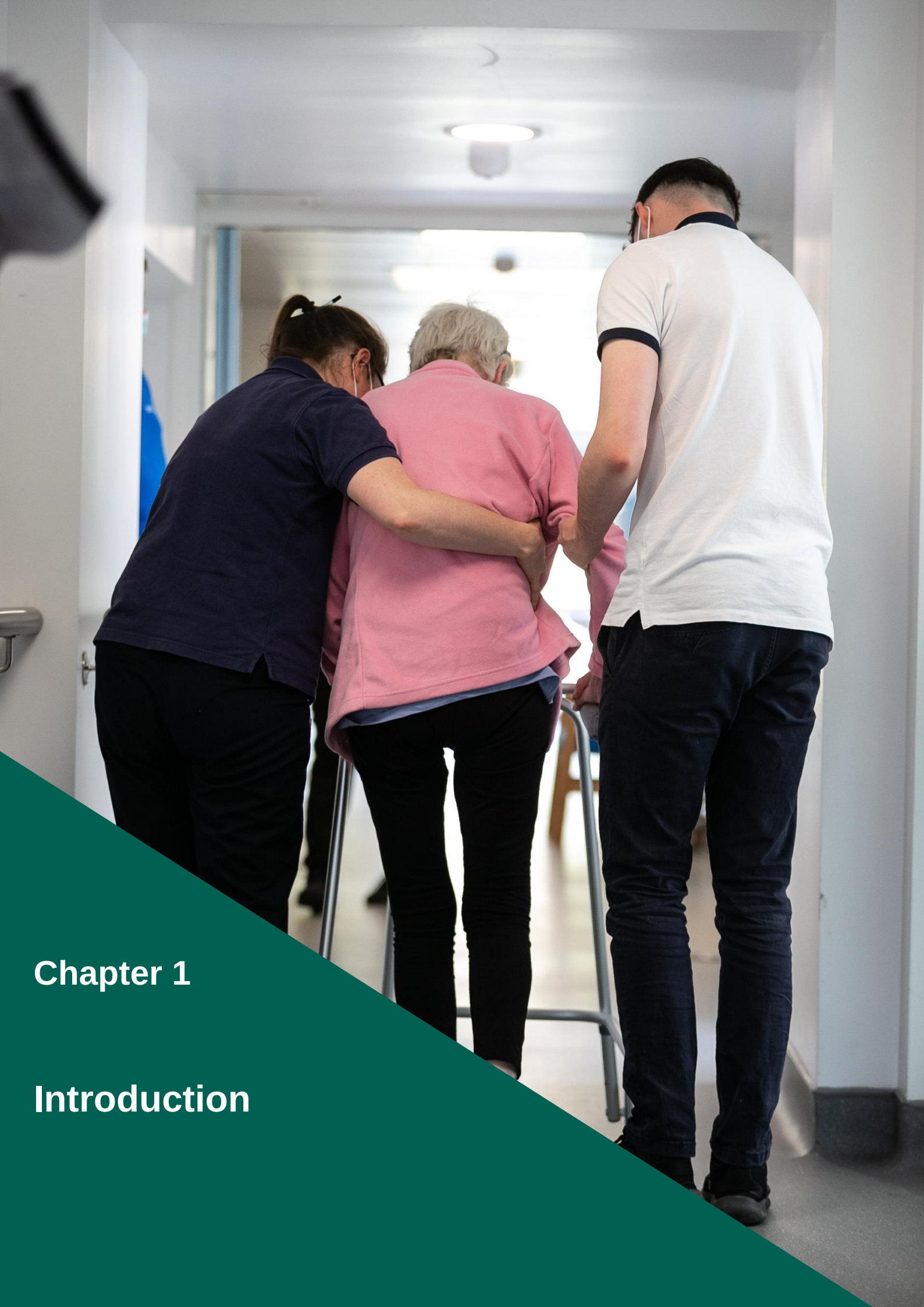
Health Service Executive
CEO's Report to the Board

27 MAY 2022



Chapter 1

Introduction

Step Challenge – encouraging HSE staff to walk more often.

1. INTRODUCTION

As COVID-19 reduces its impact with hospital numbers falling to the lowest level this year, coupled with greater numbers of staff returning to work, we have an opportunity to recalibrate and re-focus our attention and commitment to prioritised areas of work such as scheduled care and reductions in waiting lists.

The HSE has led a highly successful vaccination programme to date and is now embarking on the administration of the second booster dose for over 65s and immunocompromised, a targeted communications plan to improve uptake will be put in place.

Disability services remain an area of keen focus given the recent court judgement and subsequent media attention. Senior colleagues and I have had productive conversations with government to address the various concerns of all internal and external stakeholders. Disability services remain an area of particular challenge and will continue to receive our prioritised attention.

May sees the one-year anniversary of the cyber-attack which had a catastrophic impact on the HSE and hugely impacted the provision of many services. Immediate, urgent action was undertaken to further protect the HSE but a range of long-term actions are required to secure and protect the organisation.

Chapter 2

Governance

2. GOVERNANCE

2.1 UKRAINIAN CRISIS – IDENTIFICATION OF POTENTIAL SITES

The Department of Health has written to me to assess if there were any available properties in the HSE's portfolio that could or would be used to accommodate Ukrainian refugees, in the short, medium or long term.

A review of the HSE property database has been undertaken, of which a number of properties have been identified. Each of these properties will undergo a detailed and rigorous assessment, as to their suitability.

The HSE is totally willing to support, in any way possible, the refugees of this war.

Note: The enclosed paper on the HSE's overall response to the Ukrainian crisis summarises key issues arising and provides a snapshot of the current operational response and gives a brief description of active areas of work being undertaken under each workstream.

2.2 NATIONAL INPATIENT EXPERIENCE SURVEY 2021

Earlier this month, I attended the launch of the inpatient experience survey 2021 results, the first one to be completed during the pandemic. The 2022 survey commenced on 1st May, with eligible participants being contacted by post. The 2021 survey had 40 participating hospitals and 10,743 contributors, making it the largest survey of its kind in the country.

Results showed an 83% 'good' or 'very good' experience of patients' hospital care.

The impact of COVID was felt with patients expressing their appreciation but also missed visits from their loved ones.

Arising from this feedback and sharing such experiences of hospital care that we can continually improve patient experience and care.

2.3 CHIEF OPERATIONAL OFFICER REPLACEMENT

With the impending departure of our Chief Operations Officer, Anne O'Connor, a recruitment process has been agreed and will commence shortly.

In the interim I have appointed Mr Damien McCallion as the interim Chief Operations Officer, until the recruitment campaign has been completed.

Additionally, Ms Eileen Whelan, the Director of Nursing at Dublin's Midland Hospital Group, will be temporarily assigned to replace Damien in his current role, as National Director, Vaccination and Test and Trace Programmes.

2.4 HSE TRANSFER OF DISABILITY FUNCTIONS FROM DEPT OF HEALTH TO DCEDIY

The transfer of the Disability functions needs to be carefully managed so that the continuity of services are maintained to the greatest degree possible with the least additional administrative burden.

There are a number of critical outstanding issues remaining, which are likely to delay the date for transfer. The significant demands on the resources of the DCEDIY, DoH and the HSE in responding to the needs of Ukrainian people coming to Ireland presents additional workloads and on this basis we have asked the DoH and the DCEDIY to consider delaying this transfer to the 1 July 2022.

2.5 ASSESSMENT OF NEED (AON) WORKSHOP

Following Justice Phelan's High Court judgement, which stated that the Preliminary Team Assessment approach described in the HSE's SOP for AON, does not meet the obligations under the Disability Act (2005), a workshop was held by the National Clinical Programme for People with Disability (NCPPD) to develop new clinical guidance to support the AON process. .

Minister Rabbitte and I opened the workshop, which was attended by key stakeholders. We look forward to seeing and advancing the proposed interim guidance as this is an area currently encountering many challenges.

2.6 ONGOING MEETINGS WITH MINISTERS DONNELLY, RABBITTE, O'GORMAN AND BUTLER

Over the course of the month I have had regular engagements with a number of ministers in regard to;

- The transfer of disability services to DCEDIY.
- The Assessment of Need judgement and subsequent clinical workshop.
- Current Disability Services challenges.
- Emergency Department performance and overcrowding.

2.7 NATIONAL ADVOCACY SERVICE AWARD

The National Patient Safety Office in the Department of Health (DoH) has awarded the contract for the Patient Advocacy Service to the National Advocacy Service, running from October 2022 until October 2027.

The Patient Advocacy Service is an independent, free and confidential service that provides information and support to people who want to make a complaint about an experience they have had in a public acute hospital. In 2021, the

Patient Advocacy Service expanded its remit to include advocacy support for people in HSE-operated nursing homes.

2.8 DATA PROTECTION NOTIFICATION PROCESS – CYBER ATTACK

Since the cyber-attack in May 2021, the HSE has worked with An Garda Síochána as part of the criminal investigation into the attack.

Some information held on HSE computer systems was illegally accessed and copied. We immediately initiated a review of the data that was illegally accessed and copied, to allow us to notify individuals impacted.

The HSE continues to liaise with the Data Protection Commissioner and is working closely with An Garda Síochána and our cyber security advisors to manage this process and we hope to complete this necessary work shortly.

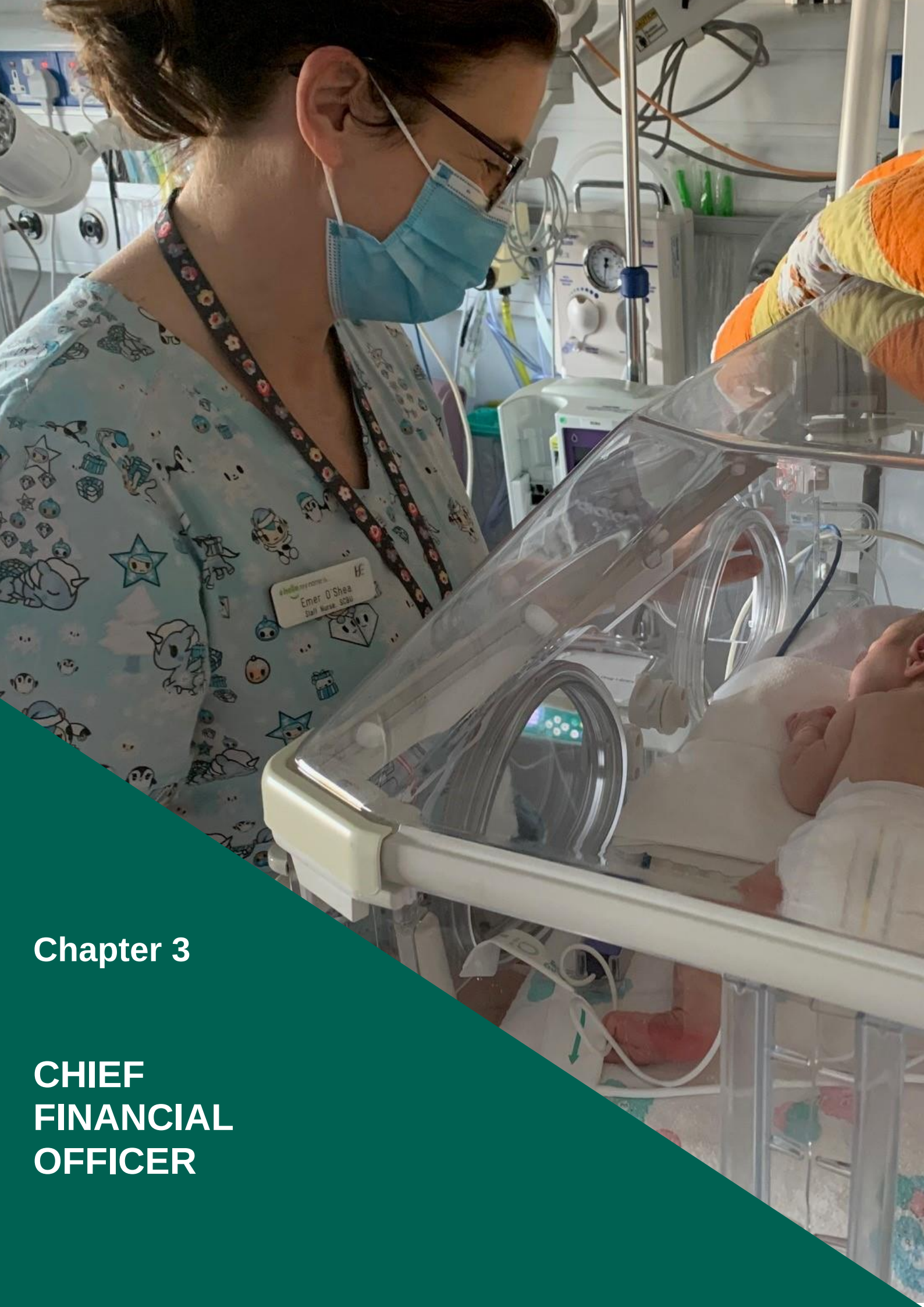
The HSE is taking every step necessary to minimise the impact of this data breach and to safeguard individuals' personal data against any potential future unauthorised activity.

Note: Attached is an appendix outlining this in greater detail.

2.9 THEATRE CAPACITY - NATIONAL PERIOPERATIVE PATIENT PATHWAY ENHANCEMENT PROGRAMME

A National Perioperative Patient Pathway Enhancement Programme is proposed as a collaboration between the HSE and the Royal College of Surgeons in Ireland.

It is planned to establish a high level Perioperative Patient Pathway Enhancement Programme Steering Group that will provide oversight and leadership for the continued roll out of the Theatre Transformation Programme and the implementation of local Perioperative Patient Enhancement Projects to deliver the programme objectives.



Chapter 3

CHIEF FINANCIAL OFFICER

3. CHIEF FINANCIAL OFFICER UPDATE

3.1 FINANCE UPDATE – MARCH YTD 2022, KEY MESSAGES

The draft revenue I&E financial position at the end of March 2022 shows an YTD deficit of €250.9m or 4.96%, with a significant element of this being driven by the direct impact of COVID-19, as reflected in the €224.1m adverse variance on the COVID-19 reported costs and €26.8m adverse variance on core (Non-COVID-19) related costs. However, from an overall perspective it is expected over the coming weeks and months, that our core (non COVID-19) activities will naturally increase and the impact of "delayed" care will also increase demand for core services.

Engagement on the 2022 costs of the HSE's COVID-19 responses is continuing with both the Departments of Health and Public Expenditure & Reform. Additionally, a second sanction request was submitted to the DoH on April 30th, which will allow the HSE to continue to operate within COVID-19 sanction to May 31st, 2022. This brings the total level of sanctioned expenditure requested to €877m or €380m over the €497m (excludes €200m Access to Care) allocated in the 2022 LoD for COVID-19 public health responses.

At the most recent meeting of the Health Budget Oversight Group (HBOG), the potential 2022 cost of COVID-19 responses was discussed at length, with particular focus on the 2022 outlook of Acute & Community specific COVID–19 responses. Particular emphasis was been placed on the requirement for the finalisation of an Operations led review of COVID-19 service responses in order that an overall outlook for COVID-19 costs can be made to Government for 2022, which will directly inform discussions around any supplementary estimate.

As previously indicated, it should be noted that current rates of expenditure on COVID-19 would indicate that even with a levelling in COVID-19 cases and hence costs as the year progresses, the cost of responding to COVID-19 in 2022 is likely to be significantly higher than the specific COVID-19 funding provided of €697m (including access to care funding of €200m).

Full year forecasts are currently underway, which is a bottom-up exercise based on first three month actuals (Jan-Mar 22), with substantial divisional oversight and engagement. This forecast will be used to inform and realign, if needed, the 2022 budget profile to year end. The consolidated full year I&E forecast will be available for circulation in May, with a full year cash forecast being prepared in line with the overall I&E forecast timeline.

The HSE Capital Plan has March YTD expenditure of €104.6m against a YTD budget profile of €139.2m leading to a positive variance against profile of

(€34.6m) or (24.9%). Included in the March YTD surplus of (€34.6m), is a YTD surplus in relation to acute capacity of (€11.5m) and the Children's Hospital of (€15.5m) (in addition to minor timing surpluses on other projects).

Based on cash utilisation to the end of March and requirements to the end of April, the HSE submitted a cash acceleration of €135m in April, in addition to the April cash profile. In addition, a further cash acceleration of €200m was submitted for May, based on expected service needs including cashing of the once-off pandemic payment. As stated in the February report this may indicate early upward stress on cash requirements and would indicate the risks which were flagged in the NSP 2022 were not overstated.

The HSE & DoH established "Financial Reporting Working Group" continues to work collaboratively to improve both financial and management reporting requirements and deliverables going forward.

3.2 YTD MARCH 2022 REVENUE INCOME & EXPENDITURE

In December 2021, Omicron, a fifth variant of concern which is significantly more contagious than the Delta variant was identified, which led to another surge in cases. Therefore, the first three months were exceptional months in terms of COVID-19 activity and expenditure, with high levels of hospital admissions relating to COVID-19 peaking at 1,624 acute admissions on 28th March, in addition to exceptionally high infection rates circulating in the community. However, April data shows the acute admissions starting to decline.

COVID-19: YTD costs of €566.9m against a budget of €342.8m leading to an adverse variance of €224.1m. Included in the COVID-19 costs of €566.9m, are the following:

- Testing & Tracing Programme costs of €225.6m
- COVID-19 Vaccination costs of €105.8m
- Private Hospitals costs of €39.5m
- Hospital and Community COVID-19 Responses of €196.0m (excl. Acutes Income deficit reported in core)
- **COVID-19 Expenditure Sanction Requests**: Based on the current HSE assessment of COVID-19 costs, which are indicating a higher range cost response to date, additional sanction requests totaling €380m have been submitted to the DoH, in order to allow the HSE to continue to operate within COVID-19 sanction to the end of May 31st 2022. A further additional sanction request will be being made in due course once a clearer path on the pandemic response and associated costs is known for 2022.

Core: YTD costs of €4,741m against a budget of €4,714m leading to an adverse variance of €26.8m, which comprised of the following:

- **Private Income**: YTD deficit of €32.8m which is mainly attributed to COVID-19 factors. Patients are exempted from charges if they have a COVID-19 diagnosis during the hospital stay. The impact of the pandemic on patient numbers, which increased considerably in March and peaking at 1,624 on 28th March means that private patient billing continued to be challenging in March.
- **Pay Deficits**: YTD deficit in Acutes' Pay of €19.0m which is mainly related to increased agency and overtime due to staff sick-leave and the unfunded FEMPI restoration of premia payments.
- **Non Pay Deficits:** Acutes and Primary Care are experiencing non-pay deficits which are mainly related to deficits across clinical costs and non-pay inflation is also emerging as a cost driver across a range of non-pay categories, primarily energy costs.
- **Disability Services**: As flagged in the NSP, there is financial pressures within Disability Services in relation to residential places and emergency cases in 2022, which are manifesting in a YTD deficit of €4.5m.
- **Community Surpluses**: The surplus in older persons of (€9.5m) is primarily related to home support and the mental health surplus of (€5.8m) is mainly due to time related savings arising from unfilled development posts. The surplus on the NHSS of (€6.7m) is activity related with the numbers supported being below NSP levels.
- **Pension & Demand Led Services**: A YTD surplus of (€20.0m) is mainly driven by a surplus in the SCA of (€27.1m). Expenditure in these areas is driven primarily by eligibility, legislation, policy, demographic and economic factors, and accordingly, it is not amenable to normal management controls in terms of seeking to limit costs to a specific budget limit given the statutory and policy basis for the various schemes.

It should be noted that a total of €697.0m has been provided in the 2022 NSP, on a once off basis for COVID-19 responses, of which €342.9m budget has been profiled YTD March 2022.

The €697m comprises:

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

There has been a significant level of important COVID-19 responses which have been put in place across our Hospital and Community Services, based on public health and infection prevention and control guidance, which are significant in operational scale and cost. Therefore, a clinically guided and operational led review is underway to determine which COVID-19 costs need to be retained during 2022.

In terms of the cost of responding to COVID-19, costs may be categorised as per below. The exercise to review and categorise the March YTD has now been compiled, with further analysis ongoing.

- 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

3.3 OUTLOOK FOR 2022

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.

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

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

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

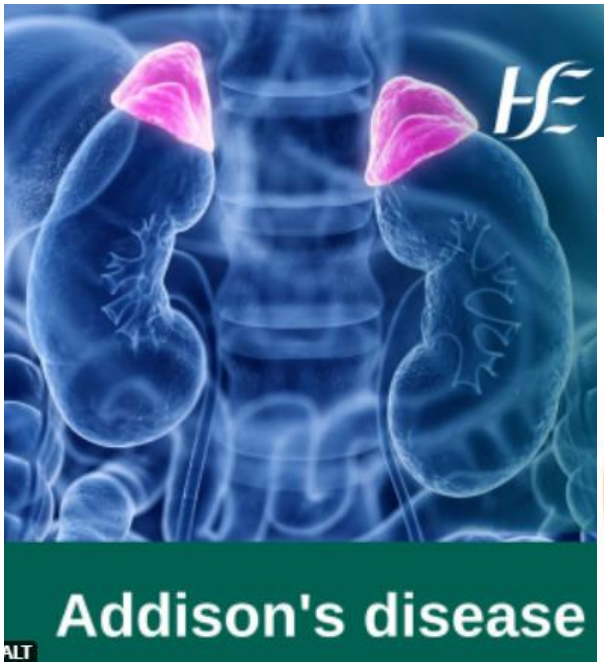
The NSP also flags the overall 2022 normal financial risk to be managed within our core operational service areas i.e. separate to pension and demand led areas, in the following areas:

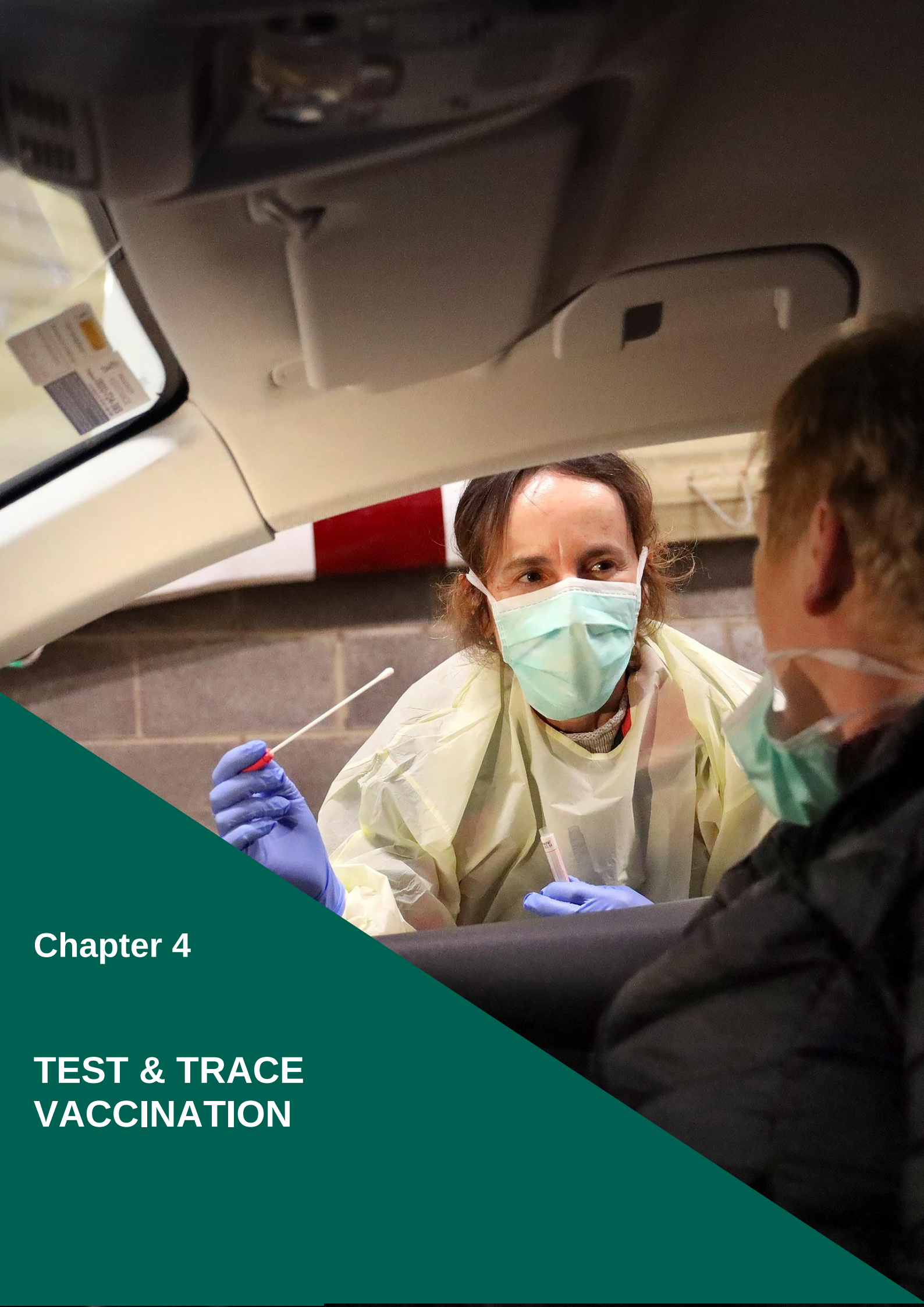
- Acute Operations (including NAS)
- Community Operations (primarily Disability Services related to residential places and emergency cases)
- Support services

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 in May. This forecast will be a bottom-up forecast with substantial divisional oversight.

There is significant analysis and information required before a "likely" year-end position can be determined as part of this process. Through this oversight any ranges initially specified can then be narrowed and a "likely" year-end position determined closer to year end. In the context of COVID-19, there will be significant complexity and uncertainty involved in forecasting around same, so any forecasts that we produce, will have risks attached compared to our normal level of projection.

These forecasts will be closely monitored with DoH colleagues and we will monitor these risks with DOH and DPER via the monthly HBOG meetings.





Chapter 4

TEST & TRACE VACCINATION

4. TEST AND TRACE / VACCINATION UPDATE

4.1 FUTURE OPERATION MODEL - TEST AND TRACING

Test and Trace is currently in Phase 1 of the transition plan to move from the current mass testing model to a surveillance-led model with a GP clinical pathway.

Demand and activity continue to reduce in line with public health testing advice and decreasing disease prevalence. The gradual scaling back of Test and Trace services is continuing in a planned manner, whilst also ensuring resilience within core systems and an ability to ramp up quickly should this be required.

The key risks associated with the scale-down of the Test and Trace programme include the attrition of staff and subsequent knowledge loss of a skilled workforce and key contracted providers.

Several key financial and operational priorities have been identified that will ensure the successful transition from the current mass testing model to the future model and these are currently being reviewed with relevant stakeholders.

Trends - the key test and trace indicators over the last week (9/5 -15/5) show a downward trend, as follows;

- Community referrals have decreased by 14.3% compared to the previous week with 9,744 community referrals, while community positivity is 41.5%.
- GP referrals have decreased by 18.6% compared to the previous week with 892 GP referrals.
- Community swabs undertaken have decreased by 21% compared to the previous week with 17,641 swabs.
- Laboratory tests have decreased by 13.8% compared to the previous week. 35,755 laboratory PCR tests were undertaken over the last 7 days versus 41,490 in the previous week.
- Overall, antigen test kits booked have decreased by 38.3% in comparison to the previous week with 13,996* test kits booked over the last 7 days versus 22,699 in the previous week.
- 5,066 people were notified of their detected Covid-19 test result in the last 7 days, a 7.7% decrease on last week. Of the cases who identified one or more close contacts, the average number of close contacts was 1.2.

Performance - Median end-to-end TAT for a not-detected result in the Community at 1.1 day and for a detected result in the Community at 1.1 days.

Initiatives – outlined as follows;

- Serial Testing in Nursing Homes continues and remains under regular review
- Since the launch of the antigen portal on Friday the 14th of January 2022, a total of 514,146 positive antigen results have been reported.
- In total, there have been over 3,466,103 Antigen Test Kits dispatched and distributed for all our programmes.

**the antigen data is for the period 09/05 – 15/05*.

Test and Trace Strategy - As COVID-19 moves from pandemic to endemic status, the HSE has developed a transition plan to move from a mass testing model to a surveillance-led and GP clinical future model. Separately, an interim emergency pandemic test and trace plan is being developed to prepare for the emergence of a new variant of concern that would result in increased morbidity or mortality, or the emergence of a new viral pathogen.

The gradual and phased approach to transition from the current Test and Trace operating model to the future state model will see a substantial shift in operations in line with Public Health Guidance, while maintaining an ability to respond and this will require significant investment. There is a clear and immediate requirement to invest in the Test and Trace function to ensure resilience for the future, this includes both long term investment costs and re-occurring costs. For instance, these include:

- €10m investment in the National Virus Reference Lab (NVRL)
- €10m - €11m investment in the National Ambulance Service (NAS) to help provide rapid response to a surge next winter
- €40.8m to maintain community test centres through the Transition Phases
- €36.8m to retain a core team and estates within the Contact Management Programme (CMP) to provide support to Department of Public Health and to the HPSC
- €4.5m to retain a core National Operations Management and Support team.

Immediate investment decisions are needed to ensure that as many elements are in place as possible by August 2022 to minimise risk, reduce costs and ensure the State has a level of readiness.

Transition Plan Update - The plan is structured to enable a risk appropriate reduction in the mass testing programme for COVID-19 as the disease moves to an endemic state. It assumes;

- a move from mass testing centres, to a GP testing model and enhanced surveillance systems on the basis of a lower demand for testing and in keeping with a reduction in disease prevalence/morbidity (it is important to

note that there are no models currently available to support epidemiological forecasting)

- a target testing capacity of c.42k– 49k PCR per week, with the potential to surge to 80k PCR per week (includes community and acute hospital testing). Any additional requirements will have to be met through activating an emergency pandemic test and trace plan.

The Transition Plan is phased as follows:

- Phase 1 – Mass Testing (March 2022 to May 2022)
- Phase 2 – Migrate to Reduced Testing Model (June to July 2022)
- Phase 3 - Surveillance Model (August 2022 onwards)

The move from reduced test centres in Primary Care will cease when a GP contract is agreed and an operational system is put in place to ensure GPs can access COVID testing for either therapeutic or clinical requirements and the HSE has the resources in place to have a surge plan. The target for this, subject to the above is towards the end-August.

We plan to reduce from a workforce of 1,800 WTEs (1st May 2022) to a workforce of 509 WTEs by August 2022. A layer of resilience will also be maintained through the transition to ensure available resources in the event of a surge.

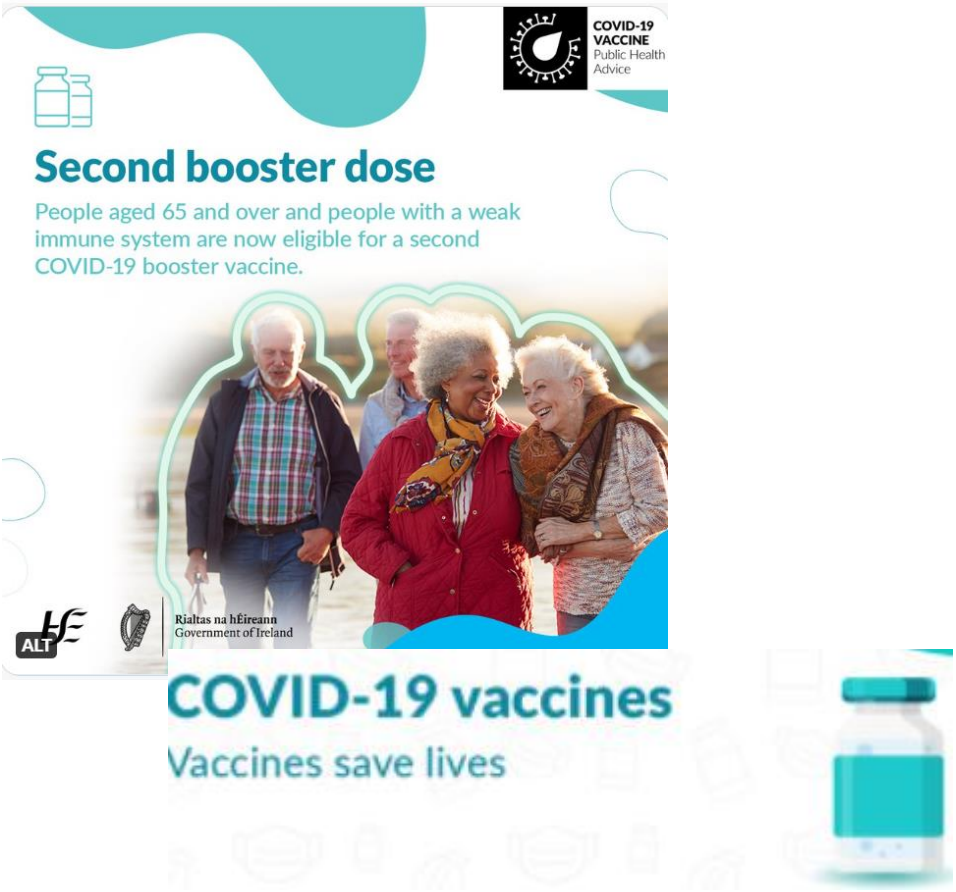
Surge Response within the GP Led Model - A surge response model will be required as part of the GP pathway in winter 2022/ 23. This response will be triggered by an agreed set of early warning criteria such as a surge in the disease in the community or pressure on GP capacity. The National Ambulance Service (NAS) will provide the first line of response to a surge with up to 200 WTEs providing c.25,000 swabs per week at pre-agreed site locations around the country. If demand increases further, NAS can be supplemented by private providers to reach capacity of 45,000 swabs per week. In addition, there will be the activation of additional laboratory capacity with key partners to accommodate the increased testing demand.

Emergency Response Plan - This plan will be triggered if a new variant of concern or a viral pathogen emerges that is a risk to population health with high morbidity and mortality arising from infection. The emergency plan is intended as a whole-of-government response and would involve a ramp up of the Test and Trace system to manage high levels of mass testing. This would involve a full rollout of testing centres across the country and a contact tracing model. It is estimated that the cost for a 12-week emergency response at full capacity would cost approximately €105m to €115m. Up to 100,000 PCR tests

per week can be achieved by week 3 and up to 150,000 PCR tests per week by week 8, if required.

Summary - The future model will be a significant shift from the current model whereby testing for COVID-19 is delivered by a GP led pathway, underpinned by a comprehensive surveillance model to support the monitoring of incidence and severity of the disease. The Test and Trace function is starting to transition towards the surveillance-led and GP clinical future model.

Currently, we are focused on reducing the current testing and tracing infrastructure in line with reduced demand on services and changes to the eligibility criteria for testing. This includes moving to lower volume testing centres, reducing the overall test and trace workforce and preparing operations for a move to the future model. Immediate investment decisions are needed to ensure that as many elements are in place as possible by August to minimise risk, reduce costs and ensure the State has a level of readiness for any potential resurgence of the disease.



4.2 VACCINATION STRATEGIC UPDATE

Strategic Update - The COVID-19 Vaccination programme remains underway with the Primary & first Booster programme having delivered high overall uptake to date (Primary uptake of ca. 96.6% and first Booster Uptake of 76.6%) placing

Ireland amongst top performing EU countries. Despite this generally high uptake, Booster programme uptake remains lower in younger age groups (ca. 57.6% uptake for the 18-39 group and 63.3% in the 18-49 group). An estimated 889k of the 12+ population remaining eligible for first Booster vaccination including ca. 77k who are currently ineligible due to having had COVID in the last 3 months (or 6 months for those aged 12 to 15).
Continued focus will remain on uptake improvement initiatives for this group which has most recently included direct engagement via HSE live to the Immunocompromised and other target groups yet to receive a first Booster, continuing access to vaccine administration locations (i.e. VCs, GPs etc.) with greater accessibility provided through self-scheduling option clinics in VCs.

The second booster programme was launched on 22 April for over 65 year olds and over 12 year olds Immunocompromised and has administered ca. 158k to date and is being rolled out in the context of operationalising the future long term operating model for COVID-19 vaccination.

Future Sustainable Model - The continued uncertainty around future COVID-19 vaccination requirements has seen the Long Term Sustainable Operating Model developed, based on a number of assumptions as part of scenario planning (e.g. timing, population scope, vaccination type, age cohort use and delivery allowing critical services in primary and acute care to operate). The resulting recommended model will be primary care led with GPs and Pharmacies delivering a significant proportion of vaccines with the balance delivered directly through Vaccination Centres. This proximity led model will remove a potential barrier to high uptake and moves cost to "pay as you go" for the programme and is similar to the approach used nationally for seasonal influenza.

Activity to operationalise this future sustainable model is ongoing with all programme workstreams defining their programme of work for the summer period but all with a key dependency for implementation being the receipt of early NIAC guidance that clarifies the scope, scale and nature of the assumed Autumn Programme.
Detailed costings have been prepared to confirm the financial priorities and investment required for the vaccination programme in 2022 and into 2023 and these are the subject of ongoing engagement with DOH & DPER.

Summary - The COVID-19 Vaccination programme will shortly begin administration of the second Booster dose to eligible people that will increase the complexity of the programme which is currently seeking to transition to the new sustainable operating model. To enable this transition, immediate

mobilisation is required to enable key deliverables of Flu Alignment, GP and Pharmacy Negotiations, Facility and Workforce Management, ICT Delivery, and Core team migration along with the investment decisions required for each. Detailed costings have been prepared to confirm the financial priorities and investment required for the vaccination programme in 2022 and into 2023.

4.3 VACCINATION OPERATIONAL UPDATE

Future Sustainable Long-Term Model for COVID-19 Vaccination - The Model for COVID-19 vaccination will be primary care led with GPs and Pharmacies delivering a significant proportion of vaccines with the balance delivered directly through Vaccination Centres.

Immediate mobilisation is required in order to ensure this programme is operationalised in a timely manner and can be successfully delivered within the required timeframe. Key deliverables at this time include Flu Alignment, GP and Pharmacy Negotiations, Facility and Workforce Management, ICT Delivery, and Core team migration.

Planning for the Autumn programme is ongoing which incorporates all of these elements but with a key dependency on early NIAC guidance that provides direction on the nature, scope and scale of the assumed Autumn programme.

The estimated budget to run the Vaccination Programme for this year is €550-€600m and work will continue with DOH to approve full sanction for all vaccination costs committed and expected to be incurred in 2022.

Plans are in development for an emergency scenario where there may be a need to suddenly and rapidly deliver a vaccine (existing or a new vaccine which targets a variant of concern) to the whole population within a short timeframe. There are a number of assumptions which underpin this model and factors such as workforce, governance and capacity, all of which are being taken into consideration.

Communications and Uptake Improvement Group - A number of initiatives have been put in place over the course of the Primary and first Booster to drive demand and thereby minimise the volume of stock that will expire and increase the overall protection from the virus in the population.

- High level of public communications and advertising.
- HSE Live has begun proactively calling the Immunocompromised cohort who have yet to receive their first Booster dose. If successful, this programme can be expanded to other cohorts.
- Continuance of access to first Booster doses through CVCs and pharmacies. CVCs will operate during hours that ensure accessibility to the public though self-scheduling and weekend clinics.

- SMS campaign to notify those eligible for a first Booster 3 months' post COVID-19 infection.

Research was undertaken on parents of 5-11 year olds to understand current attitudes toward vaccination. In summary;

- There was a general consensus that the perceived risk of COVID-19 has waned
- Parents are willing to risk their children getting COVID-19 in the short term when faced with the (unsubstantiated) safety concerns or long term effects of the vaccine
- Parents feel uncomfortable with the responsibility of vaccination and are adopting a 'wait and see' approach
- Parents would prefer if the child vaccination was available in schools or GPs and Pharmacies.

In response to the findings of this research, reinvigoration of the 5-11s primary programme through GPs and Pharmacies in August, ahead of the return to schools is being considered.

The HSE Communications team is also working on arranging interviews with a number of clinical spokespeople to promote the second booster.

Vaccine Supply - There is a large volume (3.6m) of vaccine stock in UD that is set to expire from June to May 2023 with incoming deliveries also at risk to expire

Manufacturer	June	July	August	September	October	November	May 23	Total
Pfizer >12	-	-	-	18	785,328	1,220,310		2,005,656
Pfizer 5-11s	-	-	-	135,900	330,000	115,200		581,100
moderna	63,800	211,200	106,000	70,100	296,400	44,400		791,900
novavax		82,900	114,000					196,900
janssen							25,840	25,840
Totals	63,800	294,100	220,000	206,018	1,411,728	1,379,910	25,840	3,601,396

if not administered, diverted or donated. Outlined below is the expiration profile through May 2023.

NIAC has advised that the domestic vaccination programme must retain the capacity and agility to effectively react immediately to any revised advice from the NIAC this year (including a possible emergency 'whole of population' vaccination scenario in the event of a new variant/waning immunity).

If such an emergency scenario does not come to pass, a significant volume of stock is at risk of expiry over the next number of months with incoming deliveries

(c. 6m of Pfizer/Moderna) also at risk to expire if not administered, diverted or donated. There currently is 3.6 million of vaccine stock in United Drug that is set to expire from June to May 2023.

A vaccine stock strategy has been agreed with the Department with regular meetings that will continue in order to review this strategy. This involves the Department (and all EU member states) continuously looking at any available options for deferral, re-phasing or donation. However, there is a significant global supply and demand imbalance at present with little demand for excess COVID vaccines globally.

Currently, there is limited demand for donations due to lower uptake & absorption challenges in developing countries (i.e. GAVI & bilateral offers of donations being declined until at least Q3/Q4).

There remains a number of uncertainties surrounding vaccine stock management, including:

- Emerging variants with higher transmissibility and/or severity.
- Low uptake in any future COVID-19 vaccination programme.
- Potential emergence of new vaccines more effective on potential new variants of the disease.

All EU members are encountering issues with regard to all excess supply and insufficient demand with the EU itself currently working on a potential plan to defer vaccines.

Discussions concluded last week in relation to the potential donation of vaccines to Kenya. Due to a number of uncertainties in relation to demand in Kenya, they have declined the donation at this time.

Supply Forecast Outlook - Overview of Authorised Vaccines Supplies for Quarter 1 2022 – Quarter 4 2022 (In Millions).

Vaccine	April 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Total
Pfizer	895,050	275,843	209,750	603,196	609,731	598,088	192,308	153,846	153,846	**3,691,658**
Pfizer Paediatric	30,769	38,462	30,769	-	-	-	-	-	-	**100,000**
Moderna	338,462	423,077	338,462	184,615	230,769	184,615	230,769	184,615	184,615	**2,300,000**
Total	**1,264,281**	**737,381**	**578,981**	**787,811**	**840,500**	**782,703**	**423,077**	**338,462**	**338,462**	**6,091,658**

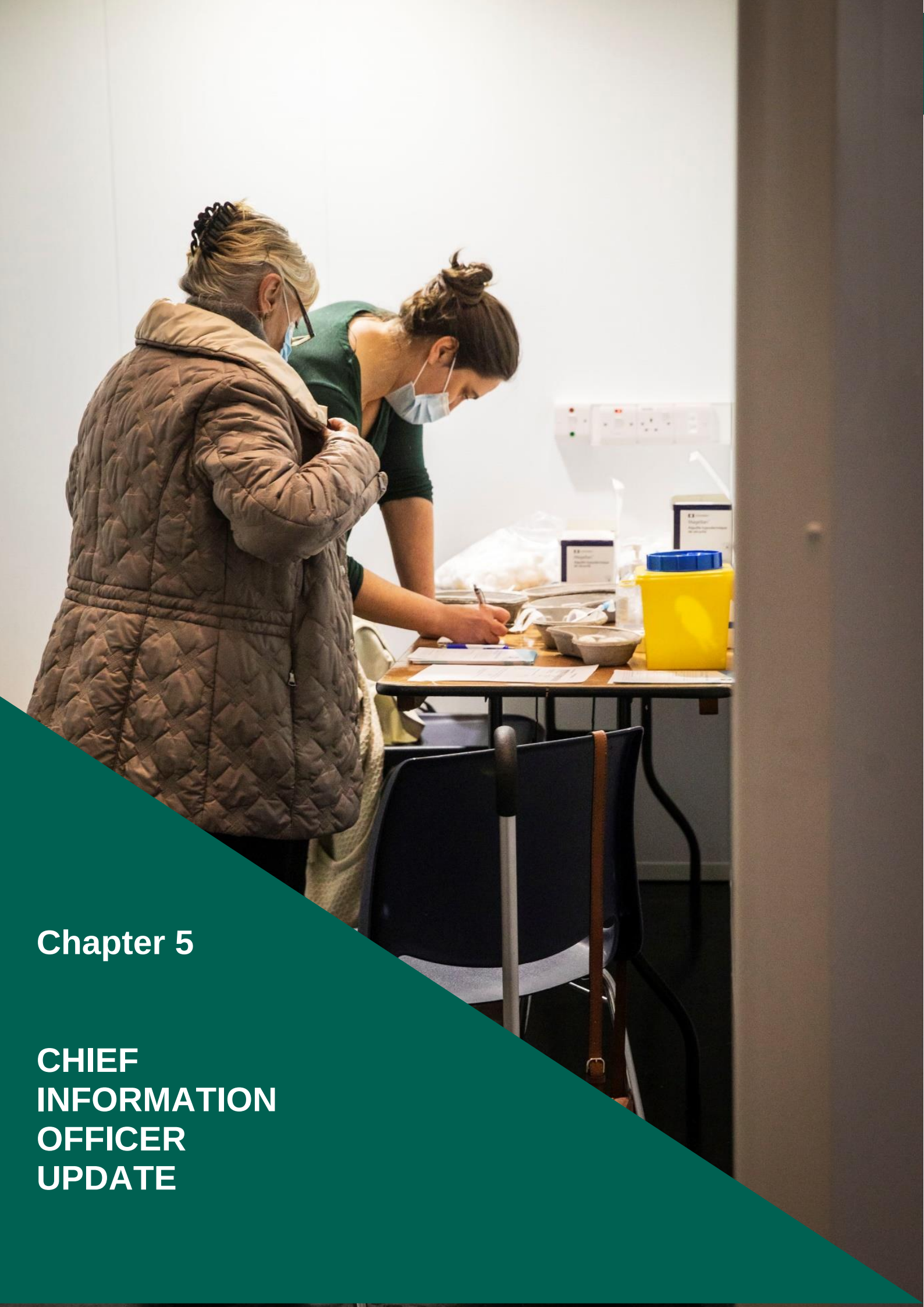
Please note that the table represents delivery commitments and may be subject to change (e.g. with regard to future donations/revised delivery schedules). The table also includes the rephrasing of 1.3m Pfizer doses from May and June to July, August and September.

The stock level above excludes AstraZeneca (AZ) as Ireland, like other EU countries, is not accepting AZ in-country (as CION/GAVI exhausted all donation avenues, incl. offers to >40 countries) and stock is managed at source with significant wastage.

The HSE and DOH are monitoring the position of stock levels and likely expiry and exploring options for the re-phasing of Moderna vaccinations. Whilst recent NIAC guidance will utilise stock levels in May and June, there is still a risk of significant volumes of stock expiry.

As part of EU contracts, we have committed to spend c. €212 million on current generation vaccines this year, with an estimated (up to) ~€50m additional funding needed should multivalent vaccine be approved before any winter programme (& if it is recommended as the core vaccine to underpin that programme).

The risk of wastage increases with the introduction of any multi-variant vaccine, as they may render current generation vaccines obsolete.



Chapter 5

CHIEF INFORMATION OFFICER UPDATE

5. CHIEF INFORMATION OFFICER UPDATE

5.1 GENERAL UPDATE

Overall eHealth Programmes. In 2022, 49 programmes of work are receiving funding under the eHealth Capital Plan and National Service Plan. These programmes are currently made up of 866 individual projects in various project stages, each underpinned by project plans and governed by project boards 34 of those programmes (69%) are proceeding to target (Green status), with the remaining 17 programmes in Red or Amber status.

Cyber Security. Interim arrangements have been established with 24/7 enhanced cyber security operations monitoring in place through three external partner companies: Microsoft, Mandiant, and Caveo. Tactical Security Improvement plan has delivered significant additional measures to protect the technology environment.

IHI Integration into Core Systems. Development work is now completed on iPMS "seeding" requirements with IHI and Eircode. User acceptance testing is well advanced. Go live for Letterkenny UH is on target for June.

Upgrade of National Integrated Medical Imaging System. Go-Live date for NIMIS 2.0 approved by NIMIS Programme Board (June 18/19) and communicated to NIMIS Sites. The Go-Live plan has been agreed with the Vendor. A period of intensive site engagement has commenced. Work to develop a full Data Protection Impact Assessment (DPIA) is well advanced. 80% of workstation devices have been replaced (on target).

Integrated Community Care Management System (ICCMS). ICCMS programme has concluded all selected vendor demonstrations, as part of structured market soundings process. Analysis of participant surveys is underway. Full business case development has commenced. Lessons Learned workshop and International Research have been completed.

Scheduled Care eEnablers. eEnablers have been assigned to Scheduled Care Workstream 4: Patient Centred Booking Arrangements (PCBA); business case procurement expected to commence in Q3. Scheduled Care Dashboard work in progress at an advanced stage; dashboard is live and has issued to HG CEOs.

2021 NSP Staffing. Recruitment is underway across all programmes that were not filled by the end of 2021. As of the end of April, 58% of targeted roles were in place (249 of 429). This is a net increase of 16 WTEs from March.

2022 NSP Staffing. Recruitment is also moving forward for 2022 NSP roles, with campaigns underway. As of end of April, 6 of the additional 158 targeted roles had been onboarded 4%.

5.2 eHEALTH PROGRAMME SUMMARY

49 Total Capital Programmes

0 Completed Programmes

32 Programmes in Delivery Stage

6 Programmes in Procurement Stage

9 Programmes in Proposal Stage

2 Programmes in Pre-Mandate Stage

eHealth National Service Plan Programmes				Project Count Within Programme (Capital Funded)					
Category	Programme	Programme Stage	RAG Status	TOTAL	0. Pre-Mandate	1. Proposal	2. Procurement	3. Delivery	4. Completed
1. Foundational Infrastructure & Cyber Technology	1.1 Network & Communications Technologies	3. Delivery	Green	174		10	43	67	54
	1.2 Refresh Current Technology & Devices	3. Delivery	Green	154		16	14	69	55
	1.3 Single Identity	3. Delivery	Green	5		2	1	1	1
	1.4 Data Centre & Cloud Services	3. Delivery	Green	44		3	9	16	16
	1.5 Healthlink Cloud Migration	3. Delivery	Amber	0					
	1.6 Cyber Security Technology	3. Delivery	Green	26		5	6	7	8
	1.7 New Technology	3. Delivery	Green	19		4	3	10	2
	1.8 IHI Infrastructure Refresh & Migration	3. Delivery	Amber	1					1
	Subtotal			423	0	40	76	170	137
2. National Programmes	2.1 IHI Integration - Sustain Consumer Systems	3. Delivery	Green	6		3	3		0
	2.2 Integration and Interoperability	3. Delivery	Amber	4		2	2		0
	2.3 Acute Floor Solution	3. Delivery	Red	3		1	1		1
	2.4 Critical Care ICT	3. Delivery	Amber	16		3	2	9	2
	2.5 Maternity and Newborn (MN-CMS)	3. Delivery	Green	26		1	5	11	9
	2.6 Medical Laboratories	3. Delivery	Red	9		3		4	2
	2.7 National Cancer Information System	3. Delivery	Amber	13			1	6	6
	2.8 National Electronic Blood Track	3. Delivery	Green	6		1		4	1
	2.9 Medical Imaging (NIMIS & others)	3. Delivery	Green	19		1	7	5	6
	2.10 CHI ICT	3. Delivery	Red	44		8	21	5	10
	2.11 CHI EHR	1. Proposal	Red	1		1			0
	2.12 CHI Crumlin-Temple St	3. Delivery	Green	12		1	7	2	2
	2.13 PAS iPMS	3. Delivery	Green	19		4	4	4	7
	2.14 ePharmacy	2. Procurement	Green	6		1	1	2	2
	2.15 EU Open NCP-SCR	3. Delivery	Green	7		2	2	1	2
	2.16 Chronic Disease Management (CDM)	3. Delivery	Amber	2				2	0
	2.17 National Forensic Hospital	2. Procurement	Green	2			1		1
	2.18 National Rehab Hospital	2. Procurement	Green	1				1	0
	2.19 interRAI Assessment Tool	3. Delivery	Green	2				1	1
	2.20 National Nursing Homes Support Scheme Replacement	1. Proposal	Green	3		1	1	1	0
	2.21 Small Solutions	3. Delivery	Green	162		66	18	43	35
	2.22 Nurse Task Force Management - Safe Nursing	3. Delivery	Green	1				1	0
	2.23 Integrated Financial Management	3. Delivery	Red	19		2	6	10	1
	2.24 National Estates System	3. Delivery	Green	2			1	1	0
	2.25 National Integrated Staff Records	3. Delivery	Amber	7		1	2	2	2
	2.26 National Single Sign-on Solution	3. Delivery	Green	2		1	1		0
	Subtotal			394	0	103	86	115	90
3. HSE Transformation Priorities	3.1 Scheduled Care eEnablers	1. Proposal	Green	7		5		1	1
	3.2 Shared Care Record	1. Proposal	Green	5		1		2	2
	3.3 Integrated Community Case Management	1. Proposal	Green	3		3			0
	3.4 Telehealth	3. Delivery	Green	11		1	2	4	4
	3.5 Endoscopy	1. Proposal	Green	0					
	3.6 Cardiology	Pre-Mandate	Green	1					1
	3.7 SSW Inpatient Journey Solution	2. Procurement	Green	1			1		0
	3.8 Order Comms	2. Procurement	Red	2			2		0
	3.9 ePrescribing & NMPC	1. Proposal	Green	3		2	1		0
	3.10 Infectious Disease Register (CIDR)	Pre-Mandate	Green	0					
	3.11 Citizen Portal	3. Delivery	Amber	2				1	1
	3.12 Immunisation	2. Procurement	Green	9		2		3	4
	3.13 Home Support Management System	1. Proposal	Green	1		1			0
	3.14 Residential Care Management System	1. Proposal	Green	2		1	1		0
	3.15 Health Performance and Visualisation Platform	3. Delivery	Amber	2		1		1	0
	Subtotal			49	0	17	7	12	13
TOTAL eHEALTH				866	0	160	169	297	240

- Green status – 34 of 39 programmes are on track with minimal risks (+2 from April)
- Amber status – 9 programmes at Amber status (-5 from April)
- Red status – 6 programmes at Red status (+3 from April)

Chapter 6

CHIEF OPERATIONS OFFICER UPDATE

6. CHIEF OPERATIONS OFFICER UPDATE

6.1 BED CENSUS UPDATE

98% of site visits have been completed. The remaining site left to complete is Kilcreene Hospital, Kilkenny. 100% of the data collected has been uploaded to the Hospital Bed Management System (HBMS). This system has been developed in collaboration with HSE stakeholder inputs.

An audit of all data available within the HBMS application has been completed. The purpose of this audit was to compare the data on the system against the raw data collected on site visits.

The provisional number of beds within the system is detailed below. This data includes the number of open beds at the time of each site visit and is unverified as the system has yet to be rolled out to each site.

Site Name	Day Bed	Inpatient	Treatment Place
Bantry General Hospital	15	62	0
Beaumont Hospital	135	658	0
CHI at Crumlin	43	164	0
CHI at Tallaght	8	41	0
CHI at Temple St	23	93	0
Cavan General Hospital	46	217	13
Connolly Hospital	25	292	17
Coombe Women and Infants University Hospital	22	155	11
Cork University Hospital	8	622	35
Cork University Maternity Hospital	7	183	14
Croom Orthopaedic Hospital	12	44	5
Ennis Hospital	12	50	24
Galway University Hospital	91	680	1
Letterkenny University Hospital	20	363	26
Louth County Hospital	19	61	4
MRH Mullingar	24	194	15
MRH Portlaoise	13	130	6
MRH Tullamore	32	210	39
Mallow General Hospital	18	37	14
Mater Misericordiae University Hospital	201	646	0
Mayo University Hospital	31	246	18
Mercy University Hospital	46	189	29
Monaghan Hospital	17	47	0
Naas General Hospital	11	181	17

National Maternity Hospital	8	148	17
National Orthopaedic Hospital Cappagh	35	92	0
National Rehabilitation Hospital	9	113	0
Nenagh Hospital	6	42	35
Our Lady of Lourdes Hospital	34	402	19
Our Lady's Hospital Navan	23	99	4
Portiuncula University Hospital	30	144	9
Roscommon University Hospital	39	58	11
Rotunda Hospital	15	150	0
Royal Victoria Eye and Ear Hospital	23	27	0
Sligo University Hospital	52	260	31
South Infirmary Victoria University Hospital	54	119	0
St. Columcille's Hospital	9	113	17
St. James's Hospital	87	796	27
St. John's Hospital Limerick	0	71	0
St. Joseph's Raheny	23	17	0
St. Luke's General Hospital Kilkenny	11	165	21
St. Michael's Hospital	20	90	0
St. Vincent's University Hospital	66	468	57
Tallaght University Hospital	24	401	74
Tipperary University Hospital	22	199	19
UH Kerry	30	114	34
UH Limerick	23	479	96
UH Waterford	31	393	48
UMH Limerick	0	54	3
Wexford General Hospital	48	210	26
Total	**1,601**	**10,789**	**836**

6.2 OUR LADY'S HOSPITAL NAVAN

The Chair of the Board wrote to the Minister for Health on the 5th of May outlining the firm view of the Board of the HSE that the reconfiguration of OLHN should proceed as a matter of some urgency given the concerns that have been raised in respect of patient safety arising from the current operating model at OLHN.

These concerns have been expressed by clinicians at hospital and national level. The reconfiguration is also supported by the Safety and Quality Committee of the Board. Following further discussion at a meeting with the MOH on the 27th April 2022, the Board has agreed that, given the risks of the

current operating model, the transition of Our Lady's Hospital, Navan to a Model 2 hospital would take place on the 7th June 2022.

The Minister has agreed a rescheduled time and date with Oireachtas members and a re-scheduled meeting with the HSE for Monday the 23rd of May has been cancelled.

6.3 MEETING WITH MINISTERS, RABBITTE AND O'GORMAN

A meeting was held on 11th May with Minister Rabbitte and Minister O'Gorman in respect of a range of disability matters including the transfer of Disabilities to DCEIDY from DOH.

At this meeting there was a good discussion in relation to recent events including media coverage naming senior HSE executives. It was agreed that the HSE would continue to work collaboratively with both Ministers and their departments to progress the reform of Disability services in line with National Policy.

Current performance reporting arrangements including escalation pathways with DOH were also noted.

The HSE recently received correspondence inviting the CEO to attend a joint meeting of the committees on Disabilities and Children on June 2nd.

6.4 NSP REVIEW

The review of the National Service Plan (NSP) in Quarter 1 of 2022 was undertaken at the request of the Minister's when he approved the NSP. This review was requested in light of the recruitment challenges identified in the NSP and the importance of monitoring progress on the recruitment targets set out in the plan in the context of its impact on the delivery of the reform programmes.

Following presentation to the Performance and Delivery Committee on Friday 20th May 2022, the Committee discussed the level of confidence of management that minimum recruitment target would be achieved and to what extent progress toward the upper target might be achieved.

This was discussed at length particularly in light of the additional challenge of the Haddington Road Agreement action that will equate to an additional 3,800 WTE in addition to the normal 9,500 WTE for resignations and retirements being required to stand still. The Committee further felt it important that the level of recruitment should be balanced across the professions and particularly noted that recruitment of Management / Admin grades was well ahead of the other professions.

The Committee noted that any assurance given to the Minister would need to be an assurance provided by the Board given the role of the Board in the approval of the NSP and, as such, the review report should be formally considered by the Board.

The NSP sets out the significant market supply challenges regarding workforce supply and therefore the risk to the overall delivery of the 11,368 WTE. The minimum target for recruitment agreed is set at +5,500 WTE, upon which the HSE will be monitored against, in addition to a higher stretch target of the 10,500. As at 31 March 2022, the overall increase in 2022 stands at + 1,778 WTE (+1.3%) which is above the Q1 recruitment target of 1,617.

Any potential underspend analysis is assessed against the total 2022 maximum Q1 recruitment target which was determined at 3,172 WTE (Full Year 2022 target of 11,368). Based on the average cost per WTE (ACPW) methodology, an estimated €12.3M potential underspend is derived in respect of Q1.

In recognition of the increased global competition together with the ambitious recruitment targets, the HSE is supplementing robust recruitment strategies to maximise the national market with comprehensive international recruitment across the clinical grades such as nursing, HSCP's, medical and dental.

The HSE has committed to an ambitious recruitment target to meet the commitments in the National Service Plan. The HSE is confident that at a minimum this will result in an additional 5,500 new WTE's by year end but will aggressively strive towards the stretch target of 10,500 additional WTE.

Chapter 7

CHIEF CLINICAL OFFICER UPDATE

7.1 UPDATE ON THE PUBLIC HEALTH REFORM PROGRAMME

The programme is progressing recruitment and implementation of reform towards definitive timelines. With effect from the 1st of May 2022, six new Public Health Areas were launched led by Area Directors of Public Health – the first Consultant in Public Health Medicine appointments in Ireland.

The establishment of the six new Public Health Areas brings the service into alignment with the Sláintecare Regional Health Areas and will enable Public Health to contribute effectively to major service design and policy implementation and ensure a population needs based approach to integrated healthcare delivery.

To enable the establishment of specialised, consultant-led multidisciplinary teams within this new model, recruitment is progressing at pace with 85% of the 250.6 WTE permanent multidisciplinary resources recruited and 33/34 WTE of the Phase 1 Consultant in Public Health Medicine posts progressing on target.

The appointment a National Director of Public Health was unsuccessful despite an extensive Executive Search and international advertising campaign. This leaves the apex of the Public Health function and a critical strategic leadership post vacant at a pivotal time of pandemic recovery and structural reform.

7.2 THE NATIONAL SCREENING SERVICE PROGRAMMES

BreastCheck - completed 12,979* mammograms of women in the eligible population in March which is above target of 12,000 by 8.2% despite a reduction in clinic capacity and absenteeism. The programme continues to be impacted by radiology shortages. However, a locum radiologist has been recruited and expected to commence in the Southern Unit in July. The second mobile unit has arrived in Ireland and once commissioned will commence screening in Monaghan.

` To mitigate the risks with consultant radiology recruitment the following actions have taken place:

- Ongoing Advertisement in BMJ and websites set up for locum Radiologists
- Interviews held and scheduled with potential locums for summer 2022 starts
- Meeting held with Chair of Diagnostic Imaging, University of Sydney & BreastScreen, South Australia to consider approaches and identify longer term strategies and potential partnerships
- Engaged with Public Appointments Service, Clinical Directors (CDs) & Hospital Medical Manpower to improve efficiencies and timelines in CAAC application processing and advertising of Radiologist posts

- Short term solutions and agreements with National HR regarding pay and recruitment
- Short term agreement to be paid higher overtime rates for any additional hours
- Package or funding to be developed to provide competitive rates to NTPF.
- National and international recruitment campaign for permanent and locum Radiology staff.
- Liaising with Faculty of Radiology regarding:
  - Intensifying training and teaching in undergraduate and post graduate levels.
  - Increase the number of training posts.
  - Engaging with NCCP on Radiologists' shortages and challenges with Hospitals Consultant post structures and reliance on NSS to staff symptomatic services.

CervicalCheck - is fully operational and completed 21,211 screening tests in March which is 15.5% below the target of 25,100. The programme is monitoring this closely and consideration is being given to an additional communication campaign in the summer.

The CervicalCheck Programme Report (2018-2020) has been published and available online **(https://www.screeningservice.ie/publications/CervicalCheck-ProgrammeReport-September-2017-March-2020.pdf)** providing statistical overview of the final years of Ireland's cytology-based population screening programme. The reporting period ended on 30 March 2020 when Ireland moved from cytology-led screening to be one of the first countries in the world to implement a primary HPV screening programme.

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 new laboratory is due to be completed in the second quarter of 2022 and operational in quarter three.

Construction is progressing well and the budget is on track. A service delivery model is currently being developed to outline anticipated increases in service volumes and the associated workforce required over the coming years. Workforce capacity remains the key limiting factor for full establishment of the laboratory.

Coombe Women and Infants University Hospital Laboratory services (CWIUH) - is currently not processing cervical screening samples for CervicalCheck since the cyberattack at the CWIUH in December 2021. This cyber-attack gave rise to the hospital losing its IT connectivity with CervicalCheck which resulted in the hospital being unable to accept samples.

The hospital recently restored its connectivity with CervicalCheck and this link is in the process of being tested.

Additionally, the CWIUH Principal Cytopathologist is currently unavailable and the hospital has been working on putting in place contingency to cover this unavailability to allow it to recommence taking samples, which it hopes to be in a position to undertake in the coming weeks.

All samples are, therefore, currently being processed by CervicalCheck's other contracted laboratory, Quest Diagnostics, until a resumption of service from the CWIUH takes place to ensure women continue to get their results in a timely fashion.

BowelScreen - screened 9,885* eligible participants in March which is 17.6% below the target of 12,000;

In April BowelScreen issued 25,003* invitations in line with operational targets. Invitations are closely monitored by the programme to match capacity within endoscopy units and maximise available colonoscopy appointments.

Invitations and completed screening tests continue to be impacted by the COVID infection rates in the community. Endoscopy services are not expected to operate at full capacity until at least June 2022.

April was Bowel Cancer Awareness month and there was a targeted awareness campaign across multiple media platforms. Mayo University Hospital was formally launched as the 15th BowelScreen endoscopy unit.

Diabetic RetinaScreen - screened 9,365* participants in March which is 4.1% above target of 9,000. The programme continues to invite participants to the new 2-yearly screening pathway.

Interval Cancer Reports - All implementation groups continue to meet and progress their project plans and deliverables. The development of an SOP to detail patient-requested review and disclosure process for cervical screening is being finalised. The Communications Interval Cancer Implementation Group have developed a draft action plan based on the behaviours and attitudes research findings. A draft interim report is being finalised by the legal framework group.

7.3 PATIENT SAFETY BILL

In a presentation made about the status of the Bill at a HSE Open Disclosure training event on 5 May 2022 the Minister flagged that he intended to introduce a notifiable incident directly related to cancer screening services at Report Stage. The Department and the National Screening Service, have given a lot of consideration to learnings from CervicalCheck, and the work of the Expert Reference Groups on Interval Cancers. These expert reports were commissioned arising from the Scally Review in 2018. These Reports set out a new and comprehensive approach to reviews of interval cancers in people who have been screened by Ireland's breast, bowel and cervical cancer screening programmes.

Under the proposed amendment to the Patient Safety Bill, these reviews will be notifiable incidents and will be subject to the same conditions as the other notifiable incidents in the Bill including, mandatory open disclosure and external notification to the relevant regulatory body.

The three recent Expert Reference Group Interval Cancer Reports (ERGICR) provided detailed recommendations on how the National Screening Service should manage interval cancers.

Following the recommendations of the ERGICR, a number of implementation groups have been established to implement the recommendations of the ERGICR reports. This includes the implementation of best practice in communicating the limitations of population-based screening (e.g. Interval Cancer) and revised consent information and procedures.

Dr Scally commended the BreastCheck programme for providing patients with a review of their screening mammogram and both CervicalCheck and BowelScreen have committed to implementing patient requested reviews. Implementation groups for each of the three cancer screening programmes have undertaken considerable work to produce standardised procedures for the conduct of these reviews. The purpose of the patient requested review is to provide patients and/or families with all of the factual information possible in regard to an interval cancer diagnosis, including review of screening tests. The approach envisaged is patient centred, sensitive and restorative. In accordance with ERGICR recommendations and in keeping with the spirit and intent of a Patient Requested Review all findings will be fully disclosed. Importantly, patients will be offered choice in what they wish to be included in the review and indeed what information they wish to be offered. The patient representatives and groups have been clear in what they seek from the process and are fully immersed in the co-design of this work. They do not seek mandatory disclosure of every aspect of their care but rather a supported, healing approach that allows them choice and agency.

In the light of the work underway to implement the recommendations of the ECGICR, the proposed amendment, whereby there would be mandatory notification and disclosure of a patient requested review, appears counterintuitive and unnecessary. It is also potentially harmful to the programme and the trust and confidence in which it is held by the public and clinicians, as it suggests an intention is to treat interval cancers with the same weighting as a patient safety incident.

Interval cancers are a recognised unavoidable and expected occurrence in all organised screening programmes. This is reiterated in recent Expert Reference Group Interval Cancer Reports (ERGICR). As such, an interval cancer is not a patient safety incident although it is acknowledged that a small number of interval cancers may also be patient safety incidents.

As a HSE service, the NSS is required to manage patient safety incidents in accordance with the HSE Incident Management Framework and Open Disclosure Policy. This includes instances where an interval cancer is attributable to a patient safety incident.

Correspondence has issued from the Chief Clinical Officer to the Chief Nursing Officer in the Department of Health outlining the above concerns and a meeting planned with the Chief Nursing Officer to understand amendments to the Patient Safety Bill and its impact on the screening.

7.4 NATIONAL CANCER CONTROL PROGRAMME

The new Chimeric Antigen Receptor T-cell (CAR-T) service for children was launched in CHI Crumlin on 27th April. The service for adults commenced in St. James's Hospital last December.

CAR-T is a highly complex and innovative treatment, which involves collecting and using the patient's own immune cells to treat their cancer. The service covers two initial CAR-T products that have been approved for reimbursement via the standard HSE assessment process for new drugs, for which patients would previously have had to spend a number of weeks in a hospital abroad.
A Memorandum of Understanding between the National Health Intelligence Unit, National Cancer Registry and NCCP had been agreed. This will facilitate improved data for population-based planning of cancer services, in line with Sláintecare.

A number of national cancer documents/initiatives are being launched in May including:

- Transforming Psycho-Oncology and Survivorship Services in Ireland: Looking forward to the next decade.
- Psycho-Oncology Model of Care, with updated information on the Best Practice Guidance for Community based Cancer Support Centres.
- Launch of the Alliance of Community Cancer Support Centres & Services.
- NCCP Children and Adolescent and Young Adults Cancer Annual Report 2021
- NCCP Framework for the support and care of Adolescents and Young Adults (AYA) with Cancer in Ireland: 2021-2026.

7.5 ADVANCED NURSE AND MIDWIFERY PRACTITIONERS

Consultation is now taking place with senior colleagues and relevant stakeholders and their teams around a process to allocate the funding for 2022 and outline the future plans for ANMPs. A separate document is attached which outlines the criteria for decision making on page 5. The aim is to complete all engagements during the week of the 16th of May.

7.6 CLINICAL WORK ON UKRAINIAN CRISIS

The Chief Clinical Office, HSE has two workstreams supporting the HSE response to the Ukrainian Crisis. The overall approach is to translate clinical patient care needs into strategies for safe, effective and efficient delivery of health services and to respond to requests from other workstreams/colleagues across the health system.

Work is being undertaken to secure 2 Doctors with a Ukrainian health knowledge and understanding ***(1. Paediatric Infectious Disease Clinical Lead and 2. GP).*** These doctors will be well positioned to advise on
(i) healthcare needs of Ukrainian population cohort and its healthcare system;
(ii) typical conditions/ailments/vaccination trends to enable mapping of needs and pathways of care for this patient cohort within the Irish healthcare context.

High level deliverables/work to date

- Collaboration on a model of care: "*Developing the HSE's Acute Hospital response to Ukrainians under the Temporary Protective Directive and other socially excluded groups*" – clinical input from mental health and children/young people perspective;
- ICGP webinars/podcasts for GPs on healthcare needs for Ukrainian refugees – advising on key healthcare topics aligned to Ukrainian population healthcare needs
- Clinical Qualifications recognition: NDTP, Medical Council & Medical Colleges regarding options for Ukrainian medical students and doctors to undertake clinical observationships & other roles that don't require registration – to help maintain current training/advancement of education while based in Ireland
- Guidance developed jointly by Screening-Public Health & Clinical Workstreams to support & guide operational response to the Ukrainian Crisis incorporating priorities/recommendations in respect of: vaccination; congregated setting advice; COVID-19; COVID-19 vaccination; blood borne viruses (BBV); other infectious diseases including TB. Guidance entitled: ***PH Advisory: Public Health priorities for displaced people fleeing war in Ukraine completed. Further clinical guidance will be needed for clinicians***
- Metabolic needs/emergencies: management of 16-17 year of age cohort (Mater CHI at Temple St) – acceptance of care agreed by both sites enabled by NCAGL & CDI clinical leadership.

Identifying the most pressing clinical care challenges and risks – identifying where pathways and other clinical designs need to be developed to meet health and social care needs of this population. Health needs assessments identify increasing complexity of care needs of Ukrainian refugees entering Ireland with reports of:

- Cases of multi-drug resistant TB;
- Increase in the number of co-morbidities;
- Low uptake of COVID vaccine;
- Social deprivation;

- Older persons with moderate to severe levels of frailty with lower levels of function (some hoist dependent) and higher levels of dependency;
- Increasing evidence of psychological and emotional distress (children, young adults and adult groups);
- Catch-up vaccination for children;
- People with disabilities;
- Dental needs
- Increase in access to maternity services.

It is, therefore, essential that we continue to prepare for and provide a rapid clinical response to changes in the health profile of Ukrainian population, through agile development and design of pathways, models of care and clinical guidance to disseminate across the healthcare delivery system and reduce

I. the risk of unmet need and
II. the potential risk of high levels of morbidity and mortality within the Ukrainian refugee population.

7.7 GENETICS AND GENOMICS

On May 12, 2022, the HSE took the first step toward developing a National Genetic and Genomic Strategy for Ireland, with the inaugural meeting of the HSE National Genetic and Genomic Steering Group. This will be a collaborative piece of work with Patient Representatives, the Department of Health, Academic Colleges and frontline clinicians.

Genomics is the study of the body's genes, their functions and their influence on the growth, development and working of the body. A genome is an organism's complete set of DNA, including all of its genes. Genetic testing can be used to examine particular individual genes within the genome, and whether a person is carrying a specific inherited altered gene that causes a particular medical condition. Genomic medicine uses information about a person's genetic makeup in devising innovative and effective new treatments and care pathways for patients.

Following a Government decision to develop this advanced area of healthcare, an expert group have begun work within the HSE. This group is chaired by Dr Mark Bale, former Genomics Advisor to the UK Department of Health. Dr Bale has a research background in microbial genetics, he has led on a number of emerging healthcare science areas and their ethical, legal and policy implications. He has led on the 2012 Human Genomics Strategy which became the 100,000 Genomes Project. The group includes representatives from a range of clinical specialties in Ireland, academic and patient representatives and international experts in the area of genetics and genomics. This group will develop an agreed strategy and implementation plan for genomics in Ireland. The work of this group will consider issues such as the shortage of trained genetic specialists, the need to enhance our laboratory capacity and genomic infrastructure and enhancing genetic genomic literacy across healthcare professionals and the public.

The strategy will define what actions and resources are needed, including funding and staffing levels, allowing the HSE to develop a genomic service for Ireland that will improve health outcomes, drive down the cost of care and fuel scientific innovation and discovery.

The strategy development will be supported by the Deirdre McNamara, Director of Strategic Programmes reporting directly to the CCO. To facilitate the strategy development Workstreams will be developed, they will include:

- Data, Policy, Communications & Engagement.
- Infrastructure.
- Workforce and collaboration.
- Clinical innovation

Leads for each of the Workstreams have been nominated. The programme has an ambitious timeline with a target date of September 2022 for completion.

7.8 STROKE

Stroke is the second leading cause of death in middle to higher income countries and the leading cause of acquired adult neurological disability. Approximately 5,800 adults were admitted to hospitals with a stroke in 2020 and this figure does not include the estimated 1500-2000 evaluated urgently for a suspected stroke and who had a threatened stroke or transient ischaemic attack (TIA). Stroke has a significant impact on Health Service Executive (HSE) resources.

The National Clinical Programme (NCP) for Stroke was set up within the Royal College of Physicians of Ireland in 2010 to reorganise and develop our acute stroke services to meet the principles set out in the 'changing cardiovascular health strategy 2010 -2019. The initial goal was to prevent one death or disability from stroke each day and prevent one stroke each day by ensuring improved access to specialist opinion with acute stroke treatment and specialist-led stroke unit care. As this work programme was implemented mortality from stroke fell from 19% to 14% and the estimated total number of strokes had fallen to approximately 7,500 from an estimated 10,000 in 2008.

Building on the work developed under the programme over 2010-2019 during 2020-2021, the Stroke Strategy was developed by the multi-disciplinary Clinical Advisory Group (CAG) under the clinical governance and leadership of the NCP for Stroke and underwent extensive consultation with internal and external stakeholders. The remit of the CAG was to produce a number of key objectives for the Stroke Strategy over the next 4 years that were; of high impact for patient care, realistic to achieve and required to ensure stroke services were adequately resourced to provide safe and effective urgent stroke care and prevention.

The strategy includes the right goals and targets and improved outcomes for patients including survival, reduced disability and the delivery of efficient and effective services that support people to live longer and in their own communities.

Stroke is the second leading cause of death in middle to higher income countries and the leading cause of acquired adult neurological disability· accounting for up to **4% of total health expenditure** annually. The strategy recommends the strategic development of service over a 4-year period 2022-2026.

Four key pillars for stroke care:

I. Stroke Prevention
II. Acute Care and Cure

III. Rehabilitation and Restoration to Life
IV. Education and Research

Implementation Plan - A cross collaborative steering group including clinical and operational leads will be set up to direct and oversee the implementation of the stroke strategy supported by a PMO function and will assist in informing the estimates process. The strategy requires a commitment to funding which will be submitted as part of the national service planning process. A communication plan is being developed with the national communications office to launch the strategy.

7.9 ECC PROGRAMME RECRUITMENT UPDATE

To date 1,887 WTE are now either onboarded (1,324 WTE) or at an advanced stage of recruitment (563 WTE), with an additional 1,700+ to be recruited throughout 2022.

There have been 51 CHNs established with 87% of Network Managers and 85% of Assistant Director of Nursing Leads in place or at an advanced stage of recruitment. Approx. 43% GP Leads in place or at an advanced stage of recruitment together with 25% of additional core CHN staff.

To date there have been 17 Integrated Care Programme Older People (ICPOP) and 5 Clinical Disease Management (CDM) specialist teams established with 30/30 ICPOP Operational leads and 24/30 CDM operational leads in place or at advanced stage at year end.

In addition, there have been 42.5 Consultant posts have been approved through CAAC process and arrangements being put in place for temporary appointments and clinical governance in some locations, pending permanent competitions.

International recruitment campaign in relation to Clinical Nurse Specialists and Advance Nurse Practitioners commenced. International recruitment to be commenced in respect of other Health & Social Care Professional Grades. Detailed draft communication plans have been developed.

7.10 UPDATE ON NEW DRUGS

The HSE has approved 16 new medicines and 14 new uses of existing medicines in 2022.

Commercial negotiations in relation to these medicines will deliver in excess of €164m in avoided additional costs over the next 5 years. Despite these price reductions, the HSE will still have invested in excess of **€118m** over the next 5 years in the reimbursement of these new medicines approved during 2022.

The reported spend above, are **net of all commercially confidential discounts** and offsets from the replacement of existing therapies.

The HSE continues to face significant ongoing challenges in funding new medicines and new uses of existing medicines. The allocation of €30m in 2022 for investment in new medicines or new uses of existing medicines will address some of these challenges.

The HSE is engaged with health care professionals to ensure that best value medicines are prescribed and used (biosimilars/ generics / preferred medicines etc.)

The HSE assesses each new medicine / each new use of an existing medicine and has carefully taken into account all of the factors it is statutorily required to consider, in advance of decision making. The HSE has also agreed revised commercial terms, leading to in excess of **€164m** in saving over the next 5 years.

Notwithstanding the negotiation of improved terms, the net budget impact to the public health service over the first 5 years, of these 30 decisions is expected to exceed €118m.

The HSE can confirm that in a number of these cases the new medicines to be funded have satisfied cost effectiveness thresholds. Notwithstanding same, the release of funds for these medicines means that those resources will not be available to meet other demands or other service needs.

In a number of cases the medicines do not satisfy cost effectiveness thresholds and the HSE has only approved funding in an attempt to address significant unmet needs. In those cases, in addition to those resources not being available to meet other demands, the HSE has a responsibility to transparently make clear that approving new medicines which meet unmet needs but which are not cost effective does result in a net reduction in efficiency across the health system. On the basis of interactions with the political system and wider society it is believed that this challenge and conundrum is understood but that reimbursement would be supported by society.

The 30 new medicines / new and expanded uses approved are detailed in the appendix attached.

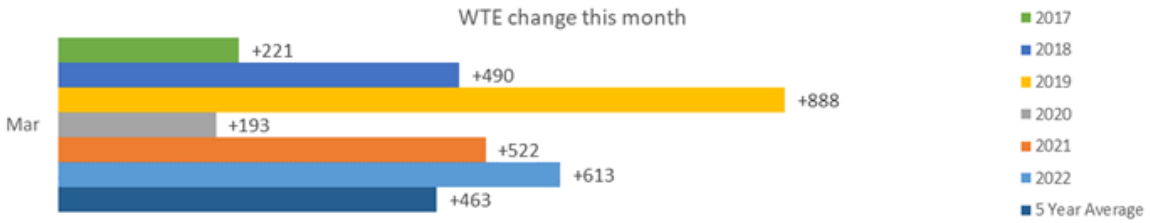
Chapter 8

HUMAN RESOURCES UPDATE

8. HUMAN RESOURCES UPDATE

8.1 HEALTH SECTOR WORKFORCE – MARCH 2022

Employment levels at the end of March 2022, show there were 134,101 WTE (equating to 153,282 personnel) directly employed in the provision of Health & Social Care Services by the HSE and the various Section 38 hospitals & agencies.



The overall increase since December 2019 now stands at **+ 14,284** WTE (+11.9%). The staff category with the greatest WTE increase is Nursing & Midwifery at **+4,132 WTE**, with Staff Nurses & Midwives also reporting the greatest WTE increase at **+2,070 WTE.**

8.2 RESOURCING STRATEGY

Under the HSE resourcing strategy, the HSE has set a minimum net additional staff target of 5,500 WTE. At 31 March staffing levels year to date are +161 WTE (9.9%) above the minimum resourcing target, with 4/6 staff categories ahead of target (Medical and Dental, Patient and Client Care, Management and Admin & General Support).

8.3 ABSENCE RATES

The reported absence rate for March 2022 stands at 9.7%. This compares to 4.9% reported for the same month in 2021, however these figures notably

include COVID-19 related absence for both periods. Excluding COVID-19 the current months' absence rate is 4.9% compared to 3.9% in 2021.

Benchmark Target	Feb-22	Certified Absence March 2022	Self-Certified Absence March 2022	COVID-19 March 2022	Mar-22	Full Year 2021	Year to date 2022
4.0%	7.8%	4.3%	0.6%	4.7%	9.7%	6.1%	9.1%

Covid-19 Absence - While the latest absence figure (30th April - 6th May 2022) is 1,232 which is a decrease of 476 on the previous week, these figures still show significant staff absence levels across our health services due to COVID-19. The highest level reported in January 2021 was 6,763, compared to 10,343 in January 2022.

8.4 REVERSAL OF HADDINGTON ROAD HOURS (HRA)

The Government recently accepted the recommendations contained in the report of the Independent Body Examining Additional Working Hours (Haddington Road Agreement) in the Public Service, established under the Building Momentum Agreement. The HSE has now received formal notification of the decision which will be implemented from July 1, 2022.

The report recommends that working time is restored to pre-Haddington Road agreement (HRA) levels.

This will see the following reduction in weekly working hours from July 1st, 2022:

- Nursing and Midwifery: 1.5-hour reduction to 37.5 hours per week;
- Specific Health and Social Care Professionals and Medical and Dental: 2-hour reduction to 35 hours per week;
- Management & Administrative: 2-hour reduction to 35 hours per week; and
- Consultants – currently subject to discussion / confirmation.

A HSE Steering Group with working groups and implementation teams has been established and impact assessment is being undertaken by all services.

The number of health service staff working full time who are impacted by the change is approximately 82,000 with the equivalent of 3,800 WTEs being reduced across the HSE. The HRA reversal will require changes to Rosters for Clinical Grades working a 24 hour /7 day and part time workers will be encouraged not to reduce their hours. All measures to reduce working hours

must incorporate the different regulatory environments that now exist e.g. safe staffing framework, HIQA requirements etc.

In terms of principles to be applied, the introduction of the reduced working week for Nurses, Health and Social Care Professionals (HSCPs) and Management & Administrative staff must not impact service delivery to the general public. There will also be a requirement to consider the development targets set out in NSP 2022 in the context of the ability to deliver them (i) on time or (ii) delivery at a later date which can be determined.

Replacement of hours lost by addition of new staff should not be assumed as the default solution. Not all staff will be replaced or will be replaceable. All options to maintain existing service levels within existing staffing compliments, particularly in non-shift working roles will be explored.

8.5 UKRAINIAN RECRUITMENT PORTAL

The Department of Health and the professional regulators (NMBI, CORU, IMC etc) working with the HSE are carrying out substantial work regarding the recognition of Ukrainian healthcare qualifications and the equivalence of these. This is very complex work as there are many differences in the Ukrainian qualifications. They are being supported in this work by the Ukrainian embassy and are part of a wider EU Working Group with representation from all EU states.

Notwithstanding detailed work underway in recruiting Ukrainian healthcare workers, HR Shared Services has set up an online portal to enable Ukrainians to register their interest in working in the health services in anticipation of Ukrainians with health experience and qualifications being recruited into the health system. This portal is currently live on the government's job page www.jobsireland.ie and on https://hbsrecruitmentservices.ie/ukraine-register-your-interest/

8.6 NEW RECRUITMENT MODEL

The new Recruitment Operating Model will introduce standardised processes for the end-to-end recruitment lifecycle; define clear roles and responsibilities and will establish clear governance; to best set up recruitment teams to deliver on recruitment activities both now and in the future. This will ensure clarity of responsibilities and consistency for both hiring managers and candidates. Each grade across the HSE has been reviewed, in partnership with agreed service representatives, and responsibility for its recruitment assigned to either Local Recruitment teams or the National Recruitment Service. The transition to new model is currently underway. Detailed training

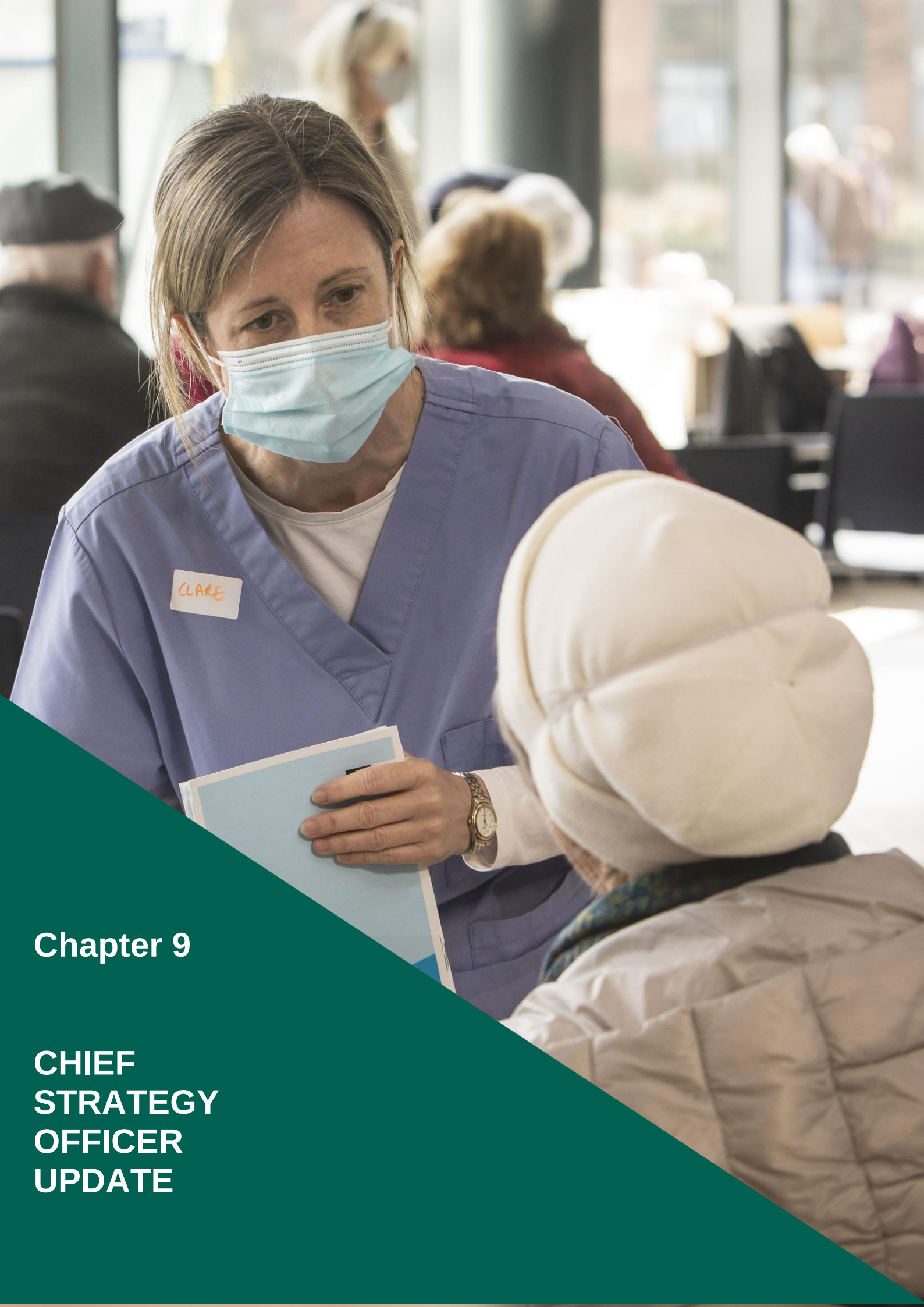
and procedures materials developed for all recruiters and available on HSELanD.

8.7 HSE BLENDED WORKING POLICY

The Civil Service Blended Working Policy Framework was published on 31 March 2022 and provides an overarching framework to inform Civil Service organisations and public bodies (including the HSE and Section 38 employers) when developing blended working policies. Under the Framework, the term 'blended working' refers to a combination of working from the employer's premises and working remotely. It is not intended that employees would work remotely all of the time. This broadly reflects the DPER Framework which sets out five key principles;

1. Support the business needs of the organisation.
2. Leadership and Management
3. Be an Employer of Choice
4. Transparency and Consistency
5. Health and Safety

The HSE policy currently being developed will reflect these general principles, with the proviso that the content should be appropriate for the health service and take account of the requirement for the vast majority of roles to be performed on-site at the employer's premises, at the service user's residence and in community settings.



Chapter 9

CHIEF STRATEGY OFFICER UPDATE

9. CHIEF STRATEGY OFFICER UPDATE

9.1 NEW CHILDREN'S HOSPITAL

Earlier this month the New Children's Hospital programme transitioned to new governance arrangements, consistent with recommendations from the PwC report (2019). The new arrangements replace the existing structures and establish the role of the CHI/NPHDB Integrated Project Delivery Team, the HSE Lead Director and the Department of Health National Oversight Group.

The new arrangements strengthen the oversight, challenge, and assurance mechanisms for the overall programme, and include the development of a 'Programme Assurance Plan'. The HSE Lead Director is supported by a HSE Assistant Lead Director, external advisers and senior HSE staff.

As previously advised to the Board, work is progressing on the New Children's Hospital build but at a slower pace than required under the contract. The National Paediatric Hospital Development Board report that all of the hospital is now at internal fit out stage, with works to significant areas now comprising flooring, joinery, and door installation.

A number of significant cost and funding pressures exist beyond the approved budget of €1.433bn, as previously advised to the Board. NPHDB report that the process of engagement with the contractor is ongoing with a view to obtaining greater cost and programme certainty.

CHI are working to minimise the impact of the construction programme delay on the CHI's programme planning and associated workstreams, including EHR and workforce. However, the extension of the construction programme will impact on the associated budgets. Engagement with project stakeholders is ongoing to address funding pressures.

9.2 HSE CLIMATE ACTION AND SUSTAINABILITY STRATEGY

As Board members are aware, the HSE has identified as a key priority for 2022 the development of a Climate Action and Sustainability Strategy.

Following discussions at EMT earlier this month, arrangements are now being taken forward to develop a draft strategy by mid-August 2022. The HSE will aim to fully align with the requirements, actions, targets set out in the Government's Climate Action Plan 2021 and where possible, exceed these requirements by acting as an exemplar in the area of Climate Action and Sustainability in the healthcare sector.

Healthier populations will fare better when climate change effects materialise, therefore, the Strategy includes a Climate Adaptation focus which incorporates using a population-health approach.

A Steering Group will be established to oversee the development of the Strategy. The key areas within the Strategy are as follows:

Infrastructure – to include opportunities to reduce energy consumption in facilities and tackling issues of embedded carbon through Modern Methods of Construction.

Procurement – to include opportunities to reduce emissions in relation to the goods and services we purchase, including supply chain issues.

Medical/Clinical Services – to include opportunities to reduce emissions associated with medical and equipment and clinical services.

Climate Change Adaptation – to consider the potential impacts of climate change on the health of the population and the health infrastructure and take appropriate mitigating actions.

Sustainable Green Environments – to include the active management and development of green spaces for the population and staff.

Measurement and Assurance – to provide accurate and consistent arrangements to capture and measure progress with the implementation of climate and sustainability actions.

Updates on progress will be provided to Board members on an ongoing basis through the Board Strategic Scorecard, with the draft Strategy being shared with members prior to finalisation.

9.3 CYBER POST INCIDENT REVIEW IMPLEMENTATION PROGRAMME UPDATE

Arrangements are in place to implement the recommendations of the HSE Post-Incident Review Report. These arrangements include fortnightly meetings chaired by the CEO, and monthly updates to the P&D Committee.

Key areas of focus at present include the appointment of an external specialist service provider to provide short and medium term ICT/Cyber support, including the provision of senior individuals to act as Interim Chief Technology and Transformation Officer and Interim Chief Information Security Officer. In addition, work is also being taken forward at present to prepare an initial investment case.

9.4 RESEARCH GOVERNANCE

As Board members may be aware, the HSE National Framework for the Governance, Management and Support of Health Research was brought to the Safety and Quality Committee and launched in late 2021.

Work continues to progress on the implementation of the Framework as well as overseeing the implementation of the HSE Action Plan for Research 2019-2029.

A National HSE Committee for the Governance, Management and Support of Health Research has been established and met in May 2022 for the first time.

9.5 BOARD STRATEGIC SCORECARD

The Scorecard for the period to the end of April is attached for Board members' consideration and approval, in the appendices.

The Board Strategic Scorecard is used by EMT to provide the HSE Board and thereafter the Department/Minister with a monthly progress report against key HSE strategic Programmes/Priorities.

The key points to note from the April Scorecard are as follows:

- The average rating for the period to the end April reduced to 3.50 from 3.75 at the end March.
- This is due to the reduction in the rating of the Climate Action & Sustainability scorecard from a rating of 5 to 4, Reform of Scheduled Care scorecard from a rating of 4 to a 3 and the Enhancing Bed Capacity scorecard from a rating of 3 to a 2.

Further details in relation to these and other scorecards is provided in the April Scorecard report

Board members are asked to note that there continues to be engagement with the DoH to ensure, as far as possible that the scorecard meets the reporting requirements of the Minister, in line with the November 2021 Letter of Determination.

9.6 REGIONAL HEALTH AREAS (RHAs)

Board members are aware that the Government recently committed to the introduction of Regional Health Areas by January 2024, with an implementation plan to be prepared by the end of this year.

Senior officials from the HSE and DoH meet on a weekly basis to progress this work; in addition, a joint RHA design workshop with the DoH took place earlier this month.

Board members took part in a dedicated session on RHAs on 26 April which provided a number of helpful insights in relation to the planning and delivery of this major change programme. The outputs of the workshop have been summarised and circulated to Board members.

A number of further engagement sessions took place in May with corporate senior managers, Chief Officers and CEO's of Hospital Groups. In early June it is intended to hold further workshops with senior leaders, clinicians from HGs, CHO's and the newly appointed Area Directors of Public Health.

Finally, working alongside the existing team led by CSO, Yvonne Goff and Caitriona Heslin, I have reassigned Liam Woods to provide senior implementation support to the programme. Liam's position, as National Director of Acute Operations will be advertised for filling on an interim basis while he is assigned to this major change management programme.

9.7 SCHEDULED CARE

In NSP 2022 the HSE committed to the delivery of maximum waiting times of 18 months for outpatients and 12 months for inpatient/day case and GI scopes. Working with DoH and NTPF, a Waiting List Action Plan for 2022 was subsequently developed setting out high-level details of the key deliverables in 2022 and how the waiting list resources available to the HSE (€200m) are to be utilised.

To oversee progress with this key change agenda, I chair a weekly meeting in addition to monthly meetings with the Waiting List Task Force co-chaired by the Secretary General and myself.

The achievement of the 2022 targets will require, inter-alia, the delivery by priorities of core activity volumes, the chronological management of that activity and the development and delivery of plans for non-recurrent in-year additionality.

Non-recurrent proposals to the value of some €40m have been approved in the acute sector, with plans totalling €12m approved in the community sector. We are currently seeking plans for further additional activity from the Hospital Groups and CHO's with a view to maximising delivery for the available resources in 2022.

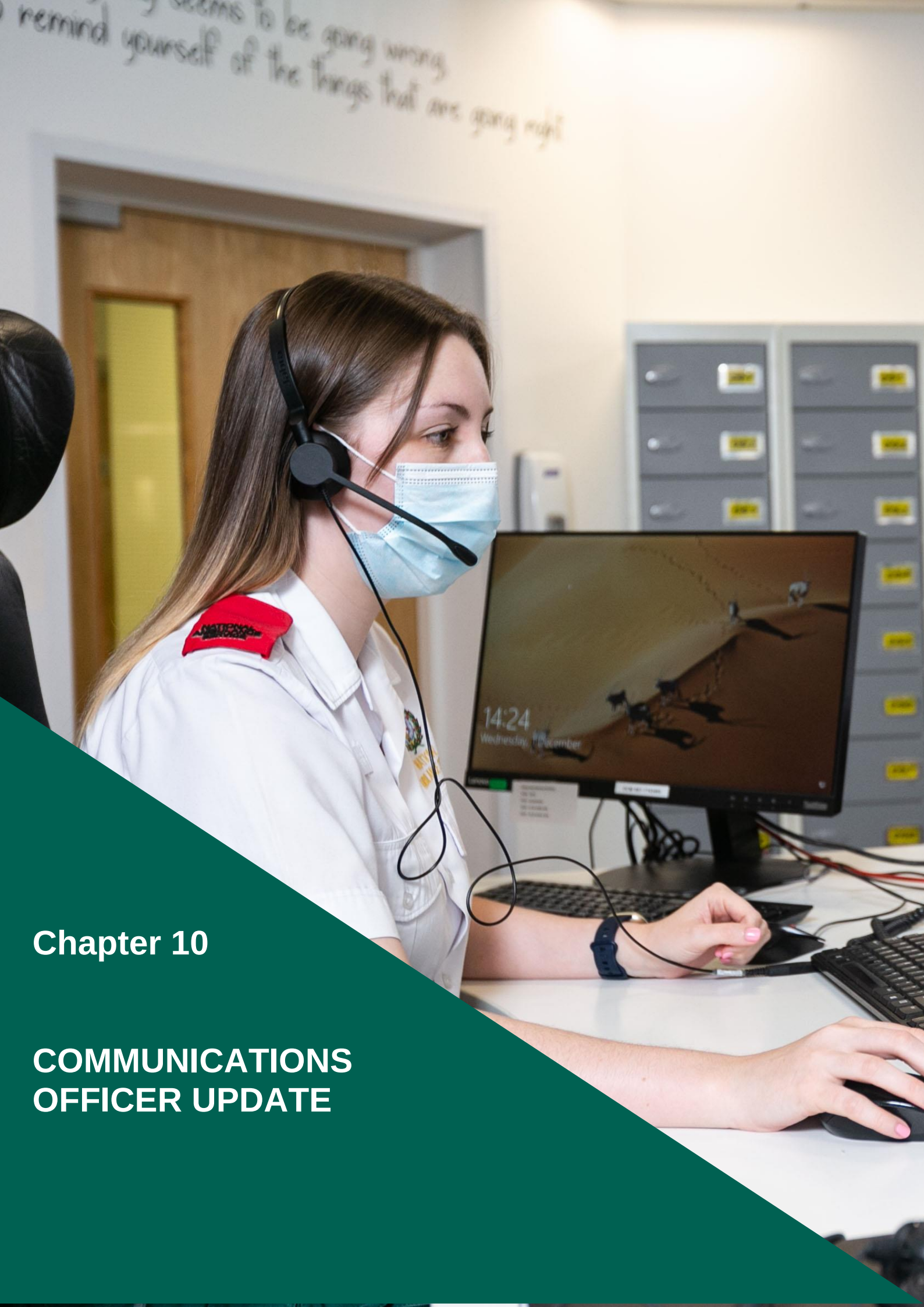
A more detailed update will be provided to Board members in July.

9.8 NATIONAL MATERNITY HOSPITAL

The Board members approved the legal Framework and Constitution for the new National Maternity Hospital at St. Vincent's University Hospital on 14 March 2022. This Framework was considered by Cabinet on 3 May 2022 where

it was decided to delay a decision by two weeks to allow for further consideration of the documents. A decision was made by Cabinet on 17 May to approve the Legal Framework and Constitution. The draft Final Business Case, submitted in December 2021, remains under active consideration by the DOH and their response is awaited.

Once approved by the Department of Health the Business case will be submitted to DPER and following their endorsement it will be the subject of a further Memo for Government. The next steps for the project include the procurement of Further Enabling Works, a Planning Application update to support Near Zero Energy Building (*NZEB*) design development, and Commencement of the Procurement process for the main works.



Chapter 10

COMMUNICATIONS OFFICER UPDATE

10. COMMUNICATIONS OFFICER UPDATE

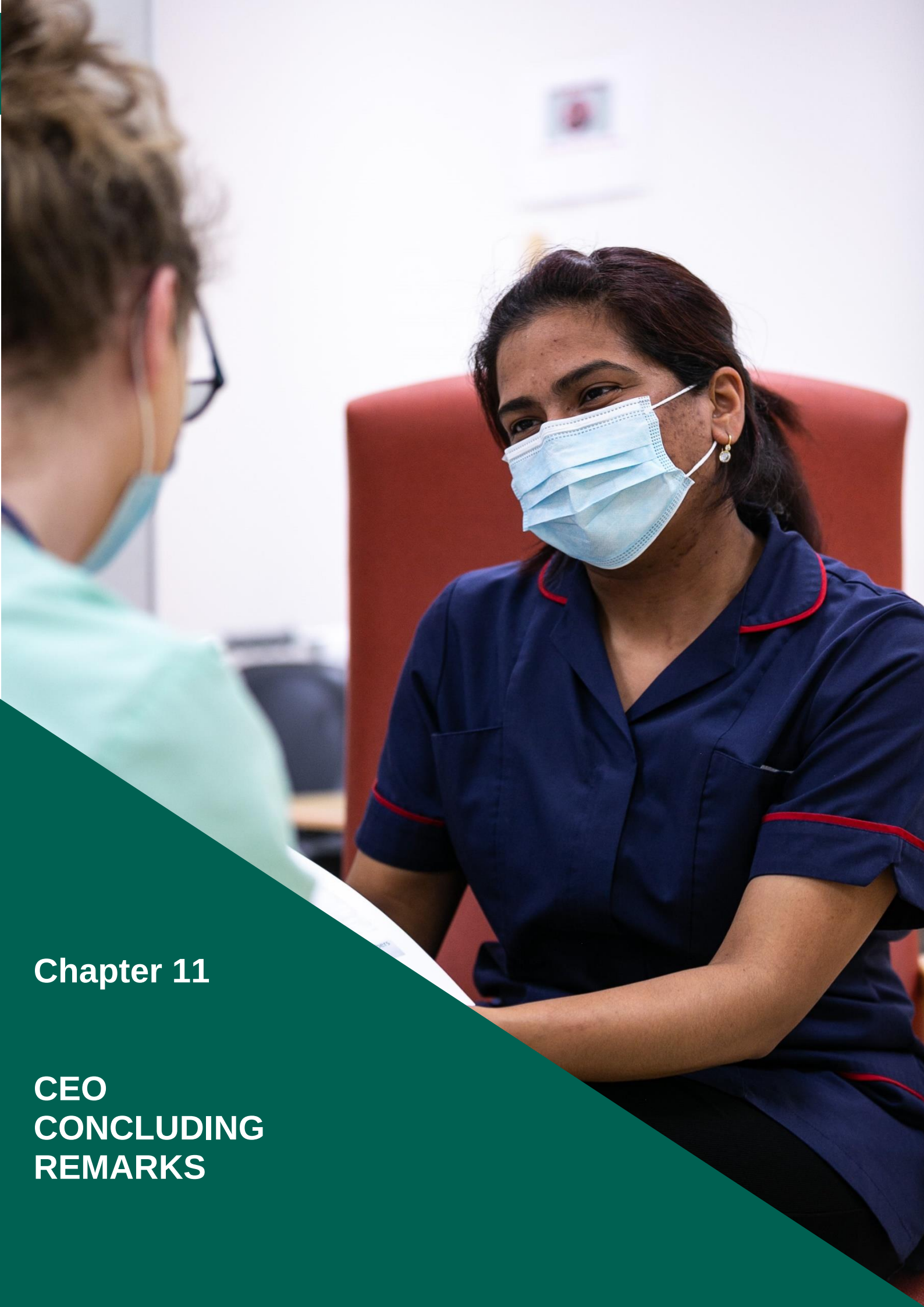
10.1 GENERAL COMMUNICATIONS UPDATE

The level of media engagement has been high in the past month, and the second week of May was the first week in 2022 that was busier than its equivalent in 2021. There was no one reason for this and it reflected interest in a wide range of issues and services.

We made more than 25 proactive announcements on issues such as the National Genetic and Genomic Strategy, the establishment of six public health areas, World Maternal Mental Health Week, hand hygiene, International Day of the Midwife, early diagnosis of cancer, International Nurses' Day 2022, and the National Inpatient Experience survey launch event with HIQA.

Work is ongoing on seeking coverage of Sláintecare related and NSP funded initiatives and we are seeing a positive shift in media responding to pitches on such matters. We also recently had clinicians on national media explaining the phenomenon of hepatitis in children.

We are coming to end the of public information campaigns on behalf of BreastCheck and BowelScreen, which have led to very substantial increases in website visits and the seeking of information. The digital team has been working with the Women's Health Task Force to develop a new range of guides in relation to conditions that affect women. The most recent guide added to this collection is menopause. https://www2.hse.ie/conditions/womens-health-a-z/



Chapter 11

CEO CONCLUDING REMARKS

11. CONCLUDING REMARKS

As the impacts of Covid-19 gradually lessen we know that we must learn from our vast experiences and plan for future potential surges of Covid-19 and for other pandemics and challenges that require large-scale attention and action. We know that we will be faced with challenges but our recent trials and tests have provided us, as an organisation, with the confidence and know-how to overcome whatever we meet. It is critical in all of this that we continue to work collaboratively with unified purpose in all sectors and, most importantly, to look after each other, being mindful of the demanding times we've been through.

We will need to invest substantially in and fully utilise the best technological solutions to address the many known challenges such as improved care coordination and improved population health, key objectives of Sláintecare. I very much look forward to discussing this and the capacity of e-technologies to help improve our services in the Deep Dive discussion paper later today.

Paul Reid

Chief Executive Officer