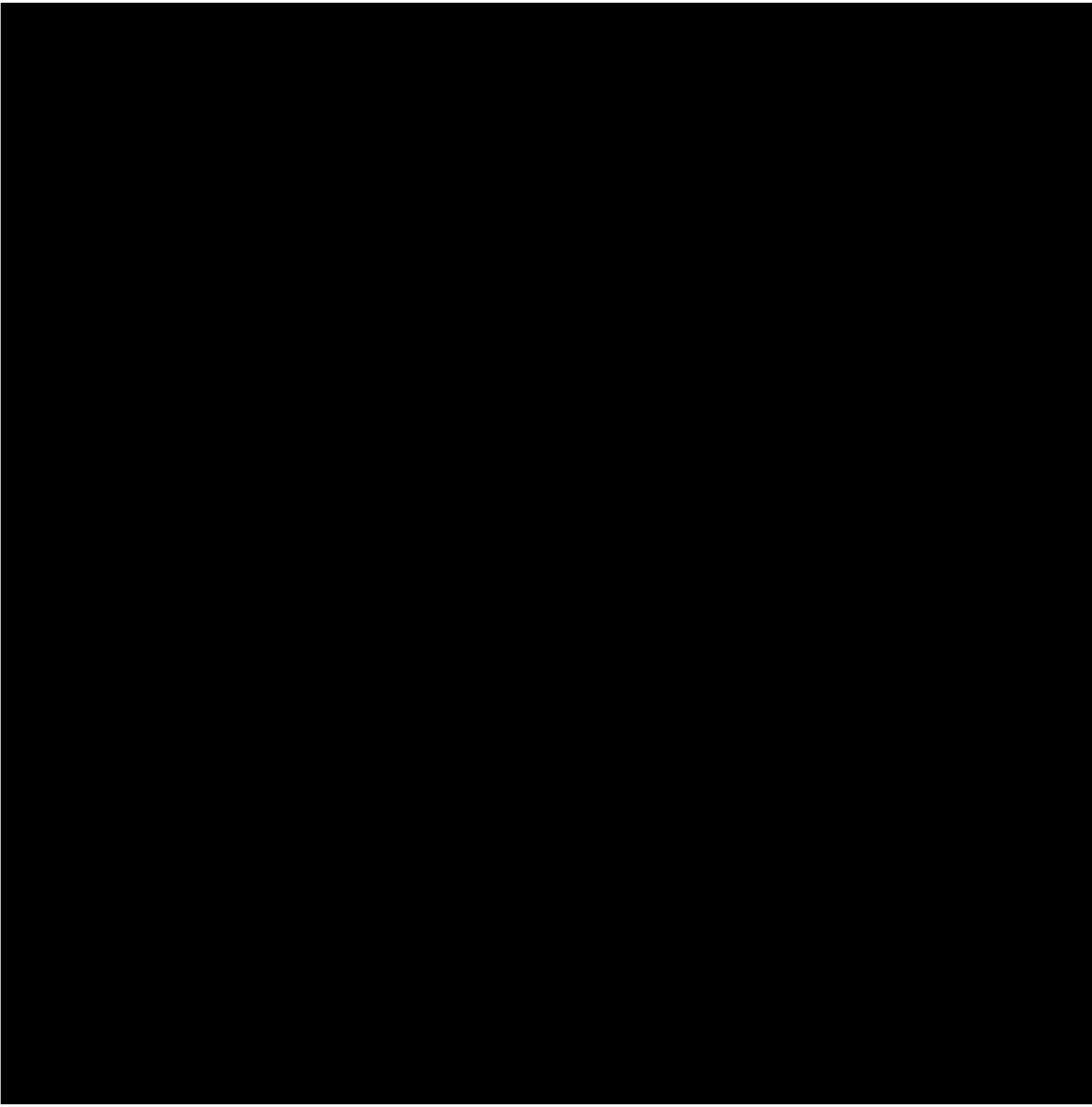


CHAPTER 6

Integrated Operations

Wreaths were laid for those who died during the COVID-19 pandemic at a ceremony held at the Garden of Remembrance on 20 March 2022. It was my great privilege to attend this ceremony.

6. INTEGRATED OPERATIONS

6.1 SOUTH KERRY CAMHS ("MASKEY") REPORT – HSE RESPONSE AND ACTIONS UNDERWAY

6.1.1 Since my last update, there has been progress in a number of areas relating to the response to the Maskey Report, as set out below.

6.1.2 The National Oversight Group, jointly chaired by the HSEs Chief Operations Officer and Chief Clinical Officer, has been established to oversee, monitor and report on implementation of the Maskey Report to the Safety and Quality Committee. It has met on two occasions. The Terms of Reference for the audit of prescribing practice are being finalised.

6.1.3 At a local level, Cork Kerry CHO is standing up a dedicated Clinical Liaison Team, which will provide clinical and advocacy supports to children and young people affected. This team will consult with families to determine how to best meet identified needs, taking into consideration the full range of specialist mental health services.

6.1.4 The Clinical Liaison Team will also identify other appropriate services in the community, as well as services available from private service providers that can support the children, young and their families. Where indicated, the 240 children and young people will be prioritised for services and removed from waiting lists.

6.1.5 This team will provide a direct pathway to HSE services and remove any access or communication barriers (including access to transport). They will also identify where other external service providers may be helpful, to include Family Resource Centres, home support and counselling services.

6.2 NATIONAL AMBULANCE SERVICE – ORGANISATION DEVELOPMENT

6.2.1 In early 2021, the HSE commissioned an Organisational Health Intervention of the National Ambulance Service (NAS) which identified that the clinical, operational, technocratic and corporate governance structures were significantly underdeveloped and under resourced which has challenged the Service's ability to evolve. In response, the HSE mandated work to re-design NAS structures and governance arrangements in a way that was fit for the future and a potential and significant growth in organisational capacity. In this regard, following an internal consultation process new structures to be introduced over a three-year period have been agreed.

6.2.2 In 2022, the key focus is on three core elements, implementing 24/7 tactical and operational management arrangements, addressing core leadership and governance by recruiting an executive team and developing educational structures to address the ongoing transition of paramedicine to BSc. Level education. At this stage, a package of posts has been approved by the EMT and have now been submitted to the Department of Health for consideration.

6.2.3 At an operational level, NAS have demonstrated an ability to play a key role in enabling a shift in the delivery of healthcare. This continuing transition will support the overall vision of Sláintecare. This significant change requires the NAS to have the appropriate levels of leadership and management resource which can support such work and it is intended that the new structures will provide this into the future.

6.3 Dental Treatment Services Scheme

6.3.1 I wish to bring to the Board's attention the matter of the numbers of dentists exiting the Dental Treatment Services Scheme (DTSS). To illustrate this, in January 2021 there were 1,311 contracts held by private dentists and clinical dental technicians (29), at present, the number of contracts is 1,103. This is a pressing matter given the number of dentists leaving the scheme with an adverse impact on medical card holders who rely on the DTSS. Challenges for service users include, delays while seeking treatment, increased travel times where there is no dental service locally. Cognisant of the immediate impact on those in need of dental treatment the COO will discuss with the DoH the critical need to prioritise the negotiations in respect of the DTSS.

CHAPTER 7

Clinical Update

Nine ambulances, fully equipped, have been donated by the HSE to support the humanitarian response to the war in Ukraine. Working closely with the HSE, Lifeline Ambulance arranged for the transport of these ambulances, each of which was also packed to capacity with a variety of much needed medical supplies.

7. CLINICAL UPDATE

7.1 PUBLIC HEALTH REFORM UPDATE

7.1.1 The Public Health Reform Programme has made significant progress in driving Public Health Reform**.** A separate paper is available, providing a progress update to the HSE Board regarding the implementation of Public Health Reforms and aligned introduction of new Consultant of Public Health Medicine (CPHM) posts. This report provides a comprehensive update with clear evidence of the progress being made in delivering the reform of Public Health in Ireland.

7.2 CRITICAL CARE CAPACITY

7.2.1 In December 2020, the Minister for Health announced a strategic multi-year plan to expand adult critical care capacity in Ireland. The plan was developed to ensure readiness of the health system for response to the ongoing COVID-19 pandemic and to support a long-term strategic goal of increasing overall critical care capacity fully addressing the critical care recommendations of the Health Service Capacity Review (2018).

7.2.2 A separate paper has been shared with the Board to consider and approve recommendations to complete the commissioning of Phase 1 beds and provide feedback on and approval of proposed plans to accelerate the implementation of the Phase 2 of the Critical Care Capacity Development Plan.

7.3 UPDATE ON COVID-19 THERAPIES

7.3.1 There have been 242 doses of Sotrovimab delivered to Irish hospitals as part of the COVID-19 Therapeutics programme up to March the 8th 2022. The eReferral system for Sotrovimab will be rolling out in phases from Thursday 10 March 2022 whereby GP's will be able to refer patients to hospitals for the monoclonal IV infusion by using HealthLink.

7.3.2 The present use of monoclonal therapies has emerged as consequence of data showing reduced efficacy of some prior therapies with emerging variants. Whilst there is in vitro data exploring efficacy of sotrovimab to present circulating Omicron variant we are not yet aware of a reduced in-vivo effect. Breakthrough CoVID-19 infection is well-established with Omicron Sublineage BA.1 and BA.2**.** It is inevitable that virus change will occur in the context of sustained community infection prevalence and associated disease in immunosuppressed patients. Continued surveillance of epidemiology, virology (genome sequencing) and therapeutic response (in addition to monitoring of international literature and experience) is critical. The Therapeutics Advisory Group has proposed the establishment of a Stewardship and Epidemiology Subgroup whilst awaiting the outcome from the submission for a resourced antiviral stewardship unit.

7.3.3 The funding for Pfizer's Paxlovid (antiviral drug) has been confirmed and a contract is expected to be executed in due course. The anticipated date for the first delivery of an order of 14,000 doses is for the end of March/ beginning of April. Confirmation is awaited in relation to the exact date.

7.4 THE NATIONAL SCREENING SERVICE

7.4.1 <u>BreastCheck</u>

BreastCheck activity capacity increased in January to approximately 75%; with 10,560 mammograms carried out which is above target by 560 (5.6%), despite the continued impact of COVID staff absences.

A national review of radiology staffing has been requested by NSS & NCCP and initiated by the office of the CCO. The aim of this group is to explore short, medium and long-term options, look at training positions, education, and the promotion of breast radiology as a career option. In the immediate term, BreastCheck continue to actively recruit and aim to appoint consultants into vacancies across all four units.

7.4.2 CervicalCheck

CervicalCheck is fully operational, with 22,992 screening tests completed in January, this is 22% below the target of 29,000. This reduction reflects the primary care focus on COVID vaccination and significant COVID infection rates seen nationally in January.

The Coombe Women's & Infant's University Hospital experienced a cyber-attack on 16 of December. To date results for all samples that were mid-processing have been issued to women and GPs. All new samples received into the Coombe are being redirected to Quest and are being processed as normal. It is anticipated that laboratory services will resume again in mid-March subject to satisfactory system's testing.

7.4.3 BowelScreen

The BowelScreen programme screened 4,502 eligible participants in January which is 64% (7,998) below the target of 12,500. Invitations and completed screening tests continue to be impacted by the surge in COVID infection rates in the community. BowelScreen colonoscopy sites are scheduling appointments at reduced capacity due to the number of COVID-19 cases and the impact on hospital capacity. Endoscopy services are not expected to operate at full capacity until at least April 2022. An additional Endoscopy Unit will join BowelScreen in Q1, 2022.

7.4.4 Diabetic RetinaScreen

The Diabetic RetinaScreen screened 6,019 participants in January which is 32% (2,881) below the target of 8,900 as some screening clinics continue to be impacted due to staff COVID related illness.

The programme continues to focus on prospective participants awaiting appointments that have accumulated due to COVID and has completed the rescreening of patients waiting for an appointment in excess of 1 year. The 2-yearly screening pathway is now in place 11 months and is proving very successful. To date of those screened approximately 88% will remain on the 2-yearly pathway.

7.4.5 Update on Cervical Check and Implementation of the Scally Recommendations

Significant progress has been made in implementing the recommendations of Dr Scally's Scoping Inquiry into the CervicalCheck screening programme. The latest quarterly progress report was published on the 3 of March 2022 and shows that just four of 170 actions, arising from Dr Scally's recommendations, remained to be completed at end 2021. Of the four remaining actions, the Department of Health is

responsible for two, the HSE is responsible for one, and the final one falls under the National Cancer Registry Ireland (NCRI). Finalisation of actions within the HSE relate to document management and access to records; and, within the Department of Health, relate to the formal establishment of the Restoration of Trust Meetings process, the progress report outlines.

There continues to be significant effort and commitment by the HSE teams and the National Cancer Registry of Ireland, and department, working closely with stakeholders including patient advocates, in implementing the recommendations. The CervicalCheck Steering Committee is chaired by Professor Anne Scott, and includes the 221+ Group and patient advocates, with an oversight role in the implementation of the recommendations.

The Minister for Health has requested Dr Gabriel Scally to conduct a final progress review of implementation of his recommendations, and this work is now underway. Progressing this final review is in line with the Programme for Government commitments, including the advancement of the women's health agenda.

7.4.6 Collaboration with International Agency for Research on Cancer

The NSS, DOH, and the International Agency for Research on Cancer (IARC), as part of the World Health Organisation, have formed a collaboration to prepare strategic guidance on best practices related to cancer screening implementation. The collaboration aims to:

(a) To develop best practices for conducting cancer audits in cervical cancer screening programmes;

(b) To emphasise good practices and key considerations including a checklist for transparent & pragmatic communication with the public, service providers & other stakeholders (related to benefits, inadequacies & harms of cervical cancer screening);

(c) To develop best practices and a legal framework that will better safeguard the interests of screening participants, providers, and managers.

7.4.7 National Cervical Screening Laboratory (NCSL)

The NCSL project is developing a new bespoke laboratory designed for use as a national 'Centre of Excellence' for cervical screening. Construction of the laboratory is due to complete in May 2022. The laboratory is due to be operational by the end

the August 2022 following fit-out and commissioning. An action plan has been put in place for the procurement of priority equipment items.

Workforce capacity remains the key limiting factor for full establishment of the laboratory. A new consultant cytopathologist is commencing in post in March 2022. A service delivery model is currently being developed which will outline the anticipated increase in service volumes over coming years and the workforce required to achieve each level of throughput. It is anticipated that sufficient workforce capacity will take a number of years to be addressed before the laboratory is in a position to be the principal provider of laboratory services for CervicalCheck.

7.5 UPDATE ON NATIONAL CANCER CONTROL PROGRAMME

7.5.1 Cancer services are operating at nearly full capacity, with some ongoing local challenges relating to staff absenteeism and acute capacity issues. Implementation of relevant recommendations of the National Cancer Strategy is continuing, with obvious challenges arising from diverted focus over the past two years.

7.5.2 Ongoing access to private services remains essential and this need is likely to continue for some time, particularly in clearing backlogs for non-complex cancer care and ensuring timely cancer treatment.

7.5.3 Staffing, recruitment and retention in cancer services continue to be challenged. Particular difficulties are being seen in relation to the availability of sufficient numbers of suitably trained staff to fill radiation therapist, radiation oncology, and nursing and medical physics posts.

7.6 GENETICS AND GENOMICS

7.6.1 Clinical genetics is an established medical sub-specialty and there are some pockets of excellence in the country. However, Ireland lags considerably behind other countries in harnessing the power of genomic data and research to inform clinical decision making.

7.6.2 There is now a large and increasing disparity between services offered in Ireland and international best practice. As a result, very few Irish patients are benefitting from advances in genomics and the gap is widening. Compared to other European countries.

7.6.3 Medical Genetics in Ireland is under-resourced for both clinical and laboratory services. As a result, patients do not have timely access to genetic opinions or to genetic testing resulting in delays in diagnosis, treatments, and interventions.

7.6.4 At present, the average waiting time for a routine genetics appointment is 2 years. Due to the lack of a genomic infrastructure, a significant volume of patient samples is sent overseas for testing leading to increased costs.

7.6.5 In addition, tests that are carried out in-house have a higher unit cost compared to other laboratories carrying out similar genetic testing. There is a shortage of trained genetic specialists, substantial knowledge gaps in the clinical workforce and a lack of genetic/genomic literacy across healthcare professionals and the public.

7.6.6 There is a lack of coordination and integration between clinical and research genomics with no centralised national body with responsibility for genetic services and the establishment of future services. Appropriate governance structures, policies, procedure, and protocols are not in place and Ireland has no strategy or funding in place to develop a genomic service to improve health outcomes, drive down the cost of care and fuel scientific innovation and discovery.

7.6.7 There have been several reports published in relation to genetics services and recommendations made for a national strategy and plan to develop and to strengthen the genomics service. The HSE commissioned the Smith Report in 2016, which lead to eight key recommendations, four of which related to the development of a Genetics and Genomic Network. Following the recommendations from this report, the government committed to establishing a National Genetics and Genomic Medicine Network (NGGMN).

7.6.8 The NGGMNs aim is to facilitate the development of a nationally coordinated service for genetics and genomics. Recruitment for a National Genetics and Genomics Medicine lead was first advertised in February 2020 and following a global, competitive, and open recruitment process a world leading expert in genomics was offered the position of Director of the NGGMN in January 2021 who declined the position due to the absence of a multiannual budget.

7.6.9 The agreed priority now is to support the progression of a Genetics and Genomics strategy with a single vision for the future of genetics and genomics. The EMT have agreed to the establishment of a national Genomics steering group to develop a national strategy and implementation plan. This will be a time limited group and the strategy should be completed within 4-6 months.

7.7 ADVANCED NURSING AND MIDWIFERY PRACTITIONERS

7.7.1 In November 2021, the Minister for Health asked that the number of ANMPs in the health service be increased from 2% to 3% of the workforce. The total nursing and midwifery workforce in the public system was 41,136 WTE (November 2021). At this time the total number of Advanced Nurse and Midwife Practitioners (ANMPs) was 733 WTE (1.75%) including 553 WTE Registered ANMP posts and 180 WTE candidate ANMP posts.

7.7.2 ANMP resources are an enhanced source of expertise both in the hospital and community. These posts should have a renewed focus on the objectives of Sláintecare and the HSE corporate objectives. There is an opportunity now to harness these advanced practice roles to support patients in the community and hospitals in managing integrated care. The DOH Letter of determination to the HSE set out a funding of 11.9 million as part of the HSE National Service Plan 2022 new development initiative to expand the number of ANMPs in 2022 service. It is accepted that €1m will be required to support the education of candidate posts and there will be 164 WTE posts available.

7.7.3 A paper is being developed by the National Director for Clinical Programme Implementation & Professional Development for a proposed governance structure to provide a strategic direction for these posts that will ensure that their future development aligns with both the HSE and Sláintecare objectives.

7.8 NATIONAL CHILDHOOD IMMUNISATION PROGRAMMES

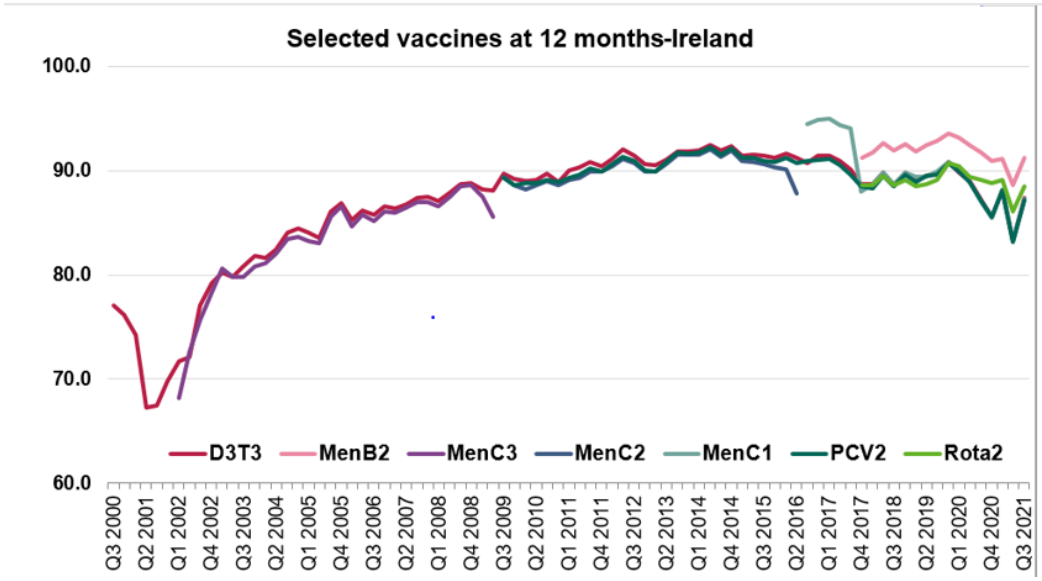
7.8.1 Immunisations are second only to clean water as the most cost-effective health intervention. The national immunisation schedule provides protection from 13 (14 if COVID-19 is included) infectious diseases based on disease epidemiology in Ireland and the recommended ages where there is most benefit. It is therefore very important that immunisations are received at the recommended time and any missed are caught up at the earliest opportunity.

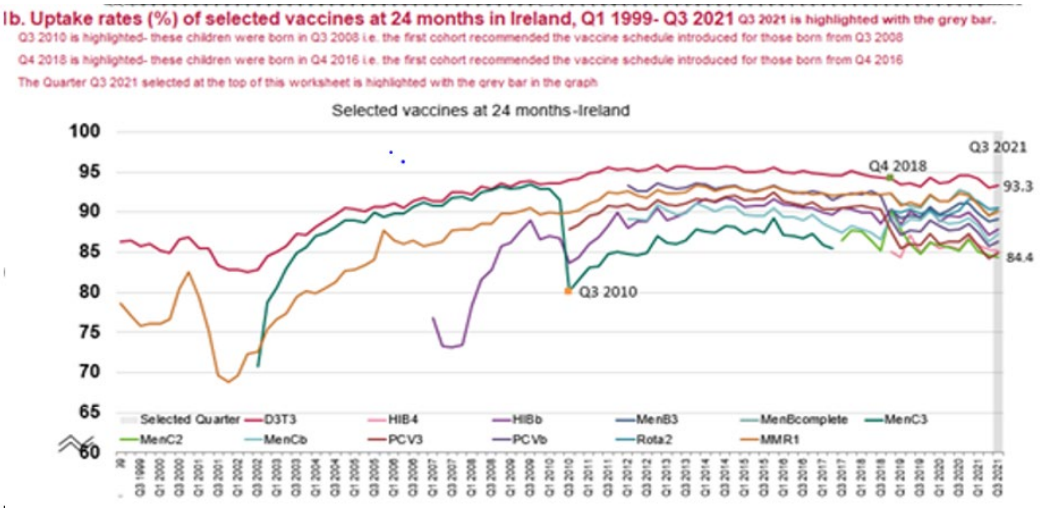
7.8.2 <u>Primary Childhood Immunisations</u>

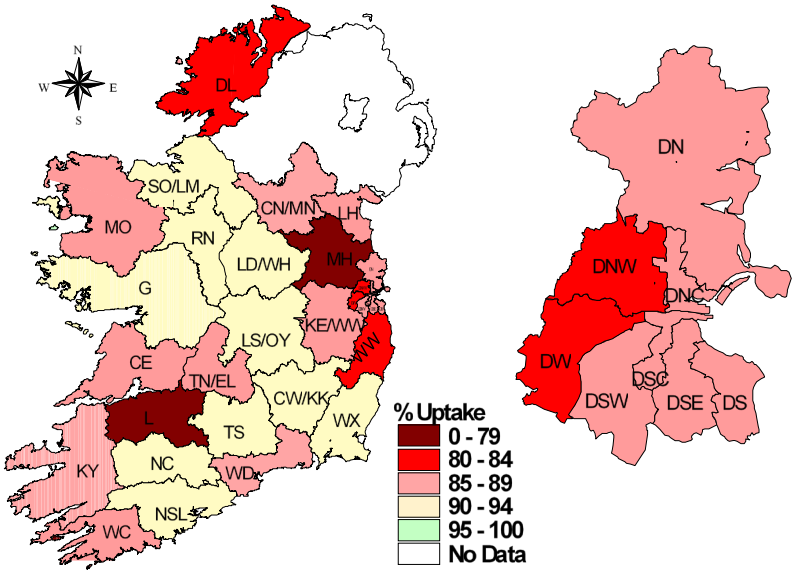
The Irish programme is delivered through General Practice and offers protection against 11 different infectious diseases over five visits at 2, 4, 6, 12 and 13 months of age. Uptake is calculated at 12 and 24 months of age. GP's provide paper returns to CHO's who in turn manually input data for immunisation recording, payment and

uptake reporting. Several different immunisation systems are in use across the CHO's and there is no integration between them.

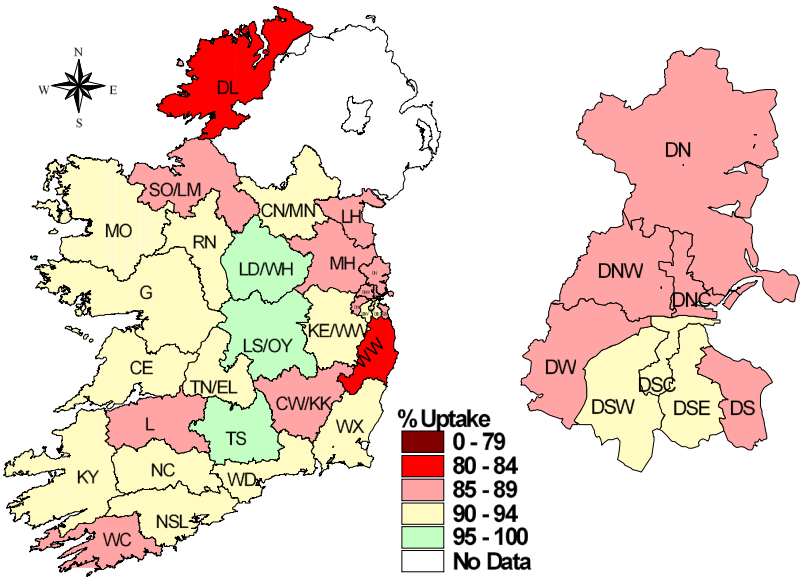
Trends in immunisation uptake at 12 and 24 months across the last 20 years is shown in the graphs below:







Three doses of 6 in 1 vaccine at 12 months Q3 2021



1 dose of MMR vaccine by 24 months Q3 2021

Source: [Immunisation uptake statistics at 12 and 24 months of age - Health Protection Surveillance Centre (hpsc.ie)]

This information shows a general decline in uptake since the start of the pandemic and also the large variability in uptake across Ireland.

The decrease in uptake in the past two years is likely to have a number of causes.

(a) parents may have been concerned about bringing their babies to a GP surgery to receive their vaccines, and due to the high workload,

(b) it may have been more difficult to obtain an appointment. During the pandemic GP's were reminded that childhood, vaccinations were essential services that should be maintained.

(c) in some areas due to practice lists being full, it can be difficult to register babies for their vaccinations, particularly if the family have recently moved into an area.

(d) the increase in information on vaccine side effects may have increased vaccine hesitancy amongst parents.

Due to the manual nature of the vaccine returns and the fact that CHO administrative staff were redeployed to COVID-19 work, in some areas there is a backlog of returns and the usual work to follow-up patients who had not attended, had to be curtailed or stopped.

A further risk to the immunisation programmes has been identified due to the notification by one vaccine manufacturer of the cessation of production of a vaccine used in the primary immunisation programme. The National Immunisation Advisory Committee are looking at how the programme can be restructured to take account of this. However, in the absence of a National Immunisation System (NIS), all the local immunisation systems will need to be upgraded urgently to accommodate recording and reporting of the new schedule.

7.8.3 **Work done to date to identify the reasons for decreased uptake and endeavours to improve it:**

(a) First national cross-sectional survey of parents of children 0-48 months to examine attitudes towards childhood vaccination, by NIO in conjunction with HPSC. (August 2021). Results show very positive parental attitudes towards childhood immunisation, 94.4% agreed that vaccines are important.

(b) NIO survey of practice nurses to determine experience of vaccine hesitancy and identify learning needs, December 2021. Practice nurses responsible for vaccine administration (94%). Majority felt confident in addressing hesitancy,

some learning needs identified which can be addressed by NIO in further communications.

(c) Survey of GPs attending ICGP weekly webinar questioned whether they take on new babies for immunisations: Yes= 46%, Yes but only if parents are already patients of the practice= 46%, No=8%.

(d) Examination of orders and deliveries of paediatric vaccines-Orders as expected therefore practices likely to be vaccinating at approximately same rate as pre-pandemic.

(e) Toolkit produced by NIO to increase uptake of childhood immunisations in General Practice- provides guidance on catch-up schedules, evidence-based interventions to improve uptake and communications strategies

(f) E-learning module developed by NIO for HSELand: Communication with people who are hesitant about vaccines

(g) Targeted communication from NIO on childhood immunisations- social media, websites accessed by parents and HSE internal communications

(h) Ongoing work between NIO and social inclusion to target harder to reach groups

(i) National Immunisation Oversight group with representation from all stakeholders, chaired by National Clinical Director for Health Protection started in Feb 2022 to discuss immunisation related issues including the fall in uptake and actions to improve this.

7.8.4 **Further work required:**

(a) All CHO's to ensure sufficient administrative staff available to clear backlog of immunisation data returns and enable timely inputting going forward

(b) All CHO's to work with NIO to upgrade local immunisation systems to incorporate new immunisation programme changes

(c) All CHO's to work with local public health departments to re-establish local immunisation committees and activities to follow-up children who do not present for immunisations

(d) National project to procure and implement a National Immunisation Information System to begin as soon as possible. New system should ensure automatic feeds from maternity systems to hold a complete record of all babies born in Ireland and automatic data feeds of immunisation returns from GP's to reduce manual data entry burden and provide timely uptake returns and work towards bar code scanning

(e) NIO to continue work to promote childhood immunisations to parents, to improve confidence for healthcare workers on catch-up vaccines and speaking to vaccine hesitant parents as well as work with social inclusion for harder to reach groups

(f) NIO are updating GP practice guidelines on immunisations

(g) Primary Care to investigate whether there is sufficient GP capacity to ensure all babies are able to receive their primary childhood immunisations close to their home.

7.8.5 School Immunisation Programmes

National childhood immunisations are also provided by CHO school immunisation teams. A second dose of MMR vaccine and 4 in 1 (booster for tetanus, diphtheria, pertussis and polio) are provided in junior infants and HPV, booster for tetanus, diphtheria and pertussis (Tdap), and Meningococcal ACWY are provided to students in first year of second level school.

Uptake of these vaccines has also unfortunately fallen during the pandemic.

(a) Junior infants uptake 2020-21 academic year:

- MMR- 79% (91% 2019-20)
- 3 in 1- 79% (91% 2019-20)

(b) First year second level uptake 2020-21 academic year:

- HPV2 – 64.8% (76.2% 2019-20)
- Tdap- 80.4% (88.7% 2019-20
- MenACWY- 71.7% (83.6% 2019-20)

There is also variability across the country in uptake; for example, HPV2 is reported as 79.8% in CHO4 but only 27.6% in CHO8. Very limited data has been returned so far for immunisations carried out this academic year, so uptake cannot be estimated.

There are several reasons for a decrease in uptake over the past two years.

(a) Firstly, due to social distancing requirements some schools were not able to allow the schools immunisation teams onto their school premises. Therefore, the teams had to find alternative sites in the community to offer vaccinations. It is known from international literature that immunisations delivered in schools have a higher uptake as it is more convenient for parents when they do not have to take their child out of school and travel potentially long distances or to places that are difficult to access with public transport to avail of vaccinations.

(b) Also due to COVID-19 re-deployment, school immunisation staff were seconded to other areas and may not have been able to provide such a comprehensive and timely service for immunisations as they would have done in previous years.

(c) Lastly, it is clear from the data returns that some CHO areas have not input the manual paper returns into the School Immunisation System (SIS) due to administrative staff re-deployment. It is therefore likely that immunisation uptake is in fact higher than reported in this document.

Further work required, as follows:

(a) All CHO's should ensure they have sufficient administrative staff to input all outstanding immunisation information from the previous and current academic years and that all data is entered within a month of vaccine administration going forward.

(b) As school-delivered immunisation programmes result in higher and more equitable uptake of vaccines, all school immunisation teams should work with their local schools to explore whether immunisations can be administered on school premises for the remainder of the academic year and next academic year now that social distancing restrictions have been lifted.

(c) All school immunisation teams should continue to offer opportunities for children to receive their vaccine where they have consented for immunisations but were unable to attend due to COVID-19 related restrictions.

(d) NIO is currently working with Department of Education to allow central sharing of pupil data to the Schools Immunisation System from next academic year to enable school teams to offer a universal service to all children enrolled in schools, particularly if consent forms are not returned from schools.

(e) NIO to work to promote school immunisations on social media channels in line with the school's team administration timeline.

(f) Invest in and progress upgrade of Schools Immunisation System and ideally progress project for point of care immunisation scanning to ensure real time data entry to allow for timely uptake reporting. This in turn would allow identification of any areas of low uptake to allow for communications campaigns targeted in these areas.

7.8.6 Immunisation systems- need to be upgraded to ensure data return and an accuracy of data entry. This upgrade is essential to implement the new primary childhood immunisation programme that will have to be introduced in the coming years. The upgrade of the immunisation system is currently being considered as part of the wider COVID 19 vaccination IT system.

If the data is accurate, a continued suboptimal uptake of vaccines recommended through the National Immunisation Programmes could result in outbreaks of vaccine preventable diseases that could put additional strain on the health system and be serious for those who contract the disease. For example, one case of measles can infect between 12-15 more people.

In summary the uptake of all national childhood immunisations has fallen during the COVID-19 pandemic. There are multiple reasons for this fall. It is known that some CHO areas are behind in data entry therefore it is unclear how accurate the uptake reported is. Without accurate and timely information, it is difficult to design interventions to target areas for improvement. The newly formed National Immunisation Oversight Group is an important group to bring together all stakeholders to discuss issues with immunisation uptake and design solutions.

CHAPTER 8

National HR Update

8. NATIONAL HUMAN RESOURCES UPDATE

8.1 NiSRP UPDATE

8.1.1 NiSRP is a multi-year national transformation programme, which will integrate and modernize SAP staff records and Payroll systems and processes across the HSE. To date the programme has delivered:

(a) A single Staff Records platform and a single Payroll technical platform to the HSE East and South East.

(b) 'My HSE Self- Service'; 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 to HSE East, South East, Midlands, Mid-West and North West.

8.1.2 The programme is currently engaged in transitioning to business with the integrated sites (Midlands, Mid-West and North West) and in the discovery and data validation phases for the HSE South Implementation. The South implementation oversight group has been formed and meeting monthly, with nominees representing all relevant areas across Cork and Kerry. Change implementation engagements are underway with all stakeholder's groups and management identified supporting the discovery and data validation activities. Implementation in the South will be complete in 2023.

8.2 NATIONAL EMPLOYEE RELATION ISSUES

8.2.1 **Portrane (National Forensic Mental Health Service) -** The issue of compensation for staff for the relocation of the entire National Forensic Mental Health Service (NFMHS) from Dundrum to Portrane was referred to the Labour Court. A hearing at the WRC was held on 11th March 2022.

8.2.2 **Medical Laboratory Scientists Association (MLSA) – Industrial Action**

(a) The HSE has received formal notice of the taking of Industrial Action by the MLSA in pursuant of its long standing claim for pay parity with Biochemistry. The action will be by way of three separate days of full withdrawal of work between the hours of 8am and 8pm, over three days in late March and early April 2022.

(b) The areas that will be involved are HSE and Section 38 Acute Hospital settings and the Irish Blood Transfusion Service. In accordance with established procedures applicable, in such circumstances, Corporate Employee Relations are seeking an early meeting with the MLSA to discuss contingency arrangements.

(c) Management continue to work to try to have the issues in dispute progressed towards resolution and will be engaging with colleagues in Department of Health, and Department of Public Expenditure and Reform in respect of the usage of dispute resolution machinery contained within the Public Service Agreement, Building Momentum.

8.3 WORKPLACE HEALTH & WELL BEING

8.3.1 Occupational Health

Guidelines for high and higher risk healthcare workers has been revised and are available on the HSE website https://www.hse.ie/eng/staff/resources/hr-circulars/guidance-on-fitness-for-work-of-healthcare-workers-in-the-higher-risk-categories-including-pregnant-healthcare-workers.pdf

In the post peak COVID-19 and as evidence emerges, coupled with the success of the national vaccination programme, and the Work Safely Protocol, individualised advice has become available, allowing many of previously categorised "High" and "Very High" HCWs to return to the workplace and/or clinical duties. Healthcare workers should be supported in their return to work by their manager and colleagues and be made aware of further supports available, such as the Employee Assistance Programme or their Occupational Health service

Employee Assistance Programme – Quarter 4 2021

(a) 946 HSE staff received support from the EAP Service in Q4-2021

(b) 3,968 Counselling sessions delivered EAP to HSE staff in Q4-2021 (average 5.68 session per client)

(c) 170 Psychosocial support calls delivered by EAP

(d) 77 Manager consultation requests received by EAP

(e) 10 days Average waiting time initial referral to first EAP appointment

The below is a representation of the EAP client's top presenting issues identified at assessment:

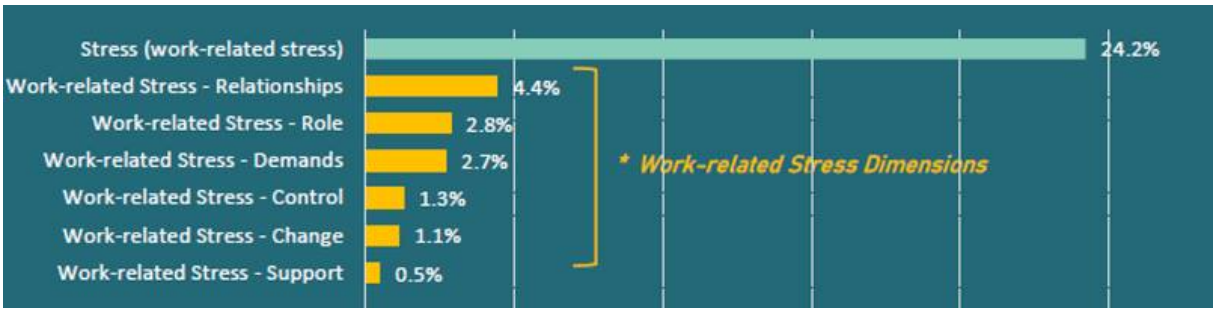
(i) **24.2%** - Stress (work-related stress) – see graph below

(ii) **15.5%** - Stress (personal life)

(iii) **13.8%** - Anxiety

(iv) **7.6%** - Bereavement / Loss

(v) **7.1%** - Family circumstances



Note: *The percentages of the six main areas that can lead to work-related stress (WRS) are expressed as percentages of the overall total of 100%, where this detail was identified or self-reported (it is typically identified as generalised WRS). The WRS figure incorporates the percentages for the six main areas of WRS (as per the UK HSE Management Standards, as referenced in HSE Policy for Prevention and Management of Stress in the Workplace, 2018).*

Workplace Health Framework – Work recommenced in January 2022. Communication and engagement continue, and the model has been presented to the Health Service Managers Risk Forum (hosted by State Claims Agency) on 2nd March 2022 and will be presented to the Joint Information and Consultation Forum (JICF) and National Staff Engagement Forum during Q2 2022. A detailed update will also be provided to the People and Culture Committee at its April meeting.

8.4 CAPABILITY & TALENT:

8.4.1 Leadership Learning and Talent Management (LLTM) – Is being rollout of the new electronic Classroom Management System (CMS) on HSeLanD is ongoing.

Staff are making good use of the facility for online booking of virtual programmes via LLTM's Catalogue on HSeLanD.

Virtual core and non-core programmes are continuing and plans are progressing for the role out of four virtual Leadership and Management development programmes. The first Leaders in Management programme is being rolled out in partnership with Public Health, Environmental Health and the National Screening Service with plans to roll out the remaining three programmes in Cork Kerry Community Healthcare, Community Healthcare East and the Saolta Hospital Group.

8.4.2 Gradlink Recruitment Update for March 2022 - The Gradlink programme is currently under review with research being undertaken into other graduate programmes in the Irish public sector and the NHS in the UK. An internal analysis of the programme data shows that 97% of Graduates who completed the programme in 2021 would recommend Gradlink while 100% of Line Managers surveyed indicated that they would be interested in hiring another graduate from the programme. All Line managers surveyed also indicated they would recommend Gradlink to other Service managers.

8.4.3 HSeLanD - Overall for 2022 to date there were

(a) 201,200 programme completions with 615,000 log-ins.

(b) 13 new programmes have been launched on HSeLanD and

(c) 31 more are currently at various stages of commissioning and development in conjunction with the Services.

8.4.4 Health Services Leadership Academy

(a) Cohort 4 of Leading Care III (Professional Diploma in Management in Healthcare – Level 9) recently completed their third residential programme.

(b) Leading Care III Cohort 3 have completed their full Professional Diploma Programme

(c) The fifth cohort of Leading Care II (MSc in Leadership in Healthcare) have completed their third residential programme. This cohort is also submitting dissertation proposals at this time.

(d) Preparations for the new Professional Diploma in Strategic Transformational Leadership in Healthcare is underway and the first intake will commence in September.

8.4.5 National Healthcare Communications Programme update as follows;

(a) A new module is currently being developed for HSeLanD to increase the reach of this very popular programme which is aimed at clinical staff in hospitals.

(b) Communication skills workshops are currently being delivered for patient advocates

(c) New supporting materials for all modules are also being finalising and will be available on the NHCP Webpage at: https://www.hse.ie/eng/about/our-health-service/healthcare-communication/ see list below.

Section	Link	
Module 3 case studies **https://www.hse.ie/eng/about/our-health-service/healthcare-communication/module-3/**	Responding to strong emotions	https://bit.ly/3peQk79
	Delivering bad news	https://bit.ly/3pfGbai
	Disclosing errors	https://bit.ly/3t2wehO
Listening skills section (NEW) **https://www.hse.ie/eng/about/our-health-service/healthcare-communication/listening-skills/**	Listening skills card	https://bit.ly/35LItqI
	Active listening skills illustration	https://bit.ly/3IEYPA3
	Gathering information skills illustration	https://bit.ly/3IBGCU4
Nonverbal communication section (NEW) **https://www.hse.ie/eng/about/our-health-service/healthcare-communication/nonverbal-communication/**	Nonverbal skills card	https://bit.ly/3MdFpoa
	Nonverbalillustration	https://bit.ly/3KvFFNV
Patient stories	Demonstrating empathy	https://bit.ly/35l4Vre
	Shared decision making	https://bit.ly/3sDetq2

	Motivational interviewing	https://bit.ly/3K4TQZY
	Emergency situations	https://bit.ly/3trAyHr
Updated skills cards **Note: Following positive feedback on a more visual format of skills card used for emergency situations and demonstrating empathy, all previous skills cards will be updated to this new format (WIP – check NHCP Webpage in coming weeks)**	Building the relationship	https://bit.ly/3ojQH01
	Providing information and planning	https://bit.ly/3pdeUFL
	Delivering bad news	https://bit.ly/3Iltsuf
	Responding to strong emotions	Sent to HSE Digital, should be available on Module 3 section of webpage next week
	Disclosing errors	Sent to HSE Digital, should be available on Module 3 section of webpage next week
Illustrations	Greetings and introductions	https://bit.ly/3gjyjjh
	Nonverbal communication	https://bit.ly/3Ht3uo7
	Active listening	https://bit.ly/3rqTAxG
	Gathering information	https://bit.ly/3uoVO2M
	ISBAR3	https://bit.ly/3rmTqrf
	Demonstrating empathy	https://bit.ly/3sxYMQ3

8.5 **STAFF SURVEY**

8.5.1 Access to the customised interactive individual dashboards was provided to each Community Health Organisation, Hospital Group and National Corporate Services during January and early February together with training on how to use the dashboards.

8.6 JANUARY 2022 STAFFING LEVELS

8.6.1 Employment levels at the end of January 2022, show there were **132,969 WTE (equating to 152,438 personnel)** directly employed in the provision of Health & Social Care Services by the HSE and the various Section 38 hospitals & agencies.

8.6.2 The overall increase since January 2019 now stands at **+13,152** WTE (+11.0%). The staff category with the greatest WTE increase is Nursing & Midwifery at **+3,587 WTE**,

with *Staff Nurses & Midwives* also reporting the greatest WTE increase at **+2,079 WTE** followed by Health Care Assistants at **+1,889 WTE**.

8.6.3 All staff categories over the period have shown significant growth with each category ranging from 6.8% in General Support to 15.5% in Management & Administration, as follows;

(a) The largest increase was in **Nursing & Midwifery +215 WTE** overall driven by the intake of Pre-registration student nurses on clinical placement. Staff Nurse & Staff Midwife (-78 WTE), PHN (-4 WTE) and Nursing other (-1 WTE) fell marginally, whereas Nurse/Midwife Manager (+32 WTE) and Nurse/Midwife Specialists & AN/MP (+18 WTE) both show growth.

(b) **Management & Administrative** showed the second highest growth increasing by +188 WTE including +51 WTE Clerical (III & IV), +100 WTE Administrative / Supervisory (V to VII) and +37 WTE Management (VIII & above).

(c) **Patient & Client Care** also shows growth, with **+128 WTE** increase; of which +47 WTE Health Care Assistants, +63 home Help; +28 Care Other and -9 WTE Ambulance Personnel.

(d) **Health & Social Care Professionals** increased by **+103 WTE** overall. There was a +34 WTE increase in Therapy Professions, +5 WTE Health Science/ Diagnostics, +21 WTE Social Care, +12 WTE Social Workers, Psychologists no change, +37 WTE H&SC other (includes 21 WTE trainees/ students. Pharmacy fell by -4 WTE).

(e) **General Support** increased by **+46 WTE**; distributed as follows, +44 WTE Support (cleaning, portering & catering) and -2 WTE Maintenance/Technical.

(f) **Medical & Dental** is the only staff category showing a decrease, at **-33 WTE**; distributed as follows, +2 WTE Consultants, +16 WTE Registrars; -44 WTE SHO/Intern (likely driven by NCHD changeovers) and -10 Medical/ Dental other.

These figures however, exclude non-direct HSE employees such as externally contracted Contact Management Programme contact tracers and vaccination staff that add an additional minimum +2,200 staff.

8.7 HEALTH SECTOR ABSENCE RATES - JANUARY 2022

8.7.1 The reported absence rate for January 2022 stands at **9.8%.** This compares to **9.3%** reported for the same month in 2021, however these figures notably include COVID-

absence for both periods. Excluding COVID-19 the current months' absence rate is **4.4%** compared to **4.3%** in 2021.

8.7.2 This months' absence rate is higher than that reported for the previous month, reported at **7.9%** (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 **4.4%** which is **0.5%** 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.

8.7.3 Of note the absence target rate for 2022 is now ≥4% as approved in the National Service Plan 2022. Excluding Covid-19 this months' absence rate of 4.4% is marginally above the new target.

Benchmark Target	Dec-21	Certified Absence January 2022	Self-Certified Absence January 2022	COVID-19 January 2022	Jan-22	Full Year 2021
4%	7.9%	3.94%	0.46%	5.38%	9.8%	6.1%

CHAPTER 9

Chief Strategy Officer

9

9. CHIEF STRATEGY OFFICER

9.1 REGIONAL HEALTH AREAS

9.1.1 The HSE are continuing to take forward planning work in relation to the introduction of Regional Health Areas (RHAs).

9.1.2 A workshop was held on 3 March 2022 with the leadership teams from the HSE and Department to provide an update on the position with RHAs and to consider and scope the key implementation workstreams.

9.1.3 The workshop was opened by the CEO and the Secretary General and was well attended by both organisations. A similar workshop is being arranged in the coming weeks for HSE Board and EMT members to engage on this matter.

9.2 SCHEDULED CARE WAITING LISTS

9.2.1 As Board members will be aware, the Minister for Health launched the 2022 Waiting List Action Plan on 25 February, which is the first year of a multi-annual reform programme to stabilise and reduce waiting lists and waiting times for scheduled care.

9.2.2 The Plan details how the DoH, the HSE and the National Treatment Purchase Fund (NTPF) aim to ensure that 1.7 million people are assessed/treated and removed from waiting lists in 2022. The allocation of €200m to the HSE and €150m to the NTPF aims reduce waiting lists by 18% percent this year which would bring the number of people waiting to their lowest point in five years.

9.2.3 In relation to governance arrangements, the Waiting List Taskforce continues to meet regularly co-chaired by the Secretary General and myself to oversee implementation of this Plan. The DoH, HSE and NTPF also meet regularly to progress the identified actions and I also Chair weekly meetings with HSE colleagues. Board updates on this key programme will continue to be provided via the Board Strategic Scorecard and more in-depth sessions as required.

9.3 NSP OPERATIONAL PLANS

9.3.1 Operational Plans to support implementation of NSP 2022 are currently being progressed and finalised. The HSE will continue to report on its performance in the delivery of the NSP 2022 through the existing DoH – HSE Performance Engagement arrangements. This will include submission of the monthly Board Strategic Scorecard and the Performance Profile and Management Data Report.

9.4 ANNUAL REPORT 2021

9.4.1 The preparation of the HSE's Annual Report is now reaching its final stages. This is consistent with the legislative requirement on the HSE to complete and adopt a report on the performance of the organisation's functions no later than 30 April each year.

9.4.2 The report is being prepared in the context of the continuing prevalence of COVID-19 during 2021, the roll-out of the vaccine programme, and the impact of the cyberattack. The draft Annual Report was reviewed by the P&D Committee at their meeting of 11 March and further drafts will be reviewed by EMT and the P&D Committee during April before being finally brought to the Board on 27 April for adoption and subsequent publication.

9.5 BOARD STRATEGIC SCORECARD

9.5.1 The January 2022 Scorecard (setting out the position for the proposed reporting arrangements for the full year 2022) was considered by the HSE Board at its February meeting and thereafter submitted to DoH and the Minister. The 22 areas within the Scorecard were chosen for their relevance to the National Service Plan 2022 and Corporate Plan 2021-2024. As noted above, the Scorecard forms a central element of Board reporting to the DoH and Minister. The HSE continues to actively work with the Department to refine the content of the Scorecard. The full suite of scorecards has been circulated separately for discussion at today's meeting.

9.6 ASSISTED DECISION MAKING (CAPACITY) ACT 2015

9.6.1 The Assisted Decision Making (Capacity) Act 2015 is due to commence in June 2022. This Act will have significant implications for health and social care providers in the provision of safe person-centred care, based on respecting the individual rights of each person. The HSE, through its National Office for Human Rights and Equality Policy, is providing strategic support, education and guidance to prepare for commencement. To take this forward, a number of strategic and operational working groups are in place. Guidance, documentation, training and information have been developed and are updated on a rolling basis.

9.7 NATIONAL CONSENT POLICY

The HSE's National Consent Policy 2022 will be launched at an online webinar on 28 March 2022. The revised policy has been updated to reflect key legal and policy documents which have been produced since 2013. The roll out of the policy will include an ongoing training and education programme to support front line staff. The supporting documentation will incorporate short plain English guides for staff, the public, for children and young people and an easy to read version of the policy. The policy will be updated when the Assisted Decision Making (Capacity) Act 2015 is fully commenced.

9.8 GLOBAL HEALTH PROGRAMME

The HSE's Global Health programme is working closely with the Department of Foreign Affairs and DoH on international engagement and continues to advise and support Government Departments to maintain a strategic collaboration with WHO and international partners. As outlined in the Board paper presented to today's meeting, the Global Health programme is coordinating HSE responses to provide support for COVID-19 services in low and middle-income countries (including HSE donations of equipment and surplus PPE). The Global Health programme has

established a transparent process to ensure donations meet humanitarian principles and adhere to HSE procedures and regulations.

Online technical assistance in quality improvement, mental well-being of COVID-19 health workers, and post-graduate medical training technical assistance continues to be provided to health services in Mozambique, Ethiopia and Zambia. Global health e-learning modules for health professionals are under development and collaborations on training and education projects with Forum of Post-Graduate Training Bodies continue.

9.9 RESPONDING TO THE UKRAINE CRISIS

9.9.1 In the context of the ongoing crisis in Ukraine, the HSE is focused on providing assistance to the people of Ukraine as well as our Ukrainian healthcare colleagues who are continuing to deliver front line care in the most arduous and tragic circumstances in the midst of a war. I chaired the first meeting of the HSE Ukrainian Humanitarian Oversight group on 1 March.

9.9.1 This Group will meet weekly and oversee all aspects to the HSE's response to the current crisis. A number of sub groups have also been established. The HSE Steering Group for Ukraine Donations has met on a number of occasions and continues to coordinate requests and donations.

9.9.2 The HSE Global Health Programme has been managing, advising and coordinating multiple aspects of our response this includes collaborations and coordination with government departments, HSE procurement, and with Irish NGOs. A considerable consignment of HSE donations are underway to assist Ukraine and surrounding countries. Some items considered initially for donation to Ukraine are now being redirected to meet the needs of people arriving in Ireland from Ukraine e.g. beds and bedding.

9.9.3 The HSE participates in weekly cross-departmental Senior Officials Group on the Ukraine. Preparations to send medical personnel to Ukraine, if needed, are also underway.

9.10 NATIONAL MATERNITY HOSPITAL

As Board members are aware, final drafts of the Legal Framework documents and Constitution for the NMH DAC were considered and approved by the Board at its special meeting on 14 March, following review by members of the Audit & Risk Committee.

Subsequent to the Board meeting, the Chair has written to the Minister advising him of the outcome of the Board's consideration. It is understood that this matter will be considered by Government in the coming days.

9.11 PROTECTED DISCLOSURES

9.11.1 The Protected Disclosures [Amendment] Bill 2022 was published in February and is expected to be enacted in the coming months.

9.11.2 Board members should note the 2022 Bill expands the definition of those who can make disclosures, the type of wrongdoings that can be disclosed and what is considered to be penalisation of those who make disclosures. It also sets out requirements for the channels by which disclosures can be made, together with timeframes for dealing with disclosures and the type of information that will have to be reported on. Of particular note is the introduction of criminal offences and penalties including fines and/ or imprisonment.

9.11.3 Of interest to the Board is the wider definition of *"worker"* in the Bill which includes new categories of worker such as an individual who is a member of the administrative, management or supervisory body of an undertaking, including non-executive members.

9.11.4 It is anticipated that the Bill, once enacted, will potentially increase the number of disclosures received by the HSE, and will place considerable additional obligations on the HSE in relation to how protected disclosures will need to be managed. In this context, arrangements to establish a national Protected Disclosures Office and Head of Protected Disclosures have been agreed by the EMT.

9.12 CYBER REVIEW

9.12.1 Work is ongoing to implement the recommendations in the Post Incident Review of the cyber-attack report. An EMT Oversight Group has been established, chaired by the CEO, which meets on a fortnightly basis. The P&D committee are also updated on an ongoing basis, most recently at their meeting 11 March 2022.

9.12.2 Key developments since the last Board meeting include:

(a) The near completion of work by PwC on the high-level planning exercise for the PIR Implementation. The plan will cover ICT/Cyber Transformation including both strategic and tactical actions, clinical and operational resilience transformation and programme management and governance.

(b) Sanction is currently being sought from the Department of Health to fill the permanent Chief Technology & Transformation Officer and Chief Information Strategy Officer roles and the relevant documentation has been submitted. The importance of progressing the sanction process has also been discussed with senior Department officials including the Secretary General.

(c) We propose to fill both of these key roles on an interim basis and a request for tender to support the IT/Cyber Transformation Programme was issued with a closing date of 22 March 2022. The interim Chief Technology & Transformation Officer will report to myself and sit on the EMT.

(d) The CIO is leading on implementation of many of the tactical recommendations set out in the post-incident review.

(e) Work has commenced on developing an investment case for implementing the overall programme with an aim to have this ready for discussion with the Department in advance of this year's Estimates process.

CHAPTER 10

Communications

10. COMMUNICATIONS

10.1 GENERAL UPDATE

10.1.1 Communications activity in relation to Covid 19 has risen significantly in the past fortnight in parallel with the rising hospitalisation and case numbers. We have been providing factual information and guidance to press on a very regular basis. Also, the number of calls to HSE Live was up 16% to 36,000 last week, while web traffic to Covid information rose 20%. This reflects growing case numbers and therefore a higher level of interest in information about related HSE services.

10.1.2 The communications team has this month set up a group to work specifically on promoting positive stories and news about work being done within the health service. Their mandate in particular is to publicise positive outcomes of service improvements provided for in the National Service Plan, including initiatives which have a positive impact on waiting lists for scheduled care. This team was set up a couple of weeks ago and we plan to report to future Board meetings on its work.

10.2 INTERNAL COMMUNICATIONS

10.2.1 This month we changed how we communicate to all staff via e mail. Up to now, staff have been receiving around two e mails each day giving information on everything from routine HR notices to service news to staff campaigns. Staff are now receiving a new publication, Health Service News, twice a week giving a well-designed newsletter type update on all relevant and timely issues. Feedback we received on the old system was that the volume of central e mails arriving in peoples inboxes meant they were more likely to be seen as less important, and the new format is intended to ensure greater staff engagement through improving the staff experience of the channel.

10.3 ADVERTISING

10.3.1 Our TV and radio ads encouraging people to stay at home when they have symptoms and get advice from hse.ie are continuing, reflecting the continuing concern about transmission in the community. The vaccination advertising campaign in relation to children aged 5 to 11, and the booster campaign for children aged 12 – 15, continues on broadcast and social media.

10.3.2 Work to improve the experience of people accessing COVID-19 and vaccination information in Irish on HSE.ie is nearing completion with final delivery end April.

CHAPTER 11

Concluding Remarks

How you can help stop the spread of COVID-19

STAY AT HOME:
If you have any symptoms of COVID-19 you should stay at home.

HAND HYGIENE:
Clean your hands regularly with soap and water or hand sanitiser.

MASKS:
Continue to wear a mask on public transport and in healthcare settings. Consider wearing a mask in crowded areas.

VENTILATION:
Let fresh air in if meeting indoors.

VACCINE:
Get a COVID-19 vaccine and booster dose.

11. CONCLUDING REMARKS

11.1 We have ambitious plans to improve our performance in scheduled care through 45 key actions. These are part of a twin track programme of investments aimed at significantly reducing the length of time that people are waiting to avail of treatment. We are making targeted investments with a view to getting more people treated as quickly as possible. At the same time, we are working to bridge the acknowledged gaps between demand and the available capacity. It will also be necessary for the foreseeable future to organise care so that COVID-19 infections or outbreaks, when they inevitably occur, will not derail progress.

11.2 We have made it clear in our recent public health messaging that there has been a significant increase in COVID-19 outbreaks across our hospitals and community facilities. Once again, we are asking people to 'go back to basics' by adopting a combination of the measures outlined in the above infographic - as appropriate to their circumstances and health status. It is unfortunately the case that reinfection is possible, because neither prior infection nor vaccination will provide full protection against the BA.2 variant. I conclude by thanking our staff and those we serve for their continued support and vigilance as we work together to restore services and clear backlogs as a matter of urgency.

Paul Reid
Chief Executive Officer