Winter Plan

October 2022 – March 2023

October 2022

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Winter context 2022/2023

There has been significant investment in the Health Service Executive (HSE) over the last number of years, particularly through annual National Service Plans (NSPs) and recent Winter Plans. This investment has facilitated the development of new services and allowed the HSE to improve existing services, including the significant emergency response to the COVID-19 pandemic.

Despite the progress that has been made in many areas of the health service due to this investment, substantial challenges remain as a result of both historical and newly emerging risks. One of the most significant challenges for the health service is the extremely high levels of emergency attendances and admissions to our acute hospitals. When we compare the level of unscheduled care (USC) provided in 2022 to date to 2019 there is a:

- 5.9% increase overall in Emergency Department (ED) attendances;
- 2.5% increase in ED admissions;
- 13.8% increase in ED attendances by those >75 years;
- 9.9% increase in ED admissions by those >75 years.

This sustained increase in the level of USC provided by acute hospitals is due to a number of factors which include:

- a lack of bed capacity to meet demand;
- reduced staffing levels and recruitment challenges;
- scheduled care waiting lists and the impact of delayed and postponed care;
- developments in primary and community care services;
- challenges in integrating patient care across acute and community services;
- increases in population, particularly the aging population, and increasing numbers of patients requiring health services including refugees and those seeking international protection; and
- the ongoing need for separate COVID-19 and non-COVID-19 pathways and the resulting Infection Prevention and Control (IP&C) requirements in both acute and community services.

While it is anticipated that COVID-19 is transitioning to an endemic state, significant uncertainty remains regarding the potential for a 'twin-demic' involving a high incidence of both COVID-19 and influenza this winter.

The HSE has developed this comprehensive plan to support acute and community services this winter to respond to anticipated high levels of emergency attendances and admissions across the acute sector, long waiting times in Emergency Departments (EDs) and high occupancy rates across acute hospital settings.

Winter Plan 2022/2023 priorities

Key priorities have been identified to address the aims of the Winter Plan 2022/2023 with initiatives accordingly at national and local level in line with the following priorities:

- Deliver additional capacity in acute & community services: To deliver additional acute and community bed capacity and increase staff capacity through the implementation of the Safe Staffing and Skill-Mix Framework and prioritisation of recruitment for existing funded posts to support Winter Plan 2022/23. The HSE also plan to extend the opening hours of a number of our of local injury units to operate between 8am to 8pm;
- Improve pathways of care for patients: To implement alternative patient pathways during the winter period to support admission avoidance, patient flow and discharge, including Enhanced Community Care (ECC) supports;
- Vaccination programme roll out for Flu and COVID-19: To deliver an influenza vaccination programme, COVID-19 vaccination programme and increase awareness and uptake for these respective programmes; and
- Implement Pandemic Preparedness Plan: To implement the Public Health Plan which includes the development of a surge and emergency response plan, in the event of a significant surge in COVID-19 infections.

Key Performance Indicators (KPIs)

Key Performance Indicators (KPIs) for USC activity remain below those established as part of the HSE National Service Plan (NSP). Of particular concern is the breaching of KPIs for patients aged over 75 years. In order to drive and sustain improvement a phased, integrated and whole systems approach is required. Accordingly, a Three-Year USC Improvement Programme is in the development phase to enable longer-term planning for anticipated future activity increases. In the first instance, this year's Winter Plan 2022/23 will provide short term local immediate action plans and national initiatives to assist with current challenges and will focus on six core KPIs which are detailed overleaf.

Figure 1: *Winter 2022/23 challenges*

Executive Summary

Table 1: *Targeted KPIs*

Metric	2022 YTD Performance	National KPI
24hr PET	95.7%	97%
24hr PET Over-75	89.4%	99%
DTOC	575	350
Length of Stay	5.1	≤4.8
8am Trolley Count	302	≤236
NAS Turnaround Time	21.6%	80%

Rigorous and regular oversight at national and local levels will be provided to support operational grip in relation to these targets. The Performance Management Improvement Unit (PMIU) will closely monitor and report on these KPIs and provide additional support as required to hospital groups and community healthcare organisations (CHOs).

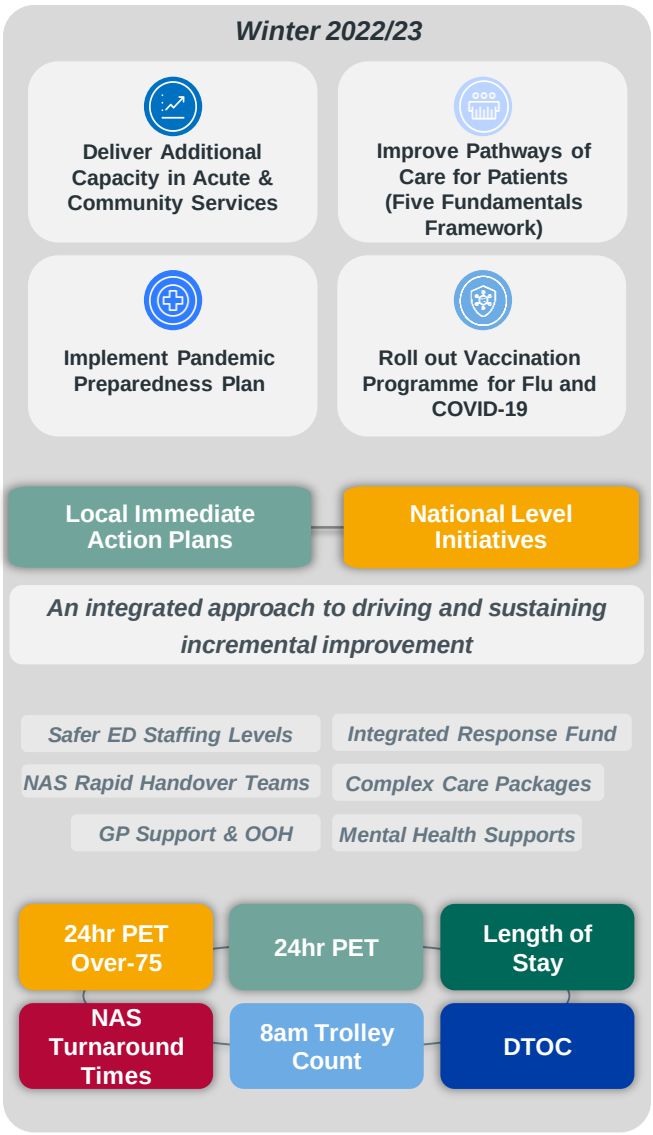
Local immediate action plans and national initiatives

The HSE has worked closely with hospital sites and CHOs to develop bespoke, integrated, local immediate action plans for Winter 2022/2023, tailored to the needs of the local context, informed by clinical engagement and supported by Senior Management Teams (SMT).

Funding will be provided as outlined overleaf at a national level across acute and community services for initiatives which provide essential support for admission avoidance, efficient patient flow and discharge processes during the winter period, including:

- An integrated response fund to expedite discharges;
- An out of hours fund to enhance diagnostic, medical and Health and Social Care Professional (HSCP) cover;
- Enhancement of teams to enable efficient patient flow including Community Intervention Teams (CIT);
- Provision of complex care packages; and
- Funding to enhance private capacity.

Figure 2: *Winter 2022/23 plan summary*



Winter Plan 2022/2023

The Winter Plan 2022/2023 aims to:

- Implement bespoke integrated local action plans focused on improving USC performance and alleviating seasonal winter pressures;
- Deliver new nationally-led, locally-delivered initiatives, based on best practice, to enhance admission avoidance, patient flow and discharge during the winter period; and
- Continue the implementation of the ongoing initiatives funded through the Winter and National Service Plans 2020/21 and 2021/22 including the provision of additional acute and community capacity.

As part of the local immediate action plans the HSE will:

- Make available an integrated response fund so that local governance structures can develop initiatives to respond rapidly to newly emerging challenges during winter;
- Set KPI targets for each site as part of the plan;
- Engage with sites to develop initiatives requiring longer-term investment and implementation to drive improvements in USC activity as part of Three-Year USC Improvement Programme; and
- Establish local integrated governance structures and implementation teams to monitor and report initiative implementation, KPI performance and proactive responses during the winter period.

Executive Summary

Winter 2022/23 investment

This component of the document outlines the aggregated planned winter investment for 2022/23. Detail on the initiatives, rationale and what will be delivered for the proposed financial ask is outlined in *Appendix 1.*

Table 2: *Winter 2022/23 costings*

Area	WTEs	Q4 2022 Cost	Q1 2023 Cost	Total Winter Cost	Recurring/Non-recurring
Acute Capacity		€5,000,000	€5,000,000	€10,000,000	Non-recurring
Acute Services - National Emergency Medicine Consultants + Support	71			€16,345,778	Recurring
Safer Staffing Phase 2	62	€1,017,098	€2,718,083	€3,735,181	Recurring
Older People Services		€8,000,000	€12,000,000	€20,000,000	Non-recurring
Primary Care & Complex case discharges		€7,250,000	€7,250,000	€14,500,000	Non-recurring
	28		€2,024,000	€2,024,000	Recurring
Community Services		€800,000	€800,000	€1,600,000	Non-recurring
		€6,050,000	€6,050,000	€12,100,000	Recurring
National Ambulance Service (NAS)		€3,400,000	€3,400,000	€6,800,000	Non-recurring
Communication		€1,485,003	€709,997	€2,195,000	Non-recurring
Hospital Groups and CHOs		€12,500,000	€12,500,000	€25,000,000	Non-recurring
Bespoke Hospital Group and CHO Initiatives	447			€35,115,769	Recurring
				€19,696,941	Non-recurring
Totals	**608.00**	**€45,502,101**	**€52,452,080**	**€169,112,669**	

Winter Plan 2022-23

Introduction

Context

Significant investment has been received through Winter Plans and National Service Plans (NSPs) over the past three years. This investment has enabled the Health Service Executive (HSE) to respond to the immediate demands of the COVID-19 pandemic, provide continuity of non-COVID-19 services and enhance all healthcare services across the continuum. It is important to recognise the essential contribution of HSE staff over the past three years, who continued to sustain, develop, deliver and enhance service provision in the face of unprecedented, challenging times.

The HSE acknowledges that significant challenges will remain this winter; this is evidenced by the increasing and sustained unscheduled care activity levels across the acute hospitals division. Despite a significant reduction in the prevalance of COVID-19 in the community, it remains a key risk to the health service. Of particular concern is the risk of a dual influenza and COVID-19 season and the significant pressures this would place on the health service. Initial modelling from the full-term Integrated Service Model (ISM) group predicts higher levels of hospitalisation for both influenza and COVID-19 this winter in excess of 2021/22 figures. An additional challenge for hospital and community services is the continuing requirement to operate separate COVID-19 and non-COVID-19 streams for attending patients.

The response

A phased, integrated response is required and a Three-Year Unscheduled Care (USC) Improvement Programme has therefore been requested by the Minister for Health. In the first instance, short-term, immediate actions will be taken by hospital sites and CHOs in order to alleviate current pressures this winter. The HSE Winter Plan 2022/23 has been specifically developed to address the challenges outlined above by providing for the appropriate, safe and timely delivery of care to patients. This plan will therefore provide additional capacity and resources to meet the expected high levels of activity during the winter period.

The Winter Plan 2022/23 includes national initiatives and individual local integrated hospital site and CHO immediate response plans. Proposed initiatives are guided by the 'Five Fundamentals Framework of Unscheduled Care' which focuses on the following critical enablers:

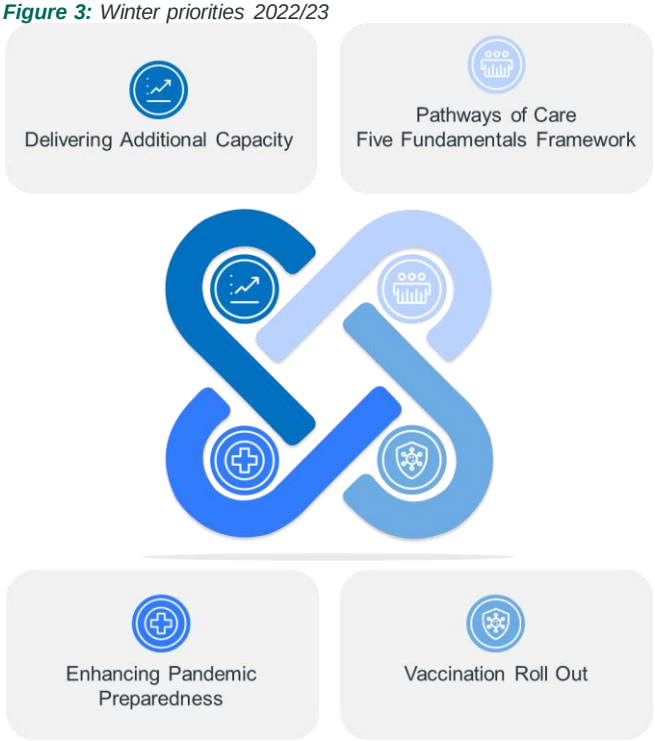
I. Leadership, Culture and Governance;
II. Patient Flow at Pre-Admission;
III. Patient Flow at Post-Admission;
IV. Integrated Community and Hospital Services; and
V. Data and Business Intelligence.

This plan has been developed following extensive consultation with the Minister for Health, Department of Health, Hospital Groups and CHOs, alongside engagement with clinicians in acute and community services. Areas of particular focus from a national perspective this winter are:

- **Building Capacity:** Development of additional acute and community capacity including the implementation of the Safe Staffing and Skill-Mix Framework, and the extension of local injury unit (LIU) working hours as feasible;
- **Pathways of Care:** Development of alternative pathways including Enhanced Community Care (ECC) supports for those at risk of hospital admission during winter, expansion of GP out-of-hours (OOH) and implementation of pathways to support patient discharge;
- **Vaccination:** Development and delivery of an influenza vaccination programme, in addition to implementation of an updated COVID-19 booster programme; and
- **Enhancing Pandemic Preparedness:** Implementation of the Test and Trace Transition Plan, with the development of surge planning and emergency response planning, in the event of a surge in COVID-19.

The Winter Plan 2022/23 will be delivered in tandem with the ongoing implementation of the outstanding components of the 2021/22 Winter and National Service Plans.

Figure 3: *Winter priorities 2022/23*



Winter 2021/22 Review

2021-22 Initiatives Delivered / Outstanding

2021/22 response

In preparation for Winter 2022/23 it is important to reflect on performance against the HSE Winter Plan 2021/22. The plan anticipated an approach requiring the maintenance of COVID-19 services, alongside the recovery and maintenance of routine non-COVID-19 services and the ongoing implementation of reforms to enhance services in line with Sláintecare. The plan also included ongoing implementation of outstanding initiatives funded as part of the NSP and Winter Plan 2020/21.

Winter 2021/22 was extremely challenging with record levels of emergency attendances and admissions across acute hospitals, ongoing high levels of COVID-19 related hospital activity and the emergence of new challenges (including the requirement for new COVID-19 pathways and ongoing issues following a cyber-attack). This placed high demand on health service capacity and delivery of service provision. Despite the challenges faced, a significant number of initiatives as set out in the Winter Plan 2021/22 and NSP 2022 have delivered:

- Increased bed capacity:
  - 907 acute beds have been delivered and 321 additional beds are funded and due to be delivered by year end 2023;
  - 68 critical care beds have been delivered and an additional 20 beds are funded and due to be delivered by year end 2023 as part of Phase 1 commitments;
  - The full allocation of 73 sub-acute beds have been delivered;
  - 342 community beds have been delivered with an additional 202 due to be delivered by year end 2022; and
  - Over 65,836 private bed days have been used in 2022.
- Over 14.2 million home support hours have been delivered in 2022 with an additional 13.4 million due to be delivered by the end of 2022;
- In 2022, over 53,154 Community Intervention Team (CIT) referrals have been made;
- The GP out-of-hours service has received over 655,924 calls to date in 2022;
- Over 188,516 scans have been completed as part of the GP access to diagnostic initiative in 2022; and
- Pathfinder have completed over 1,671 visits in 2022. This involves a multidisciplinary team visiting patients at home and, where possible, facilitating hospital avoidance as a result.

Lessons learned

Leadership, culture and governance

- The National Winter Oversight Group provided clear leadership and focus over winter 2021/2022 through a schedule of Senior Management Winter Operational meetings, Winter Oversight meetings and specific meetings with Hospital Group Chief Executive Officers (CEOs) and Community Healthcare Organisation (CHO) Chief Officers;
- Integrated and collaborative working was operational across acute and community services throughout the winter period and can be built upon to establish year-round USC improvement with explicit clarity on the roles and reporting relationships of those involved; and
- Continued use and further development of the National Project Management Office (PMO) portal during winter 2021/22 strengthened the sharing of performance data within the HSE and to the Department of Health (DoH) through the generation of high-quality weekly reports and illustration of service delivery across the spectrum. Further improvements can be achieved through a focus on user compliance regarding completeness and timeliness of reported data.

Demand management: Patient flow pre-admission

- The concerted focus on admission avoidance and ambulatory care had a positive effect across several sites. Hospital avoidance initiatives such as Community Intervention Teams (CIT) / Outpatient Parenteral Antimicrobial Therapy (OPAT) / Frailty Intervention Therapy Teams (FITT) and the continued development of ECC programmes all demonstrated positive impacts across Patient Experience Times (PET) and overall service provision. Reporting on activity and impact of these alternate pathway initiatives will be further developed as implementation continues throughout the winter period;
- Direct GP access to diagnostics both internally and externally was a key enabler to improving PETs by providing a high level of diagnostics across MRI, X-ray, DEXA and CT; and
- Enhancement of GP out-of-hours services was beneficial to hospital avoidance with the percentage of referrals from GP out-of-hours to EDs remaining stable at low levels throughout the winter period.

Winter 2021/22 Review

2021-22 Initiatives Delivered / Outstanding

Lessons learned *(cont'd.)*

Demand management: Patient flow pre-admission (cont'd.)

- The high levels of attendances and admissions for the over-75 age group requires particular consideration given the high level of medical and multidisciplinary team input required. These patients often have multiple and complex needs and frequently require longer lengths of stay within acute settings alongside additional supports to facilitate safe discharge.

Operational flow: Patient flow post-admission

- Notably, with the onset of the Omicron wave of COVID-19 in January 2022, all acute sites continued to manage COVID-19 and non-COVID-19 pathways with the yearly predictable winter demands and increased ED attendances. The need to maintain dual pathways impacted the use of Acute Medical Assessment Units (AMAUs) / Surgical Assessment Units (SAUs) / Day Wards and this had a significant impact on acute hospitals' ability to move patients quickly from ED to inpatient beds across many acute sites;
- Additional funded bed capacity was delivered across acute and community settings through increased public capacity and using private providers which collectively had a positive impact on the delivery of USC and operational processes in relevant sites. However, difficulties were encountered in delivering the profile of beds as planned due to capital and estates delays and difficulties recruiting staff;
- The high numbers of patients attending ED had a significant impact on patient flow processes. The use of AMAUs as ED overflow for patients impacted the opportunity for earlier senior clinical decision making, contributed to delayed decisions and led to higher overnight conversion rates. The high level of emergency presentations and admissions also had an impact on SAUs / Day Wards / General Wards with additional surge capacity open, and led to significant challenges in the appropriate transfer of patients through the hospital; and
- The number of patients impacted by Delayed Transfers of Care (DTOC) increased during the winter period due to widespread community transmission and resultant COVID-19 outbreaks in both acute and community settings. It is important to note that despite the challenges experienced, discharges continued to be facilitated.

Integrated community and hospital services

- Building on the integrated approach to winter planning from previous years, at local level, each area has an Integrated Management Team comprising the relevant Acute (Hospital Group), CHO and Public Health representation as required; and
- A weekly meeting was held with the National Integrated Winter Oversight Group and local Integrated Management Teams to report on performance and for any issues or risks to be discussed to enable timely oversight, management and responses in an integrated manner at local and national levels. The areas using a strong integrated working approach clearly demonstrated positive outcomes.

Using information to support sustainable performance improvement

- The PMO portal provided accurate and timely weekly data which was invaluable during the winter period and was a key resource and enabler for assisting the delivery of measurable service improvements. The use of this 'operational intelligence' informed overall performance trends and was critical in enabling evidence-based decision making; and
- The weekly USC reports were enhanced to inform both national and local services with the addition of detailed data at site level.

Winter 2022/23 Context

Expected Demand Scenarios

COVID-19, flu and other respiratory infections

The Health Protection Surveillance Centre (HPSC) has outlined three potential scenarios regarding respiratory illness this winter*:

Figure 4: *Potential scenarios – respiratory illness*

1 High Flu Season
COVID-19 season - Vaccine Escape

- Influenza c.4350 hospitalisations, c.225 ICU admissions
- COVID-19 cases will be a function of the extent of vaccine escape and so are difficult to estimate

2 High Flu Season
COVID-19 season - vaccine is effective against severe disease

- Influenza c.4350 hospitalisations, c.225 ICU admissions
- COVID-19 c.17,000 hospitalisations, c.700 ICU admissions

3 Low Flu Season
COVID-19 - vaccine is effective against severe disease

- Influenza c.2900 hospitalisations, c.150 ICU admissions
- COVID-19 c.17,000 hospitalisations, c.700 ICU admissions

Within the six-month Winter 2022/23 period, there is expected to be a peak in activity.

**The High Flu Season example is based on week 40, 2017 to week 13, 2018 influenza. The Low Flu Season example is based on week 40, 2018 to week 13, 2019 influenza. The COVID-19 example is based on week 40, 2021 to week 13, 2022. Increased pressures in respiratory demands can be extrapolated to pressures being experienced in community services including testing and tracing.*

Demand modelling is underway to predict Pessimistic, Intermediate and Optimistic scenarios for the winter period.

Other drivers of winter demand

While respiratory infections are a key focus for HSE planning, and an important factor driving demand for health services over winter, there are also other considerations:

Demographic factors: Population growth and ageing create year-on-year demographic pressure for health services. Preliminary Census 2022 findings reported by the Central Statistics Office (CSO) indicate that population growth is well-ahead of recent projections. This means recent analyses of demographic pressure on health services are likely to under-estimate the potential impact of population growth and ageing on demand. In addition, as of 22nd September 2022, 59,640 refugees arrived in Ireland with further arrivals expected. The volumes of these arrivals is already greater than the year-on-year growth in population and will add to demographic pressure on health services.

Cold weather: Cold weather over the winter months leads to excess morbidity and mortality. This is through the direct effect of cold weather, and due to temperature-mediated effects on air quality. Rising energy poverty reported by the Economic and Social Research Institute (ESRI), which may deteriorate further over winter, means that older people, poorer people and those in socially excluded groups experiencing severe health inequalities, may be at increased risk of cold-weather related illness this winter than in usual years. This will increase demand on health services.

2nd order impacts of COVID-19 and "Recoiled Spring": There have been disruptions to healthcare access, especially elective care, since the onset of the COVID-19 pandemic in 2020. This unmet need for care may present as demand for USC over winter, increasing complexities and length of stay. For some groups in the population, COVID-19 and associated restrictions also impacted access to activities and services that maintain good health, such as physical activity and social interaction, which may lead to accelerated progression of frailty. Combined, these 2nd order impacts of COVID-19 may create a "recoiled spring" effect releasing additional demand for health services over Winter 2022/23.

Figure 5: *Hospitalisations demand – Medium / long term*

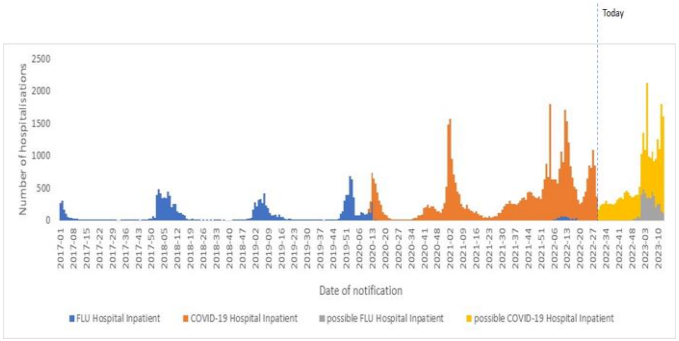
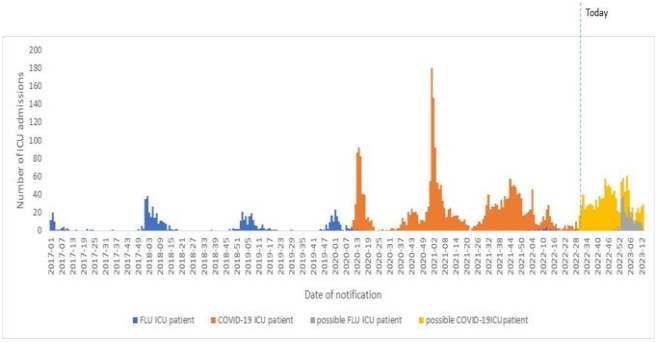


Figure 6: *ICU demand – Medium / long term*



Winter 2022/23 Context

Unscheduled Care (USC)

USC Overview 2019 – 2022 YTD

Unscheduled Care (USC) demand continues to grow year on year. Winter 2021/22 saw a 9.6% increase in attendances in comparison to the previous Winter period. This year has seen a record volume of patients attend EDs on a weekly basis. In recent weeks, the average number of attendances has increased, noting there has been a sustained increase in attendances in those patients aged over 75 years, many of whom present with complex needs requiring admission and input from a wide range of multidisciplinary teams.

The greatest challenge to addressing the high trolley count and poor patient experience times are the delays encountered in accessing acute inpatient beds, especially for older people.

To alleviate ED congestion, this plan sets out the requirement to ease pressures on EDs by delivering care in the most appropriate clinical setting, maximising patient flow from community to hospital and appropriate discharge while maintaining optimal inpatient length of stay and strengthening the existing integrated (hospital and community) approach to patient flow.

Given the continued high volume of patients aged over 75 years attending and being admitted to our hospital, there will be a continued delay in accessing acute inpatient beds which will result in ED congestion, high occupancy levels and high trolleys in certain sites.

Figure 7: *Emergency department attendances*

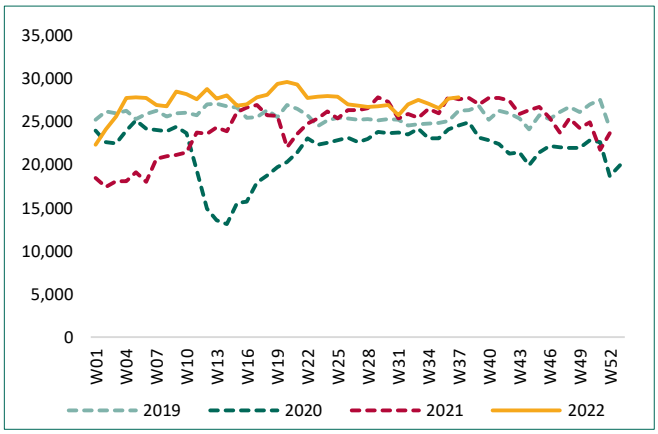


Figure 8: *Emergency department admissions*

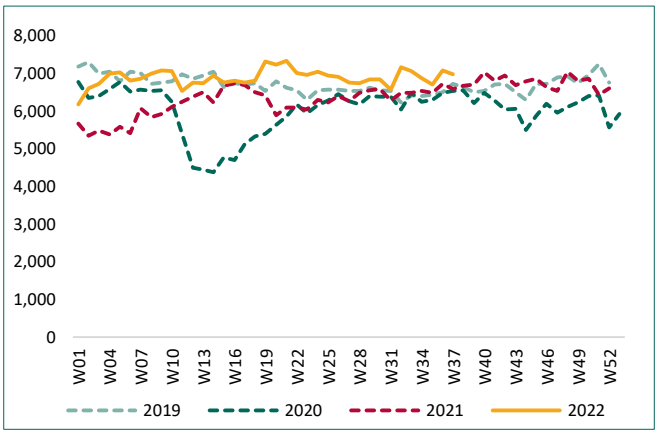


Figure 9: *Emergency department attendances (Over-75 years)*

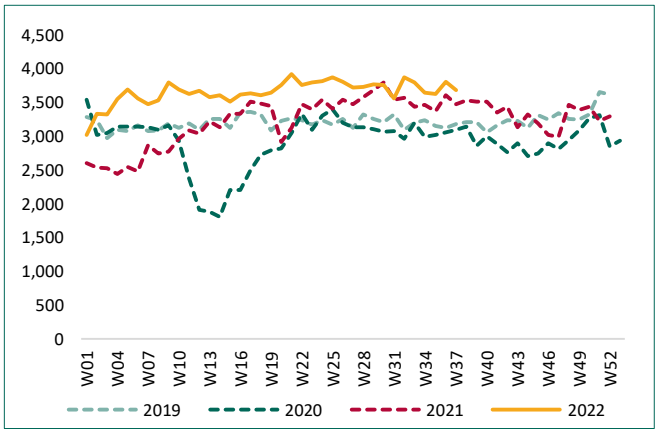
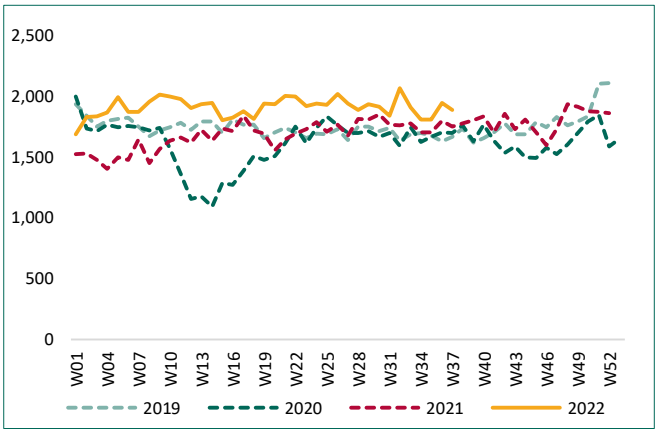


Figure 10: *Emergency department admissions (Over-75 years)*



Winter 2022/23 Context

Three-Year Unscheduled Care (USC) Improvement Programme

Three-Year USC Improvement Programme vision

- To deliver safe, efficient and high-quality care in our EDs;
- To provide effective leadership for improvement and ensure that change is clinically led and excellently managed at local levels;
- To support and implement pragmatic and effective solutions to improve patient and staff experience;
- To set clear expectations and targets regarding performance improvement;
- To provide integrated governance systems to improve operational grip and drive performance and improvement; and
- To implement the Performance and Accountability Framework to provide accountable structures and supports for effective and efficient performance delivery.

Three-Year USC Improvement Programme

The overarching aim of the Three-Year USC Improvement Programme is to transform USC delivery across all acute and CHO services in a structured, systemised and governed manner which is measurable and sustainable. This programme will adopt a three-year phased approach. Figure 11 below outlines the approach at a high level, underpinned by the Five Fundamentals Framework. The approach is reinforced by the ethos – 'clinically led, excellently managed'.

Year 1 of this programme will target incremental improvements in KPIs associated with those patients aged over 75 years. The agreed KPIs will be tailored for each site and will target incremental improvements in KPI performance.

Targeting improvements for patients aged over 75 years is an immediate priority as attendances and admissions for this age group have exceeded previous records consistently this year. Appropriate targeted solutions are required to address the sustained levels of activity for this cohort as evidence demonstrates these patients are at risk of:

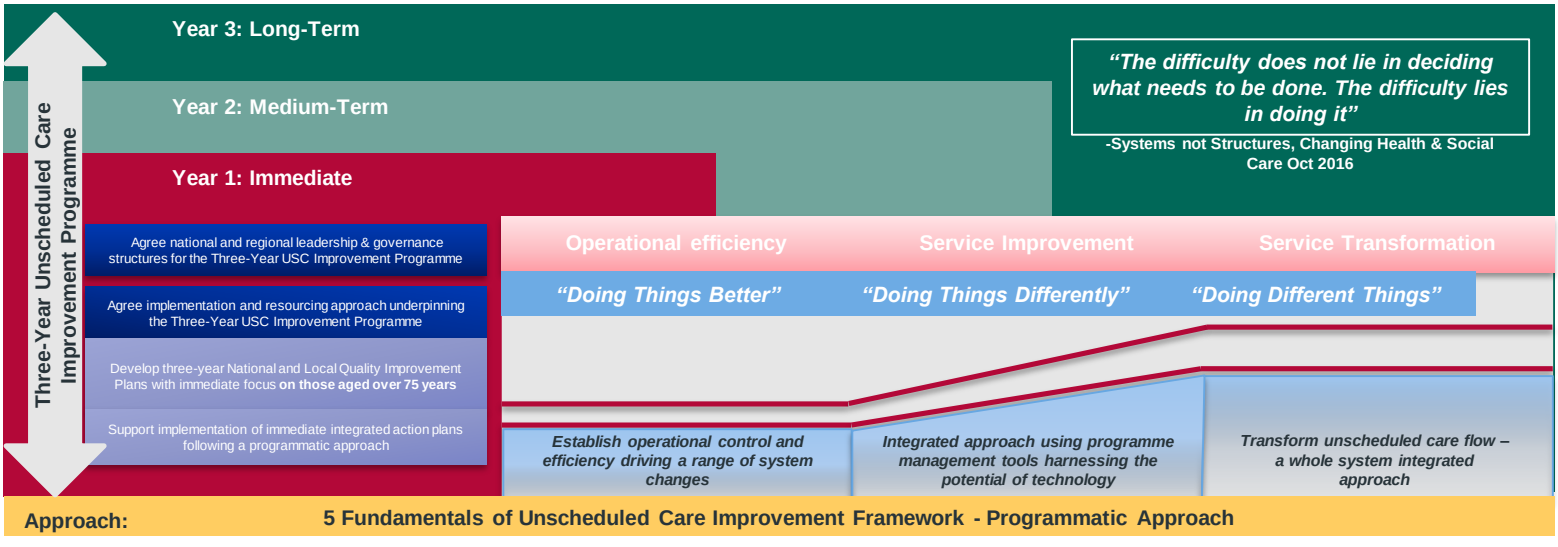
- increased mortality rates associated with longer ED wait times;
- prolonged length of hospital stay if admitted; and
- readmission, institutionalisation and functional decline.

Addressing and improving USC performance for this age group has the potential to address and drive overall USC improvements by improving the care experience and outcomes for older adults and in-turn enhancing patient flow, capacity and access to care for the general public including scheduled care.

Patient flow academy

The Three-Year USC Improvement Programme aims to introduce the concept of a Patient Flow Academy. Patients typically move through healthcare systems in condition-based pathways, and how they move along these pathways impacts upon patient experience and outcomes, as well as on staff and resources. A patient flow academy would focus on education and on continuous improvement.

Figure 11: *Three-Year USC Improvement Programme approach*



Winter 2022/23

Winter KPI Targets

Winter Key Performance Indicators (KPIs)

All initiatives proposed in the Winter Plan 2022/23 focus on one or more of the KPIs listed in Table 3. These will function alongside the full suite of KPIs in the HSE NSP.

Table 3: *Winter KPI targets*

Metric	2022 YTD Performance	National KPI
24hr PET	95.7%	97%
24hr PET Over-75	89.5%	99%
DTOC	575	350
Length of Stay	5.1	≤4.8
8am Trolley Count	308	≤236
NAS Turnaround Time	21.6%	80%

Enhanced Focus

As part of the Winter Plan 2022/23 there will be a specific focus on six KPIs. It is recognised that achieving the KPI targets this winter will be challenging. The initiatives outlined in this plan, in conjunction with the Three-Year USC Improvement Programme, will target incremental improvements in the KPIs illustrated in Figure 12. Rigorous and regular governance and oversight will ensure that set KPIs are prioritised.

Figure 12: *Targeted KPIs for Winter 2022/23*

24hr Patient Experience Time (PET) & 24hr PET > 75

As part of the Winter Plan 2022/23 the system will aim to ensure that no patient aged over 75 years is waiting for a bed for more than 24 hours.

Focusing on PET and enhancing compliance with PET targets will have a positive impact on trolley numbers. *Figure 13* highlights numerous sites under significant pressure to meet set KPIs, and enhanced supports will be provided to these sites as part of the 22/23 Winter Plan and Three-Year USC Improvement Programme. Individual site level targets will be set in year 1 of the Three-Year USC Improvement Programme and will be bespoke to each hospital site.

Delayed Transfers of Care (DTOC)

Initiatives in the Winter Plan 2022/23 will also focus on ensuring no more than 350 weekly delayed transfers of care (DTOC), whist actively working to decrease this figure.

Length of Stay (LoS)

A universal over-14-day LoS process will be rolled out across all acute hospitals. This process will target reducing the number of wasted acute bed days and support the Sláintecare vision of "Right Care, Right Place, Right Time."

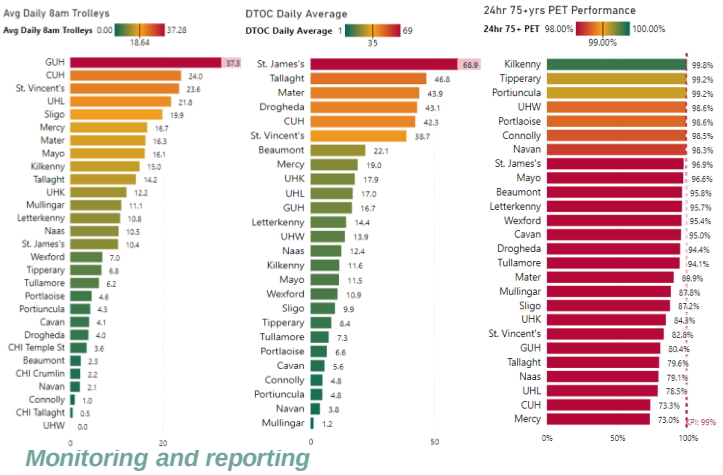
08:00hrs Trolley Count

The HSE continues to work toward ensuring that no more that 236 patients will remain on trolleys awaiting admission on any given day, whilst acknowledging that certain sites as outlined in *Figure 13* will remain challenged. An enhanced focus with individual site targets to reduce trolley numbers across all sites will be a priority this winter.

National Ambulance Service (NAS) turnaround times

Initiatives implemented as part of Winter 2022/23 will seek to improve the percentage of ambulances that have a time interval of less than or equal to 30 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call.

Figure 13: *Average daily 8am trolley count and DTOC - 2022*



Monitoring and reporting

Each Hospital and CHO will put monitoring and reporting arrangements in place on a daily, weekly and monthly basis. Consideration will also be given to enhance public reporting.

Monitoring and reporting of progress against the Winter Plan will be coordinated and managed by a National Programme Management Office (PMO). The PMO will ensure that programme and project reporting is aligned, integrated and reflects the status of all the projects being delivered. The PMO and local implementation teams will utilise the reporting portal developed for the 2020/21 Winter Plan to support responsive decision-making and robust management practices.

The PMO will report weekly through the USC Improvement Programme Steering Group. These reports will be forwarded to the DoH weekly and reviewed as part of the weekly engagement between the PMIU and DoH.

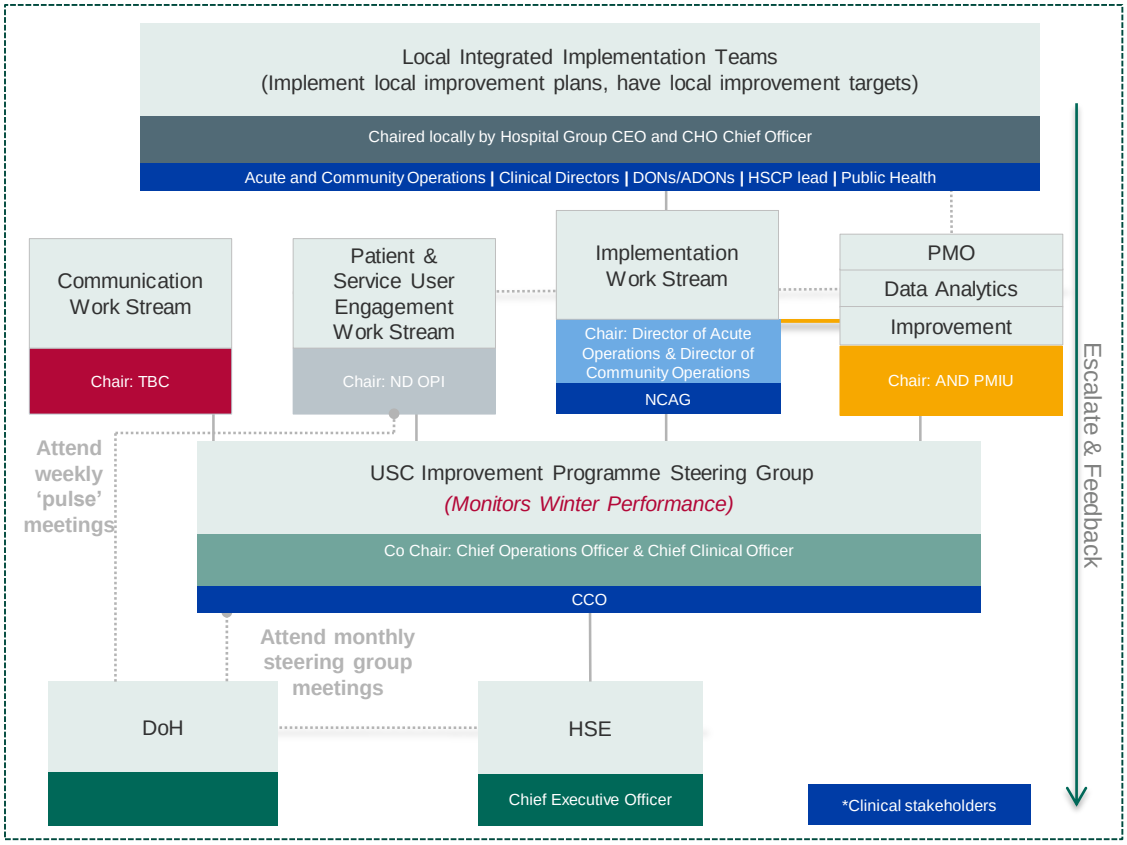
Winter 2022/23

Governance and Accountability

Governance and accountability

The HSE's Winter Plan for 2022/23 aims to address the significant challenges faced by the health service this winter. The scale of these challenges and the demands that the health system will face requires both a robust, cohesive plan and an associated integrated system of governance and accountability, to ensure delivery against the plan. Figure 14 below outlines the national, area and site level leadership and governance structure as part of the Three-Year USC Improvement Programme. The Winter Plan will lead into year one of the improvement programme and will align with the governance structure of the overarching programme. All structures will support improvement in line with the Five Fundamentals Framework.

Figure 14: *Proposed governance structure*



Operational grip

The HSE's Winter Plan for 2022/23 will promote a universal approach to enhancing operational grip and accountability at both national and local levels. This will provide greater focus on effective strategic and operational delivery and governance structures. Joint governance groups (Hospital and CHO) will provide a framework for the implementation, monitoring and reporting of KPIs, immediate actions undertaken, Winter/NSP initiatives and performance.

National perspective

From a national perspective, the HSE Board will, through its Performance and Delivery Committee, seek assurance on the implementation of the Winter Plan from the CEO and his Executive Management Team. The Chief Operations Officer, supported by other members of the Executive Management Team, is the lead Executive for the implementation of the service provision components of the Winter Plan.

Local perspective

To ensure oversight at a local level, each area has Local Integrated Implementation Teams that will implement local winter initiatives.

Performance and improvement monitoring

Rigorous and regular oversight at national and local levels will be provided to support operational grip in relation to the identified prioritised KPIs. The PMIU will closely monitor and report on these KPIs, winter plan implementation and provide additional support as required to hospital groups and CHOs experiencing significant pressures during winter.

Hospital & CHO Integrated Priorities 2022/23

Hospital & CHO Integrated Priorities

Winter 2022/23

Integrated hospital group and CHO winter 2022/23 responses

Table 5 overleaf outlines examples of the initiatives that each hospital site and associated CHO will implement during the winter period to enhance patient flow and target core winter KPIs. Performance against each of these actions will be monitored and governed locally by the integrated implementation teams.

In addition, national funds will be available for integrated implementation teams to access for the following areas:

Table 4: *National funds for integrated implementation teams*

Initiative	Rationale
1. Emergency department safer staffing	
An analysis by site has been completed and the number of additional Emergency Medicine Consultants required to enhance the delivery of safe and timely care to patients in ED is 51 Whole-Time Equivalents (WTE). Due to recruitment limitations, these posts will be filled initially with locum Consultants to ensure full impact over the winter period. An additional 20 WTE Registrars, will be required to support the ED Consultant posts.	With senior clinical leaders and decision makers on the front line, there will be increased efficiency making clinical decisions and in directing patients to the most appropriate care pathway for their specific needs. This will positively impact performance KPIs, ensure consistent discharge of patients to new alternative care pathways and boost staff morale.
2. Emergency services support (including enhancement of local injury units)	
Funding will be provided (based on KPI performance and requirement for alternative pathways) to specific locations nationally to extend **local injury unit (LIU) hours**, availing of overtime in the first instance. This fund will also purchase private capacity for minor injuries as required. Allocation of this fund will be provided by Acute Operations.	Enhancing the **operating hours of LIUs** and opening private capacity for minor injuries will provide alternative pathways to ED, and reduce the number of attendances, streaming the right patient to the right location.
3. Local fund to maximise out of hours services	
Each integrated implementation team will be allocated a specific amount of funding for spend on out of hours services including diagnostics, ED resources, HSCPs for weekend working. This will function on an overview spend basis to ensure rapid access to these services.	Investment in out of hours services ensures that patient flow is not limited by opening hours, ensuring a round-the-clock solution to patient flow. ED attendees will benefit from shorter wait times and will be less likely to be admitted unless it is deemed medically necessary. Weekend discharges will be enhanced.
4. Hospital & CHO integrated priorities	
Hospital Groups and CHOs have submitted bespoke requests for funding to enable local patient flow initiatives. Acute Operations and Community Operations have reviewed in detail all submissions to ensure investment is allocated to the initiatives that will provide the greatest benefits to patients and enhancement of patient flow from an acute and community perspective.	Local ownership of these initiatives is essential for ensuring the realisation of the Sláintecare vision. Local services will be empowered to address the specific service needs of the local population in a manner that aligns to the strengths of staff skills and knowledge. These local initiatives are conceptualised around improving performance KPIs and patient experience.

Bespoke Integrated Priorities

Winter 2022/23

Integrated hospital group and CHO winter 2022/23 responses

Table 5 outlines examples of the initiatives that each Hospital site and associated CHO will implement during the winter period to enhance flow and target core winter KPIs. Performance against each of these actions will be monitored and governed locally by the integrated implementation teams.

Table 5 : *Immediate actions under the Five Fundamentals Framework for USC*

Category	Initiative	KPIs Impacted
1. Leadership, culture and governance	Joint governance groups (Hospital and CHO) to be implemented locally to monitor implementation of immediate actions, Winter/NSP initiatives and performance of the ECC programme.	All KPIs
	Local integrated USC meetings to develop solution-based approaches to escalation, diagnostics, flow and discharge issues with escalation to Senior Management locally as required.	All KPIs
	Engagement with Primary Care and GP colleagues through local governance structures to communicate alternate access and pathways. Engagement of all hospital sites with Primary Care CHO and GP colleagues through established Local Integrated Care Committees (LICC) to communicate alternate access and access routes.	All KPIs
	Establishment of a weekly, integrated (acute and community) long-stay review (patients > 7 days/14 days Length of Stay (LoS)) process/senior team huddle.	LoS
	Continuously involve and discuss ECC implementation, while encouraging GP participation in pathway development/enhancement.	ED Avoidance
2. Patient flow at pre-admission	Maximise usage of community support services by strengthening and standardising referral pathways to support admission avoidance and facilitate rapid discharge e.g., CIT, ECC, Integrated Care Programme for Older Persons (ICPOP), GP Diagnostics and emergency outpatient slots.	ED Avoidance LoS DTOC
	Rapid development of standardised pathways between ED and LIUs, where available to maximise streaming of appropriate lower acuity presentations from ED.	ED Avoidance
	Enhance diagnostic capacity by 1) utilising mobile diagnostic capacity and 2) ring-fencing diagnostics referral slots from EDs.	ED Avoidance
	Direct referral from ED to alternative settings e.g., Model 2s, other step-down facilities and community hubs.	ED Avoidance
	Review role of Advanced Nurse Practitioners (ANPs) in ED to target admission avoidance.	Admission Avoidance
	Enhancement of frail elderly services and services targeting patients aged over 75 years in EDs and back into the community through ECC programme, and other already established pathways.	ED Avoidance
	Implement 'Discharge to Assess' models for high volume pathways including ring-fencing Outpatient Department (OPD) slots to allow for 'Discharge to Assess' models of care.	PET 8am Trolley Count
	Targeted education, communication and engagements delivered by ECC both at a national (e.g., ICGP, IMO, IGPNA) and local level to inform GPs of alternative pathways.	ED Avoidance
	Implementation of interRAI including recruitment of 128 Care Needs Facilitator posts & implementation of interRAI across 3 initial areas - Home Support, ICPOP & Residential Services.	LoS

Bespoke Integrated Priorities

Winter 2022/23

Table 5 (cont'd) : *Immediate actions under the Five Fundamentals Framework for USC*

Category	Initiative	KPIs Impacted
3. Patient flow at post-admission	In-reach of Community Intervention Teams (CIT) to promote early discharge (pull approach).	LoS
	Introduce an operational tool with SAFER flow bundle and enhance education regarding SAFER to support its consistent implementation. Explore the use of digital solutions to support implementation.	All KPIs
	Review scheduled activity on site and find alternative options in Model 2s, Model 3s (review Group capacity), alternative community/home arrangements for non-medical complex cases, and Private Hospitals.	LoS/PET
4. Integrated community and hospital services	Incorporation of data on available community bed capacity as part of joint governance and local integrated USC meetings. This data should include bed closures, for Long Term Care (LTC), step down and rehab beds.	LoS
	Rapid development and deployment of standardised integrated pathways through established community supports and services including ECC, ICPOP and Chronic Disease Management (CDM) teams targeting those at risk of hospital admissions and early supported discharge.	All KPIs
	Target community capacity to facilitate outpatient diagnostics.	All KPIs
	Review of regulations to allow safe discharging of patients to long term care facilities at weekends or evenings which is criteria based.	LoS
	Community to expand nationally the routine daily "pull" approach utilising a single point of contact on-site for each acute hospital to facilitate discharge.	All KPIs
	Targeted use of TCB funding to support complex discharges.	LoS
5. Using information to sustain and support performance improvement	National reporting structures in place to provide USC activity (all key performance metrics) on a national and site level basis with additional insights being supported by the PMIU.	Al KPIs
	PMO performance reports to be circulated to all Chief Executive Officers and Chief Officers.	-

National Winter Priorities 2022/23

Winter Priorities 2022/23

Figure 15: Winter priorities 2022/23

Deliver Additional Capacity in Acute and Community Services

Improve Pathways of Care for Patients (Five Fundamentals Framework)

Implement Pandemic Preparedness Plan

Vaccination Programme Roll Out for Flu and COVID-19

Deliver Additional Capacity in Acute and Community Services

Delivering Additional Capacity

Acute and Community Capacity

As previously explained, the HSE is anticipating extremely high demand this winter. Both the NSP and Winter Plans 2020/21 and 2021/22 have targeted enhancing capacity in acute and community settings to facilitate patient flow through admission avoidance, inpatient and discharge pathways. In 2021/22 challenges were faced when implementing additional capacity due to successive COVID-19 waves, infection control requirements, access challenges to undertake the work, increased timeframes to complete the capital programmes, staff absenteeism and recruitment challenges. The additional capacity delivered in the system to date is presented in Table 6 below alongside the additional capacity planned for delivery for the remainder of 2022 and 2023. Responding to the additional demands anticipated during Winter 2022/23, outstanding initiatives targeting additional capacity funded through the Winter Plan and NSP will continue to be implemented.

Table 6: *Capacity*

Funded Initiative	Target as funded from NSP & Winter 20/21 & 21/22	Delivered 21/22	Remaining for Delivery in 22/23
Acute Beds	1,228	907	321
Critical Care Beds	88	68	20
Sub-Acute Beds	73	73	N/A
Public Community Beds	544	342	202
Private Intermediate Care Beds*	*Demand-based*	*Demand-based* (~533 per week)	N/A
Total	1,933+	1,390 (excluding private IC beds)	543

***** *Private Intermediate care beds contracted on a weekly basis. Figure as per 11/8/22*

Over 1,933 beds have been delivered to date as part of Winter and NSP funding. The priority for Winter 22/23 is to deliver the remaining 543 beds as outlined above. Furthermore, additional initiatives for Winter 2022/23 will be targeted at optimising and creating capacity at three critical stages in the patient pathway. To support the enhancement of capacity in acute settings, the following initiatives will also be implemented:

Integrated over 14-day process

A universal action will be rolled out across all sites to ensure all patients in an acute bed for more than 14 days are reviewed every week. Teams in each acute hospital will visit their allocated wards on a Wednesday morning each week to:

- Capture the progress of each patient along their agreed care pathway;
- Highlight, challenge and unblock delays (internal and external waits); and
- Support safe and timely discharges.

Each patient's journey will be critically reviewed to identify the required steps to reach discharge and to ensure the timely implementation of critical interventions.

SAFER patient flow

SAFER is a national tool used to reduce delays for patients in inpatient wards. The tool should be implemented through effective, collaborative board rounds with engagement from the Multi-Disciplinary Team (MDT). It consists of the following elements:

S **Senior review** – all patients will have a senior review before midday;

A **All patients** will have a Predicted Discharge Date (PDD) and Clinical Criteria for Discharge;

F **Flow of patients** to commence at the earliest opportunity from assessment units to inpatient wards;

E **Early discharge** – aim for discharges before 11:00 AM each day; and

R **Review** – a systematic, daily MDT review of patients with extended lengths of stay.

SAFER will support reductions in LoS, and will help to improve patient flow, safety and communication. *Appendix 2* includes further details on SAFER. The use of digital solutions to support implementation will be considered.

Delivering Additional Capacity

Acute and Community Capacity

Community bed usage

The HSE has examined and identified factors contributing to the under-utilisation of community beds. These factors include:

- patient choice and preference for limited single occupancy rooms;
- delays in capital works to support reconfiguration of beds in line with regulatory requirements;
- COVID-19 related infection, prevention and control (IP&C) requirements including outbreak measures;
- delays due to admission policies;
- staff COVID-19 related absenteeism; and
- recruitment challenges.

In response to these challenges several strategies will be deployed to increase the utilisation of community beds during the winter period including:

- improved processes and systems to support real-time data on available community beds for local acute and community services;
- targeted recruitment of approved discharge liaison coordinators as part of local immediate action plans and national level initiatives;
- improved communication to ensure efficient transfer and turnaround of beds to support acute discharge;
- ongoing liaison with Public Health regarding IP&C requirements; and
- utilisation of established Community Support Teams (CSTs) to support high standards of IP&C during the winter period.

National Transitional Care Bed (TCB) funding

Demand-led Transitional Care Bed (TCB) funding will continue to be available to support patients discharging from acute hospital settings to long stay care in nursing home beds; and for patients who require convalescence care before returning home. Same-day approval funding is available to all acute hospitals to support:

- Nursing Home Support Scheme (NHSS) – once patient has been medically approved as requiring long stay care;
- Convalescence up to 6 weeks;
- Delays in Home Support providers;
- Patients who require home adaptations to facilitate their care on return home; and
- Patients with legal complexities which is preventing completing the NHSS process.

TCB activity has substantially increased against planned targets during 2022, as shown below:

Table 7: *TCB activity*

2022	Target	NHSS	Convalescence/ Home Support	Total New Approvals	Extensions 2022
January	620	397	279	676	98
February	528	499	279	778	100
March	680	492	330	822	95
April	703	441	313	754	137
May	587	510	344	854	108
June	732	431	333	764	100
July	757	397	341	738	138
TOTAL	**4607**	**3167**	**2219**	**5386**	**776**

COVID-19 criteria is still in place for acute hospitals to facilitate an earlier discharge for patients medically recommended for long stay care. This will continue to be monitored and reviewed in line with DTOC numbers and pressures on acute hospital services.

Delivering Additional Capacity

Acute and Community Capacity

Delivering additional capacity – key actions for Winter 22/23

Admission avoidance

- Strengthen and standardise referral pathways to maximise the use of community support services to better facilitate admission avoidance and rapid discharge;
- Expand LIUs and standardise pathways from ED to redirect appropriate lower acuity presentations and implement a direct referral process from ED to alternative settings such as step-down units;
- Enhance access to diagnostics by enhancing community capacity to facilitate OPD diagnostics, GP access and out-of-hours (OOH) supports, and mobile diagnostics in the community;
- Enhance frail elderly services in ED and into the community through the ECC programme;
- Ring-fence outpatient department (OPD) slots to allow for 'discharge to assess' models of care; and
- Rapid development and deployment of standardised integrated pathways through established ICPOP and CDM teams targeting those at risk of hospital admissions and early supported discharge.

Inpatient flow and length of stay (LOS)

- Make use of private capacity to enhance inpatient flow;
- Conduct a gap analysis on resources required for patient flow (e.g., Discharge Coordinators); and
- Implement an integrated over-14-day process.

Discharge

- Review use of HSCPs at the weekend to promote targeted weekend discharge;
- Review regulations to allow safe discharging of patients to long-term care facilities at weekends or evenings;
- Develop in-reach discharge models and incorporate data on community bed capacity to support discharge;
- Profile social care targets for discharge on a weekly basis;
- Invest in aids and appliances to facilitate discharge and introduce an operational tool with SAFER flow bundle; and
- Use TCB funding to support complex discharges and prioritise use of community teams to facilitate discharges.

Delivering Additional Capacity

Community Services

Services for Older People

Short stay and respite services

Short stay and respite capacity will be maximised this winter to support acute hospitals in reducing overall length of stay (LoS) for older people. Available capacity will also be utilised to facilitate ICPOP teams to deliver admission avoidance initiatives.

Each ICPOP team will have ring-fenced community bed-based capacity to deliver sub-acute care and rehabilitation for those patients whose needs can be met in non-acute clinical environments. To facilitate this initiative, each ICPOP team will receive additional Non-Consultant Hospital Doctor (NCHD) Registrar support to monitor and manage patients using community bed capacity. These Registrars will also support ED consultants with streaming patients presenting at ED departments to alternative clinical settings such as community-based facilities where they will have consultant oversight from the ICPOP team.

Each CHO area will ring-fence home support capacity to support more older people to remain at home and additional CIT capacity will also be made available to ICPOP teams to facilitate maximum admission avoidances. Finally, ICPOP teams will have access to a ring-fenced budget to access aids and appliances for patients on their caseloads at risk of hospital admission.

Home care and re-ablement

The NSP 2022 aims to deliver a total of 24.2 million Home Support Hours to provide additional capacity for long term care avoidance, waiting list reduction and re-ablement. In addition, 250 ongoing re-ablement packages for services users will be provided to support them to remain at home.

Figure 16: *Home support hours*

As of the end of August 2022, more than **14.2 million home support hours have been delivered** to clients in the community

An **additional 10 million** hours are due to be delivered by year end 2022

The allocation of hours will continue to be monitored throughout the course of the winter period and will be an important part of the health service response to winter pressures. Services for Older People will continue to support the delivery of home support hours through the recruitment and retention of staff.

Community services – key actions for winter 22/23

Maximise short-stay and respite capacity

- Utilise available capacity to facilitate ICPOP teams to deliver admission avoidance initiatives;
- Ring-fence community bed-based capacity for ICPOP teams;
- Allocate additional Registrar support to ICPOP teams and ED Consultants to manage community bed utilisation and stream appropriate patients to alternative clinical settings;
- Ring-fence home support capacity in each CHO;
- Make available additional CIT capacity to ICPOP teams to support care for patients in the community; and
- Provide ICPOP teams with access to ring-fenced funding to access aids and appliances.

Home care and re-ablement

- Continue to deliver home support hours in line with the NSP.

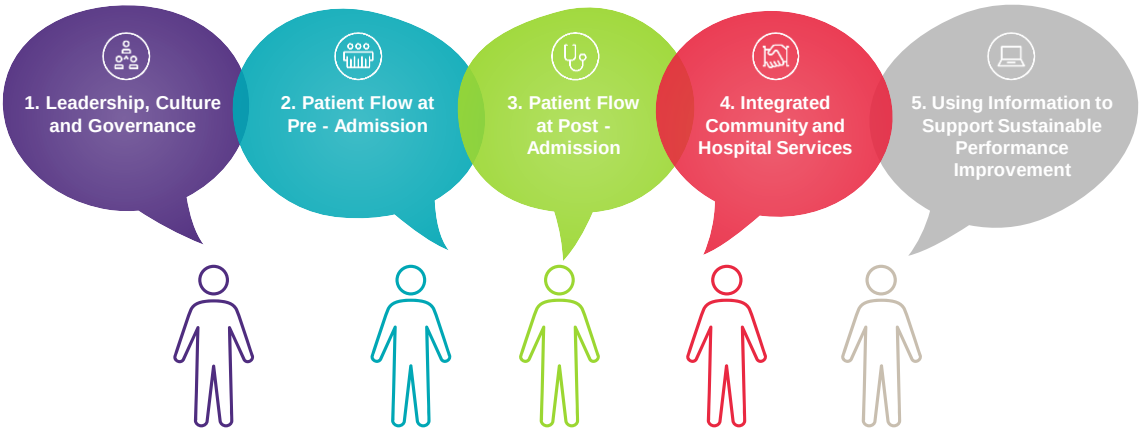
Improve Pathways of Care for Patients (Five Fundamentals Framework)

Improve Pathways of Care for Patients

Key Actions – Five Fundamentals Framework

The 'Five Fundamentals of Unscheduled Care' were designed and developed as an integrated framework to support sustainable and scalable unscheduled care improvement in line with the Sláintecare vision and goals. The Fundamentals were developed through an international review of published frameworks for improving unscheduled care performance. A focus of the winter plan is on patient flow at pre-admission to reduce the number of patents that require admission from our EDs.

Figure 17: *Five Fundamentals of Unscheduled Care*



Governance structures

The Five Fundamentals framework requires a locally-led, bottom-up approach to embedding the Winter Plan, ensuring frontline healthcare workers, teams, patients and their carers are actively involved in the development and delivery of solutions. Governance structures will be implemented in line with *Figure 14 (page 15)* to ensure successful delivery of the Winter Plan 2022/23.

Communication: Total winter cost of €2,195,000

All initiatives outlined in the Winter Plan 2022/23 will be clearly articulated and communicated to each Hospital Group and CHO. Each Hospital Group and CHO will communicate a clear approach to their Winter Plan to all relevant stakeholders including staff, patients, local communities, public representatives and local media.

Enhanced Community Care (ECC): Funding through NSP

Three core elements within the ECC programme will support reducing ED attendances over the winter period.

1. Integrated Care Programme for Older Persons (ICPOP)

The ICPOP programme delivers specialist services for older people with high-level needs including patients aged over 75 years with frailty, dementia and high falls risk. During the winter period ICPOP teams will continue to facilitate early discharge and hospital avoidance as well as complex case management in patient's homes. This will be supported by:

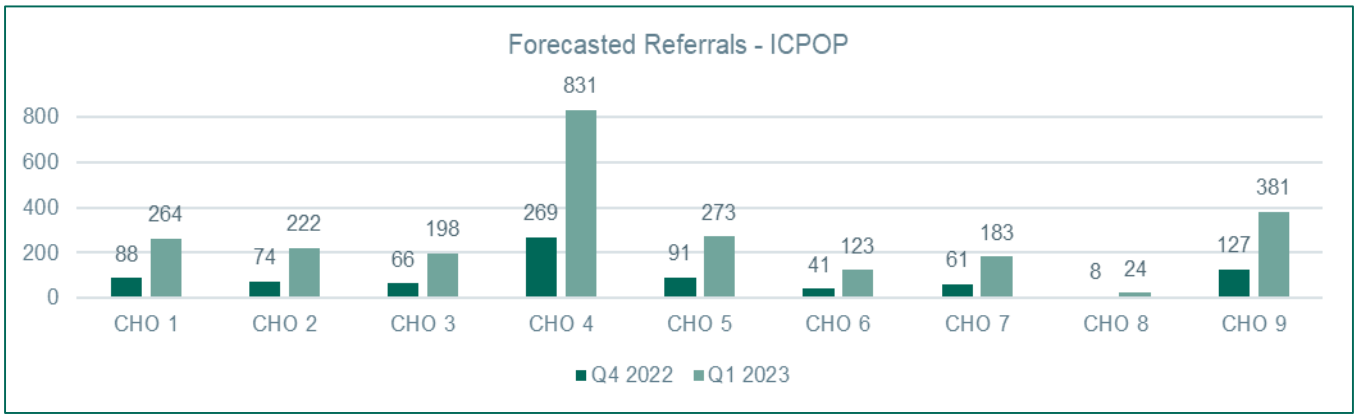
- Direct access to home support services – ring-fenced and a pathway via CHO;
- Direct access to ring-fenced community short stay beds in CHOs;
- Continued use of a dedicated phone line for GPs into the ICPOP geriatrician;
- Expanded use of the alternative ALONE model of home support; and
- Implementation of InterRAI through recruitment of 128 key staff supporting structured assessment for Home Support, ICPOP & Residential Care.

ICPOP Pathways have been piloted in Cork Kerry Community Healthcare (CKCH) and are due to be rolled out across 30 networks. Forecasted activity for each CHO for Q4 2022 and Q1 2023 is highlighted in *Figure 18 overleaf*:

Improve Pathways of Care for Patients

Key Actions – Five Fundamentals Framework

Figure 18: *Forecasted referrals*



2. Integrated Care Programme for Chronic Disease Management (ICPCDM)

Community Specialist Teams deliver specialist services to support Community Healthcare Networks (CHN), targeting four ambulatory care sensitive conditions – diabetes, asthma, COPD and heart failure. During the winter period this will continue to be facilitated by:

- Ensuring rapid access to consultant and specialist nursing clinical advice avoiding ED and OPD attendances;
- Ensuring access to community diagnostics– Spirometry/Echocardiography;
- Providing self-management support services , e.g., Cardiac and Pulmonary Rehabilitation, Diabetes Structured Education, foot protection services, diabetes prevention and weight management; and
- Providing a case management function for complex care needs.

3. General Practice & Community Healthcare Networks

Leveraging the ECC & GP Agreement 2019, GP practices in each CHN, proactively and systemically identify patients likely to have a preventable unplanned attendance at the emergency department, to provide a safe alternative to attending EDs, by maintaining people in their homes through prevention and interventions. Benefits to date include:

- Standardisation of approach, documentation and processes – within and across CHNs;
- Patients triaged more accurately & interventions applied to individuals based on need using a team-based approach;
- Plan of actions and better integration and collaboration between services including GP's, Primary Care, and Mental Health;
- Better service user engagement and care at home – some patients have attended the Clinical Team Meetings (CTMs); and
- Increased awareness by GPs of services being provided in the CHN and how to access them.

Activity Estimates:

- First Phase - 96 CHNs Q4 2022; 2,553 to 6,700 patients likely to have an avoidable ED attendance; and
- Year One 2023 - full roll out to 16,000 to 21,000 patients per year likely to have an avoidable ED attendance.

There are a number of critical dependencies that underpin the success of the ECC programme as outlined in Table 8 overleaf.

Improve Pathways of Care for Patients

Key Actions – Five Fundamentals Framework

Table 8: ECC critical dependencies

Initiative	Supported By	Dependency
Complex case management	• Support provided by ICPOP Teams in the home setting • Direct access to home support services	• Ring-fenced access to home support and pathway via CHO • Expansion of alternative model of home support ALONE Type Model
Access to community short stay care	• Direct access to ring-fenced community short stay beds in CHOs	• Support via Medical Oversight to ICPOP Consultant/Team
Enhanced linkage GPs & Geriatricians	• Support via dedicated phone line GPs to geriatrician	• Administration support • Geriatrician involvement
Specific focus on additional vulnerable cohort	• Dementia Services • Falls • Frailty at Front Door	• Direct access to dementia-specific supports
Critical dependencies • **interRAI** ✓ **interRAI – recruitment of 128 Care Needs Facilitator Posts** ✓ **Implementation of interRAI across home support, ICPOP and Residential Services** • **General Practice** ✓ **General Practice supports including Out of Hours (OOHs) over the extended winter period** • **ICT System** ✓ **Referral management & scheduling** ✓ **Real time reporting**		

Aids and Appliances: Total winter cost of €4,500,000

Investment in aids and appliances will be provided to support individuals at home and in the community, promoting their independence to avoid hospital admission and facilitate safe and timely discharge home. The aids, adaptations and associated similar supports will be determined according to local CHO community need and local service arrangements. A ring-fenced allocation of funding will be provided to ICPOP for the duration of winter.

GP Access to Diagnostics: Total winter cost of €10,000,000 for GP support and OOH

Expansion in provision of GP access to diagnostics, which proved successful last winter and through 2022 to date, will be enhanced for the winter 2022/23 period to increase diagnostic availability, reduce ED attendances and facilitate hospital avoidance particularly for those aged over 75 years. To date in 2022 over 188,516 scans have been completed through the GP Access to Diagnostics initiative and Winter 2022 will see 120,000 scans completed from October to March.

GP Out of Hours: Included in €10,000,000 for GP support and OOH

The GP Out-of-Hours Service will continue into 2023. From February 2022 to date there have been 655,924 contacts with GP Out-of-Hours services. As part of Winter 2022/23 this service is to be expanded to provide full coverage in rural areas in CHO West.

Improve Pathways of Care for Patients

Key Actions – Five Fundamentals Framework

National Ambulance Service (NAS): Total winter cost of €6,800,000

To respond to rising demand for access to emergency services, including the predicted implications of winter, NAS is focusing its preparedness activities on the following measures:

Leadership & governance

- Recruiting a Winter Planning and Implementation Lead to drive all winter initiatives; and
- Implement the 24/7 Tactical Management Unit to proactively manage pressures, escalations and support staff.

Promoting staff well-being

- Promotion of high-level uptake of vaccinations against influenza and COVID-19.

Managing demand

- Completing the implementation of 9 Pathfinder Teams to treat older people at home; and
- Strengthening the capacity and clinical leadership of the NAS Clinical Hub to provide clinical advice and refer more patients over the phone.

NAS Capacity Action Plan

- Promoting the safe and effective deployment of additional staff overtime to increase emergency response capacity;
- Leveraging the capacity of voluntary ambulance services to support hospital discharges and flow;
- Engaging with private ambulance companies to support inter-facility transfers and flow; and
- Deploying capacity to support rapid handover of patients from ambulance to ED to ensure emergency ambulances are available for 999 calls.

Mental Health Services: Total winter cost of €3,000,000

Based on the demand for mental health services there will be enhanced capacity sourced externally as part of Winter 2022/23. This capacity will be used to provide placements in specialised rehabilitation units (SRUs) for individuals with complex and enduring mental health illness. HSE Mental Health Services will continue to work closely with CHOs, local Mental Health Teams and Community Rehabilitation Mental Health Teams to support the national SRUs and also the enhancement of community rehabilitation services for service users with complex mental health needs. This allocation will only be used where it will assist discharge from acute hospitals. It should be noted that bed capacity in Acute Mental Health Units is generally running at or beyond capacity and often it is not possible to take immediate discharges for mentally ill patients from acute units.

Improve Pathways of Care for Patients

Key Actions – Five Fundamentals Framework

Social Inclusion Services: Total winter cost of €1,100,000

Social Inclusion Services will deliver enhanced services to support local people to receive the best possible services to meet their needs. As part of Winter 2022/23 there will be a targeted vaccination programme and development of complex care packages for socially excluded groups experiencing severe health inequalities, including refugees.

Community Intervention Teams (CIT): Total winter cost of €2,024,000

As part of Winter 2022/23 there will be an investment of €2.024 million over the year to expand all CIT teams across the country with a particular focus on the Mid-West and North-West regions.

Palliative Care: Total winter cost of €500,000

As part of Winter 2022/23 additional funding will be made available to enhance Palliative Care Services. Palliative Care will continue to deliver and enhance services to support local people with life-limiting conditions and their families, to easily access palliative care services, to receive the best possible care in their own homes and in their local community services. Enhancing community-based services which support people with life-limiting conditions with symptom management and end of life care, will also further reduce acute hospital admissions. This funding will deliver 1,340 nights of night nursing to 380 patients and families.

Disability Services: Total winter cost of €5,100,000

Disability services will continue to deliver and develop services to support local people to receive the best possible care in their own homes and in local community services. The funding as part of Winter 2022/23 will be used to provide 18 residential packages to support:

- disabled people admitted to hospital and who are ready for discharge but require a residential support package; and
- provide residential supports to older parents for who a discharge from hospital requires an alternative arrangement to replace the caring role they have been providing to a family member.

Integrated Action Teams Fund: Total winter cost of €20,000,000

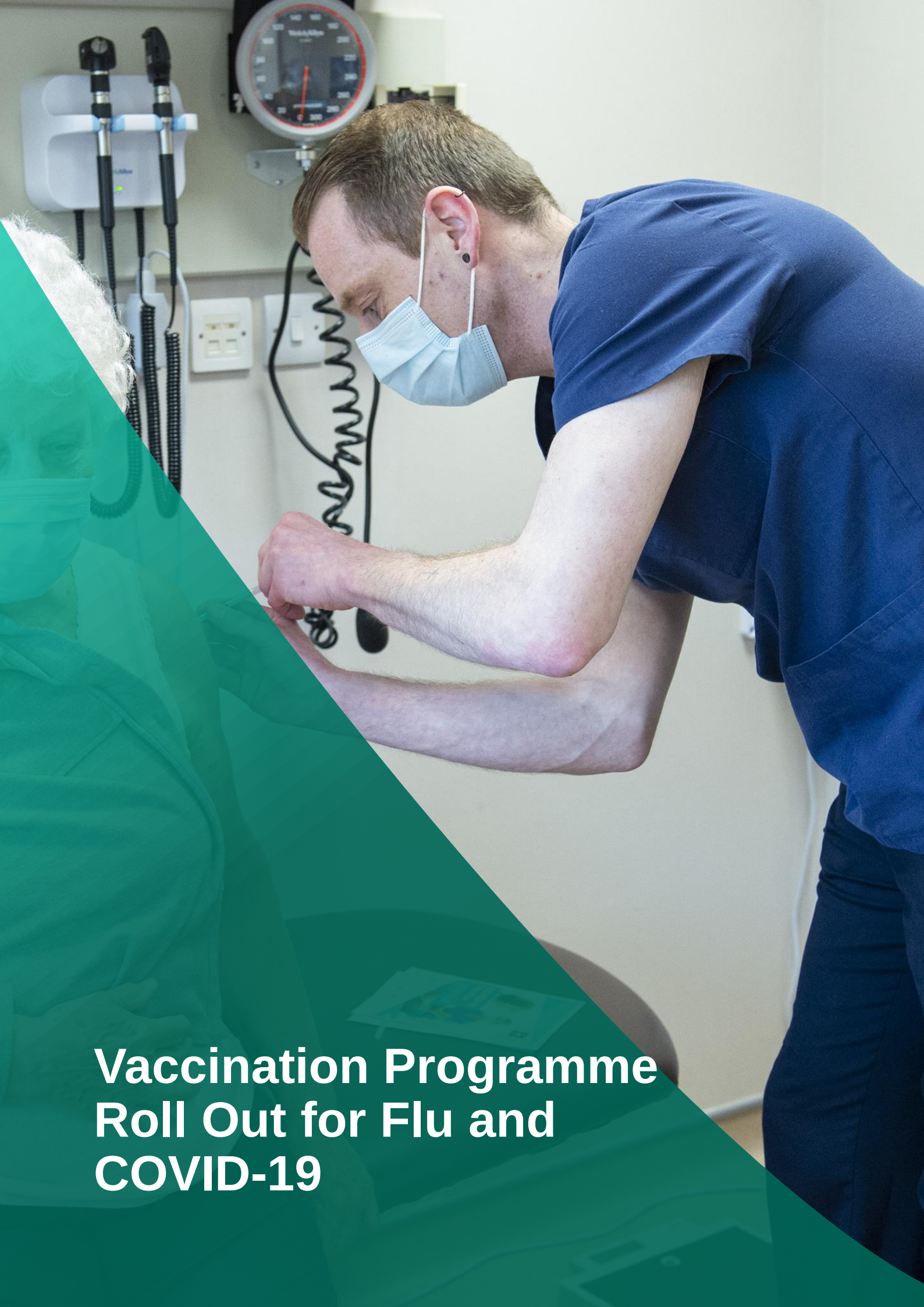
€20 million will be allocated to an integrated action team fund. Each CHO and Hospital Group lead together can request the release of funding for specific initiatives that will enhance patient flow throughout the winter period. For example funding to prepare a patient's home to enable a safe discharge. This fund will be managed by the Older Persons office and strict criteria will be in place for access.

Winter Reporting

Winter reporting will underpin the successful delivery of Winter 2022/23 initiatives. Reporting dashboards will provide the information necessary to enhance decision-making, thus ensuring escalation processes are triggered so that the leadership and governance structures can act on real time information.

The PMIU will provide reporting support on a weekly basis at national level and to the Hospital Group CEOs and CHO Chief Officers to inform decision-making during the winter period alongside the timely implementation of Winter 2022/23 initiatives. The following reports will be prepared and circulated to relevant national and local teams with additional insights provided by the PMIU:

- **Unscheduled Care Activity Report**: This report details USC activity at national, hospital group and site level, alongside performance against KPIs.
- **PMO Winter Report**: This report details the status of all initiatives as part of NSP and winter funding and will be used to identify initiatives that are performing in line with their targets. Additionally, initiatives that are failing to deliver against their targets will be identified and measures will be put in place to ensure that the initiatives are delivered in full.



Vaccination Programme Roll Out for Flu and COVID-19

Vaccination Programme Roll Out for Flu and COVID-19

Public Health Vaccination Plan(s)

Guidelines regarding HSE Public Health COVID-19 and Acute Respiratory Infection Preparedness for Autumn and Winter 2022/23, are currently in development and due for imminent release. Additionally, an Interim Emergency Response Plan for COVID-19, which incorporates a Vaccination Programme, is being developed. The vaccination roll out outlined in the Winter Plan 2022/23 will align with these Public Health guidelines.

Latest National Immunisation Advisory Committee (NIAC) guidance

NIAC released new guidance on 22nd July 2022 for the future phases of the COVID-19 Vaccination Programme. Following its initial guidance to all those who are unvaccinated or incompletely vaccinated to come forward for the doses they are eligible for (primary, first booster, and for those over-65 and the immunocompromised, a second booster), NIAC now recommends the following:

- A first mRNA COVID-19 booster vaccine for those aged 5-11 years who are immunocompromised and are associated with a suboptimal response to vaccines at the time of their primary or additional vaccination;
- A second mRNA COVID-19 booster vaccine for those aged 50-64 years, those aged 12-49 years who have underlying medical conditions associated with a higher risk of severe COVID-19 or are residents of long-term care facilities;
- Healthcare workers are recommended for a second mRNA COVID-19 booster;
- A second mRNA booster vaccine for pregnant women at 16 weeks or later who have not already received a booster vaccine in their current pregnancy; and
- A third mRNA COVID-19 booster vaccine for those aged 65 years and older and individuals aged 12-64 years who are immunocompromised and are associated with a suboptimal response to vaccines at the time of their primary or booster vaccination.

NIAC advised that following the primary vaccine series or confirmed SARS-CoV-2 infection, a four-month interval is recommended for any subsequent COVID-19 vaccine doses. NIAC recommends that those aged 5-11 years who are immunocompromised, 50-64 years and 12-49 years who are medically vulnerable, receive their booster doses as soon as feasible.

NIAC have also advised that COVID-19 vaccines may be given at the same time or at any interval before or after any vaccine. This includes seasonal influenza and pertussis vaccines during pregnancy. Co-administration, where possible, has been suggested for over-65s and those aged 12-64 years who are immunocompromised.

Autumn programme planning

The HSE has subsequently begun planning for an autumn programme. The delivery model is still expected to be primary care-led with GPs and pharmacies delivering a significant proportion of vaccines, with the balance delivered directly through Vaccination Centres. It is expected that the autumn programme will begin as soon as feasible through COVID-19 Vaccination Centres (CVCs) and HSE channels for those groups eligible for a first and second booster. Pregnant women may also receive their vaccination at this time.

Third booster doses will then be administered, in conjunction with flu vaccination, where practical, by community channels (GP & Pharmacy) to those aged over 65 years and to those who are immunocompromised from October, following the four-month interval since their second booster or previous COVID-19 infection.

There are currently ongoing campaigns, including advertisement and paid advertisement posts, reminding people that COVID-19 vaccination helps to protect them as the new autumn/winter COVID-19 campaign kicks off. Key activities for the delivery and operational effectiveness of the autumn programme by October 2022 are:

Governance & operating model

- Newly developed governance structure developed and in place for an aligned influenza and COVID-19 autumn Vaccination Programme (aligning in areas/cohorts where practicable through the GP/Pharmacy cohort).

Operations/HSE channels

- Negotiations for the leases on 15 vaccination facilities in addition to identification of secondary sites;
- Procurement of mobile vehicles; and
- Maintenance of training and access to resources and core operations team.

Information Communications Technology (ICT)

- ICT development to enable Flu and COVID-19 alignment where practicable;
- Development of Mobile TrackVax solution; and
- Candidate list for Sprint 23 following the receipt of NIAC guidance.

GP & pharmacy

- Contract negotiations with Irish Pharmacy Union (IPU) and Irish Medical Organisation (IMO) are due to be completed to enable the Primary care led element of this intended sustainable model.

GP & pharmacy ICT integration - ongoing

- Recruitment of Core Team; and
- Recruitment of internal staff required to deliver the sustainable model across all functional areas.

Vaccination Programme Roll Out for Flu and COVID-19

Dependencies and risks

There are key dependencies to achieving the aforementioned programme in a timely manner, these are:

Date of delivery of flu and COVID-19 vaccines into Ireland

Current planning assumes the required vaccines will be available in the country and that there are no supply issues - this is subject to confirmation, EMA approval and NIAC guidance.

GP negotiations

- GPs are a key channel to enable co-administration of flu and COVID-19 vaccines.

Statutory Instrument (SI) expansion

- Expansion of SI to enable a broader workforce to administer both COVID-19 & flu vaccines if required.

ICT

- The development of ICT systems to enable GPs and pharmacies to record both flu and COVID-19 vaccines at the same time for their patients is a key enabler of the autumn programme.

Agreed risks to the successful mobilisation and delivery of an autumn programme relate to:

- Vaccine expiry;
- The ability to co-administer COVID-19 and flu vaccinations in primary care settings;
- Low uptake of second boosters;
- Financial sanction for vaccination activity;
- Lack of clarity on requirements for future phases of COVID-19 Vaccination Programme; and
- Workforce and recruitment challenges.

Vaccination roll out – key actions for winter 22/23

Governance and operations

- Ongoing advertising campaigns reminding people of the protection provided by the COVID-19 vaccination as the new autumn/winter COVID-19 campaign kicks off;
- Development of a new campaign to remind people of the importance of the vaccine to incorporate COVID-19 and flu;
- Complete negotiations for the leases on 15 vaccination facilities in addition to identification of secondary sites; and
- Ongoing maintenance of training and access to resources and core operations team.

ICT

- Continued implementation of ICT work necessary to enable flu and COVID-19 alignment where practicable; and
- Ongoing development of the Mobile TrackVax solution.

GP and pharmacy

- Completion of contract negotiations with IPU and IMO to enable the primary care led element of the sustainable model; and
- Recruitment of the GP and pharmacy ICT Integration Core Team and internal staff required to deliver the ongoing sustainable model across all functional areas.

Implement Pandemic Preparedness Plan

Implement Pandemic Preparedness Plan

Test and Trace Programme

The Test and Trace Programme is Public Health-led and is currently in **Phase 2** of the gradual transition from the mass testing model for COVID-19 to a surveillance-led future model with a GP clinical pathway that is planned for autumn 2022.

The Transition Plan was developed in March 2022 to outline a clear pathway to the future model, in line with Public Health guidance, while also retaining an ability to respond to a surge in demand. Request for sanction for funding expenditure for 2022 was sent to the Department of Health in late April which has since been followed up with the detailed plans and costs for agreement and sanction.

The Transition 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. The Transition Plan is phased as follows:

Figure 19: *COVID-19 Transition Plan*

The key steps in transition planning are:

- Core team positions are being extended to the end of 2022;
- National Ambulance Service (NAS) recruitment process for 200 permanent Intermediate Care Operatives has commenced;
- Testing centres are being moved from mass sites to predominantly HSE sites;
- Testing swabbing staff are being reduced from 1,000 to c.250; and
- Contact Management Programme (CMP) will consist of a core team of 200 people.

Public Health have commenced planning the implementation of the enhanced surveillance systems including recruitment of staff and necessary infrastructure.

Surge planning

A key feature of the transition plan is the development of a surge response model, which will be required as part of the GP pathway in Winter 2022/23. The surge response will be triggered by an agreed set of criteria such as a surge in the disease in the community or pressure on GP capacity. 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. If required, additional laboratory capacity will be put in place to deal with increased testing demand.

Emergency response planning

The Emergency Response 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. 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. Confirmation is required for resourcing and site locations with discussions ongoing. Site locations are to be identified and evaluated. It is expected there will be support required from Government departments and agencies to supplement the workforce during a transition into emergency response. In addition, outbreak supports will continue to be provided to the nursing home sector and scaled-up as required.

Alignment with public health strategies

HSE Public Health strategies and guidelines for COVID-19 Testing, Tracing and Surveillance will shortly be finalised. The Test and Trace Programme for Winter Plan 2022/23 will align and incorporate measures outlined within these Public Health strategies ('HSE Surge Plan for Test and Trace Function', 'Interim Emergency Response Plan; COVID-19 Test and Trace and vaccination programmers', 'HSE Public Health COVID-19 and Acute Respiratory Infection Preparedness: Approach for Autumn/Winter 2022/23' and 'Strategy for end state approach for COVID-19 testing, tracing and Surveillance management').

Implement Pandemic Preparedness Plan

Respiratory surveillance reporting

The National Health Protection Surveillance Centre (HPSC) will provide stakeholders with a weekly summary report that includes a snapshot of recent, current and percentage changes to the following indicators:

- the number of notified cases;
- the positivity rates;
- the number of outbreaks in nursing homes, hospitals, residential institutions and community hospitals and long-stay units;
- the 14-day incident rate per 100,000 population;
- percentage change in viral load by location as indicated by wastewater surveillance;
- the number of positive cases in acute hospitals;
- the number and incidence of SARI hospitalised cases;
- the number of cases in ICU/HDU;
- the number of deaths; and
- the number of cases of a variant of interest or concern.

These indicators and associated graphs will be complimented by a short narrative report that provides a qualitative explanation and interpretation of the epidemiological changes observed. It will also reflect on demographic and geographic trends as well as the incidence among socially excluded groups experiencing severe health inequalities.

Monitoring of community transmission and incidence of disease

The HPSC will analyse, interpret and report on the incidence of respiratory disease using a number of well-established surveillance programmes.

a. Case-based surveillance

COVID-19, influenza and RSV are notifiable diseases and must be reported to the Medical Office of Health (MOH) by the medical practitioner and laboratory that detects the case. In turn, the MOH is required to notify HPSC. This case-based surveillance provides basic epidemiological information. It is affected by testing policy. If testing policy going into the winter is not changed (i.e., Ireland continues with a policy of testing being driven by clinical need), then this case-based surveillance will remain a relatively sensitive indicator of change in community transmission over time.

b. Outbreak surveillance

Departments of public health and hospitals notify HPSC of outbreaks of respiratory disease. HPSC report outbreaks disaggregated by type of location including nursing homes, hospitals, residential institutions and community hospitals and long-stay units.

c. GP sentinel surveillance

The GP sentinel surveillance scheme monitors COVID-19/influenza-like illness (ILI) disease incidence rates in the community, provides an early warning system for the circulation of SARS-CoV-2 and influenza, Respiratory Syncytial Virus (RSV) and other respiratory viruses (ORV) with epidemic and pandemic potential, and monitors the epidemiology of these respiratory viruses identifying age groups most affected. GP sentinel surveillance will be expanded from 61 to 100 general practices, but this will not be in place within a timeframe that will inform winter planning.

d. Wastewater surveillance

Samples from 68 wastewater catchment areas across Ireland are taken on a weekly basis. These 68 wastewater catchment areas cover 80% of the population connected to public wastewater treatment facilities. Wastewater surveillance provides geographical and temporal trends of SARS-CoV-2 circulation in included catchment areas unbiased by health seeking behaviour or testing policies.

e. Serosurveillance

Data from serosurveillance are used to estimate levels of past infection with, or protection against SARS-CoV-2, predict potential outbreaks, identify age groups at risk, and plan future vaccination programmes. Monitoring quantitative antibody levels over time are used as a proxy for waning immunity.

Monitoring of disease severity

Morbidity, mortality and the geographic and demographic characteristics of cases are collected and reported on routinely.

Monitoring circulating strains of COVID-19 and influenza

The Routine National Surveillance stream ensures that a random sample of COVID-19 cases are selected from the population to undergo whole genome sequencing in an unbiased manner. As per ECDC guidance, this routine surveillance stream aims to sequence a sufficient number of specimens per week to detect a SARS-CoV-2 variant circulating at 1%-2.5%.

The Targeted Sequencing stream includes the following target groups; travel associated cases at times when new variant of interest/concern emerge, vaccine breakthrough infections/re-infection, Public Health request as part of outbreak investigations, hospital outbreaks/Health Care Associated Infections (HCAI) outbreaks, investigation of epidemiological changes/viral pathology shifts, risk groups and vaccine-effectiveness studies.

Implement Pandemic Preparedness Plan

COVID-19 Response Teams/Community Support Teams

There are currently 573 Nursing Homes registered by the Health Information and Quality Authority (HIQA) in Ireland, with approximately 32,000 residential places. In response to the COVID-19 pandemic and following subsequent advice from the National Public Health Emergency Team (NPHET), COVID-19 Response Teams (CRT) were stood up by the Area Crisis Management Teams (ACMT) to provide additional supports to long term residential care facilities, including Nursing Homes. The CRTs continue to work with all Nursing Homes (public, private and voluntary).

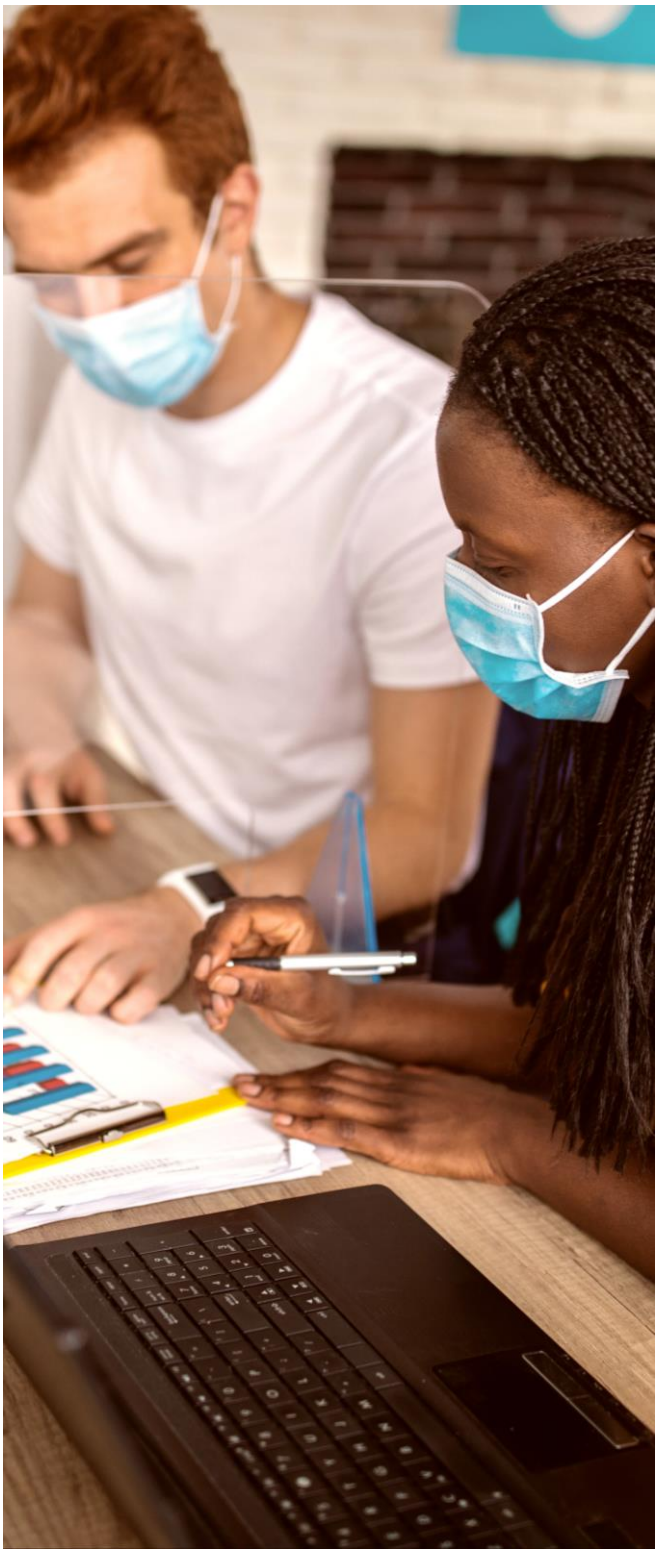
The composition of the CRT's include (either as part of its core membership or as 'access to' when required) Public Health, Infection Prevention and Control, Older Persons Service Managers, Consultant Geriatricians, Nursing, and administrative supports. The CRTs can, if necessary, be flexibly enhanced with additional skillsets depending on the nature and setting of the outbreak in question.

It is the responsibility of the private Nursing Homes to respond to the support and advice given by the CRTs, as directed by legislation, national policy and guidance, including:

- Infection Prevention and Control;
- Outbreak Management;
- Future Admissions;
- Nursing Home Management;
- Staffing;
- Visiting Guidelines; and
- Advocacy services.

A National CRT Forum has been established to facilitate consistency in the work of the CRTs and sharing of learning. This Forum will also contribute to the establishment of new integrated Community Support Teams (CSTs) on a permanent basis, as recommended by the Nursing Home Expert Panel (Nursing Home Expert Panel, Recommendation 7.1).

Due to the success of CRTs and as recommended by the Nursing Home Expert Panel CRTs are now in the process of transitioning into Community Support Teams. These teams will become a permanent enabler for nursing home care facilities to identify and manage future infection outbreaks as their main focus in Phase One of implementation while also supporting the wider integration of these facilities into the general community health service provision to occur in Phase Two.



Workforce Planning

Workforce Planning

Safer Staffing and Skill Mix

As part of the Winter Plan 2022/23, each of the 29 Emergency Department hospital sites and associated CHOs will outline what is required in terms of funding/WTEs for building capacity and ensuring safer staffing and skill mix. The overarching aim of building capacity initiatives and outlining funding/WTEs is to not only address risks associated with the winter period but also have an impact nationally on USC performance, as the first step in a three-year USC Improvement Programme. It is recognised that a core risk to the delivery of the Winter Plan 2022/23 is the ability to recruit sufficient numbers of staff. A key priority is the recruitment of additional staffing in EDs including Emergency Medicine Consultants, Registrars and nursing staff. It is acknowledged that these posts are required to be filled on a permanent basis. In order to mitigate the recruitment risk, funding has been provided to fill these positions on a locum basis during the winter period.

Safe Nurse Staffing and Skill Mix Framework

The DoH developed the Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings (Phase I) in response to an increasing body of research evidence linking satisfactory nurse staffing to patient outcomes. The principal objective of the Framework is to determine the staffing and skill mix range required for medical and surgical care areas in the acute setting, using an evidence-based framework. Acuity and dependency are measured on Nursing Hours per Patient Day (NHpPD) in the medical and surgical settings. The implementation of the framework and the components committed to for delivery by year end will form part of the Winter Plan 2022/23. This framework will also include Phase Two ED nursing staffing. It should be noted that it will be challenging to attract and recruit the additional manpower required.

Phase I

This phase of the Framework identifies the assumptions, elements, external factors and nursing workforce planning governance structures to determine safe nurse staffing and skill mix for registered nurses and healthcare assistants in inpatient adult wards. Phase I utilises Nursing Hours per Patient Day as a measurement of patient acuity and dependency.

To date funding of €25m has been received (with circa €24m allocated to date) and in the order of a further €25m revenue (for staffing and ICT annual support) will be required in 2023 to complete the remaining Model 4 sites, fully implement the Framework within Model 3, Model 2 and specialist elective hospital sites. This funding is being sought through the estimates process for NSP 2023.

A capital requirement is also being submitted to the Office of the Chief Information Officer (OoCIO) for a required acuity and dependency software system.

Phase II

The scope of Phase II relates to adult EDs. Phase II utilises Nursing Hours per Patient Presentation as a measurement of patient acuity and dependency. ED attendances based on the breakdown of Manchester Triage Categories are utilised in the calculation of staffing requirements. Phase II is to be progressed on all 29 sites, as part of winter planning.

- The scope will involve a review, projection and allocation of funding by and for, all 29 ED sites;
- The HSE National Lead for Safe Nurse Staffing and Skill Mix has worked with DoH and HSE senior nursing staff and have determined that a supplementary funding requirement of €1.017m is required in 2022 to augment NSP 2022 and progress Phase II implementation across all Emergency Departments in 2022;
- The DoH is currently working to assess the data/methodology for calculating further funding required to fully develop/deliver Phase II. At present, the 2023 requirements, based on 6 months activity data, will be in the order of €2.7m.
- Access to and affordability of living accommodation, along with attracting and recruiting the additional staff are key challenges and dependencies in implementation of the Safer Staffing Framework.

Emergency department staffing

Winter planning will ensure early sanction of core staff such as ED consultants, Geriatricians, Respiratory Consultants and Advanced Nurse Practitioners (ANP) across hospital and community. Each hospital will complete a gap analysis of staffing as part of the immediate response plan to inform the early sanction of posts based on local requirements. The National Doctor Training Programme will support the review of long-term staffing requirements across all sites.

Emergency Medicine Consultants

Individual site analysis has been completed and the number of additional Emergency Medicine Consultants required to enable patient flow is 51 WTE. Due to recruitment limitations, these posts will be filled initially with locum Consultants to ensure full impact over the winter period. To support ED Consultants, additional staffing will be required including 20 Registrars. Every effort will be made to recruit to these posts to support the Emergency Medicine Consultants. Further discussions will take place as part of the Three-Year USC Improvement Programme in relation to Clinical Nurse Specialists and HSCP requirements to support these consultants and registrars. With senior clinical leaders and decision makers on the front line, there will be increased efficiency in directing patients to the most appropriate care pathway for their specific needs. This will improve patient care, positively impact performance KPIs, ensure consistent flow of patients to new alternative care pathways and boost staff morale.

Communication Planning

Communication Planning

Continued reliable communications from the HSE will be an essential part of the HSE Winter Plan 2022/23

Our communications activities over autumn/winter 2022/23 will focus on providing clear and comprehensive information to the people in our care and their families, the wider public, our staff, and our partners e.g. GPs.

Using insight-based messaging, communications will support patients and their families access the healthcare they need this winter via the most appropriate pathway.

A comprehensive stakeholder communications programme will support patients, families and GPs to identify the most appropriate care based on need across the spectrum, from HSE.ie and HSElive, Pharmacy, GP, GP OOH, Injury Units, Medical Assessment Units, community-delivered programmes, NAS and EDs. Messages will be tailored according to people's location, language, and life stage as appropriate.

The HSE will provide guidance on how to keep well this winter in addition to updates about COVID-19, the flu and other respiratory illnesses.

These will include what we need to continue to do such as maintaining protective behaviours, how to respond when we do feel ill, and critically the importance of COVID-19 and flu vaccines when available.

Communication objectives

The HSE communication plan will address the following themes and topics during the winter period:

- Health services – how they will care for you, signposting to information and how to access appropriate care, activity updates, crisis response;
- Keeping well – self-care for people with common or chronic illnesses, when to get help;
- The importance of vaccination this winter:
  - COVID-19 vaccines – ongoing programme of information and guidance on vaccine rollout and developments;
  - Flu vaccination – campaigns for healthcare teams in local settings, national campaigns for at-risk adults and children aged 2-17 years; and
- Respiratory illness including COVID-19 – how to protect you and yours, guidance for various settings, protection.

Approach

- Working closely with Hospital Groups and CHOs, undertake a full programme of communications with national and local plans and monitor and evaluate these programmes on an ongoing basis;
- Utilising all channels based on the message, timing and relevance;
- Communications resources will be deployed in an effective, co-ordinated way and take current public health advice into account; and
- Communications will play a strong supporting role in getting the health service and the public through this complex and challenging season.

Communications elements outlined in the Winter Plan for 2022/2023

Media briefings

- Regular media briefings, both for Winter and during the COVID-19 pandemic, have proven to be excellent in terms of engaging with the media and the public around key progress and messaging. These will be local and national briefings.

Trained spokespersons

- Skilled spokespersons, in particular from our clinical staff, at local and national level have been particularly helpful in engaging the public, media and public representatives.

Staff communications

- Our staff should have access to factual, relevant and important information about challenges, performance and initiatives across the health service. This will include regular updates from senior HSE leadership.

Public representative engagement

- Continued engagement with local public representatives, government and leaders will continue to ensure they are appropriately briefed to answer the questions and queries of their constituents. This will take place at local and national level.

Performance reporting

- Weekly or daily updates on our key performance and capacity data, shared online and on social media.

Public information, advertising, stakeholders and partners

- Mass media advertising campaigns will cover all key topic areas - vaccines, self-care and pathways of care - targeted across a range of channels including TV, radio, print, digital media, social media and paid search; and
- Local schedule of briefings will be developed by Hospital Groups and CHOs to provide information and progress updates on their integrated action plans. These briefings will include political and media representatives alongside local implementation groups.

Appendices

Appendix 1: Winter 2022/23 Costings

Winter 2022/23 Costings

This component of the document outlines the planned winter spend for 2022/23. Within this document the rationale for each initiative and what will be delivered for the proposed financial ask is outlined in detail.

Table 10: *Winter 2022/23 spend breakdown*

Area	Service	Description
Acute Capacity	Procurement of private capacity	• Procurement of additional private capacity to provide scheduled care for public patients on waiting lists.
Acute Services	Safer Staffing Phase 2	• Funding to implement Safer Staffing Phase 2.
Older People Services	Transitional Care Funding	• Provision of private transitional care beds to support the discharge of older people and care within appropriate settings.
Older People Services	Short Stay Respite Services	• Support individuals and their families/carers to maintain health and well-being through short-stay respite beds.
Primary Care & Complex case discharges	Aids & Appliances	• Required to maintain safety and independence for individuals in community settings.
Primary Care & Complex case discharges	Enhanced CIT Capacity	• CIT provides rapid and integrated responses to patients in the community with an acute episode of illness requiring enhanced services for short periods.
Primary Care & Complex case discharges	GP support & OOH	• Provision of GP access during out of hour periods to provide primary care medicine expertise.
Community Services	Social Inclusion (Vaccination and Complex Support Packages)	• Provision of targeted supports to vulnerable patients through vaccination and complex support packages.
Community Services	Complex packages	• Provision of complex care packages to patients with high complex care needs to maintain individuals at home.
Community Services	Disabilities	• Funding will be used to provide 18 residential care packages.
Community Services	Palliative care	• This funding will deliver 1,340 nights of night nursing to 380 patients and families.
Community Services	Mental health placements	• Funding for placements for individuals with complex and severe needs in SRUs.
NAS	Private capacity	• Utilisation of private ambulance capacity to provide additional surge capacity.
NAS	Rapid HO Teams	• Deployment of rapid handover teams to ensure emergency ambulances are available for 999 calls utilising overtime and private capacity.
Communication	Proposed Communication Initiatives (TBC)	• Communication campaigns to provide updates and service information to the public and health professionals.
Hospital Groups and CHOs	Emergency Services support - including extension of LIU hours, utilise private capacity	• Expansion of HSE LIUs; and • Utilisation of private capacity for treatment of minor injuries.
Hospital Groups and CHOs	Integrated Action Teams Fund	• Utilisation of fund to target required out of hours services to support patient flow as identified locally.
Bespoke Hospital Group and CHO Initiatives	Local site and CHO responses	• Implementation of tailored local immediate action plans during the winter period to support improvement in unscheduled care provision during winter.
Emergency Departments	Emergency Medicine Consultant Posts + support	• Increasing senior decision-makers to target the out of hours periods and sites under pressure.

Winter 2022/23 Investment

This component of the document outlines the planned winter investment for 2022/23. Within this document the rationale for each initiative and what will be delivered for the proposed financial ask is outlined in detail.

Table 11: *Winter 2022/23 spend*

Area	Service	WTEs	Q4 2022 Cost	Q1 2023 Cost	Total Winter Cost	Recurring / Non-recurring
Acute Capacity	Procurement of private capacity		€5,000,000	€5,000,000	€10,000,000	Non-recurring
Acute Services	Safer Staffing Phase 2	62	€1,017,098	€2,718,083	€3,735,181	Recurring
Older People Services	Transitional Care Funding		€6,000,000	€10,000,000	€16,000,000	Non-recurring
Older People Services	Short Stay Respite Services		€2,000,000	€2,000,000	€4,000,000	Non-recurring
Primary Care & Complex case discharges	Aids & Appliances		€2,250,000	€2,250,000	€4,500,000	Non-recurring
Primary Care & Complex case discharges	Enhanced CIT Capacity	28		€2,024,000	€2,024,000	Recurring
Primary Care & Complex case discharges	GP support & OOH		€5,000,000	€5,000,000	€10,000,000	Non-recurring
Community Services	Social Inclusion (Vaccination and Complex Support Packages)		€550,000	€550,000	€1,100,000	Non-recurring
Community Services	Complex packages		€2,000,000	€2,000,000	€4,000,000	Recurring
Community Services	Disabilities		€2,550,000	€2,550,000	€5,100,000	Recurring
Community Services	Palliative care		€250,000	€250,000	€500,000	Non-recurring
Community Services	Mental health placements		€1,500,000	€1,500,000	€3,000,000	Recurring
NAS	Private capacity		€1,500,000	€1,500,000	€3,000,000	Non-recurring
NAS	Rapid HO Teams		€1,900,000	€1,900,000	€3,800,000	Non-recurring
Communication	Proposed Communication Initiatives (TBC)		€1,485,003	€709,997	€2,195,000	Non-recurring
Hospital Groups and CHOs	Emergency Services support - including extension of LIU hours, utilise private capacity		€2,500,000	€2,500,000	€5,000,000	Non-recurring
Hospital Groups and CHOs	Integrated Action Teams Fund		€10,000,000	€10,000,000	€20,000,000	Non-recurring
Bespoke Hospital Group and CHO Initiatives	Local site and CHO responses	447			€35,115,769	Recurring
					€19,696,941	Non-recurring
Emergency Departments	Emergency Medicine Consultant Posts + support	71			€16,345,778	Recurring
Totals		**608**	**€45,502,101**	**€52,452,080**	**€169,112,669**	

Appendix 2: SAFER Patient Flow

SAFER Patient Flow

SAFER is a practical tool used nationally to reduce delays for patients in inpatient wards. It's important to implement all of the elements together to achieve the full benefits. When followed consistently, length of stay reduces and patient flow and safety improves.

1 The SAFER patient flow 'bundle'

S **Senior Review**. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. All staff should participate and discuss next steps for a patient's care journey to avoid delays.

A **All Patients** will have a Predicted Discharge Date (PDD) and Clinical Criteria for Discharge, by assuming ideal recovery and no unnecessary waiting. Patients must be informed when they are expected to go home and keep them up to date with changes.

F **Flow of patients** to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am. Patients confirmed to go home that day will have appropriate supports in place i.e., inform the family the previous day.

E **Early Discharge**. Each day, aim for discharges before 11am. This can be supported by staff knowing the PDD's for patients.

R **Review**. A systematic multidisciplinary (MDT) review of patients with extended lengths of stay needs to occur daily in order to progress any barriers to care.

2 Board rounds

A key way to implement SAFER is through effective board rounds.

These are a collaborative way to review patients through a MDT. They work by helping the team focus on removing any barriers which will potentially prevent patients from going home.

To support this process, all patients identified with a barrier to care are to be escalated to a CNM or bed management.

For next day discharges, colleagues are to be informed, including junior doctors and pharmacists to enable them to prioritise and support completion of the discharge process, including confirmation of the patient's package of care, transport, and arrangement of medication and equipment.

3 Patient and family communications

Effective communications with patients and their families is another key factor in the implementation of SAFER.

All patients should know the answers to the following questions:

- Why am I in hospital?
- When am I going home?
- Will I receive any tests or treatment today?
- Will I see a doctor today?

Appendix 3: ECC Activity (CKCH)

ECC Activity (CKCH)

Currently there are 3 hubs operational: 1) Kerry, 2) Cork – North City, and 3) Cork – South City. The activity associated with each and overall totals is included in the figures presented below:

Figure 20: *Monthly referrals*

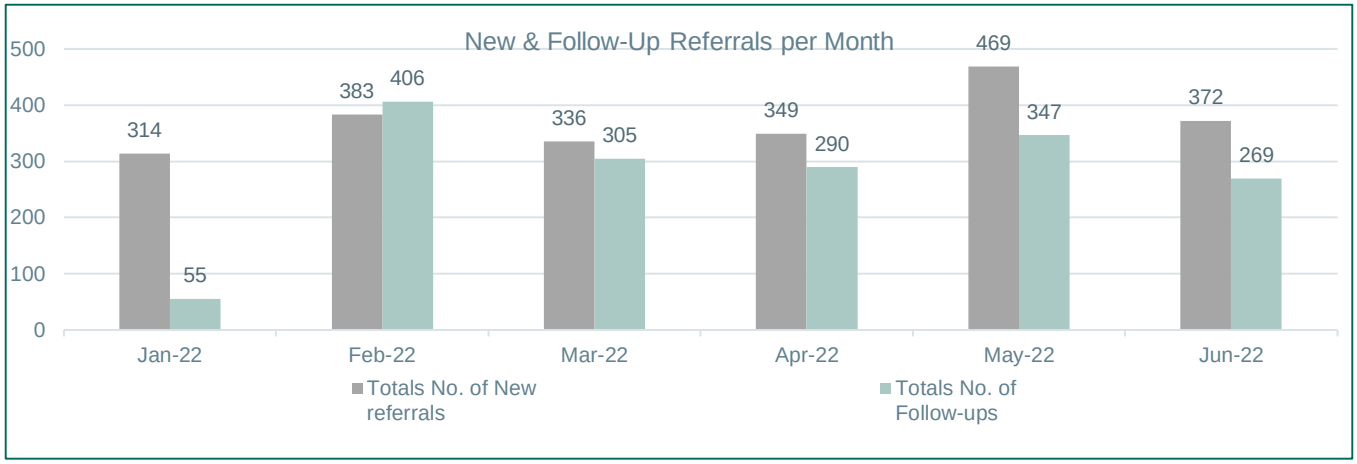


Figure 21: *Number of patients seen every month*

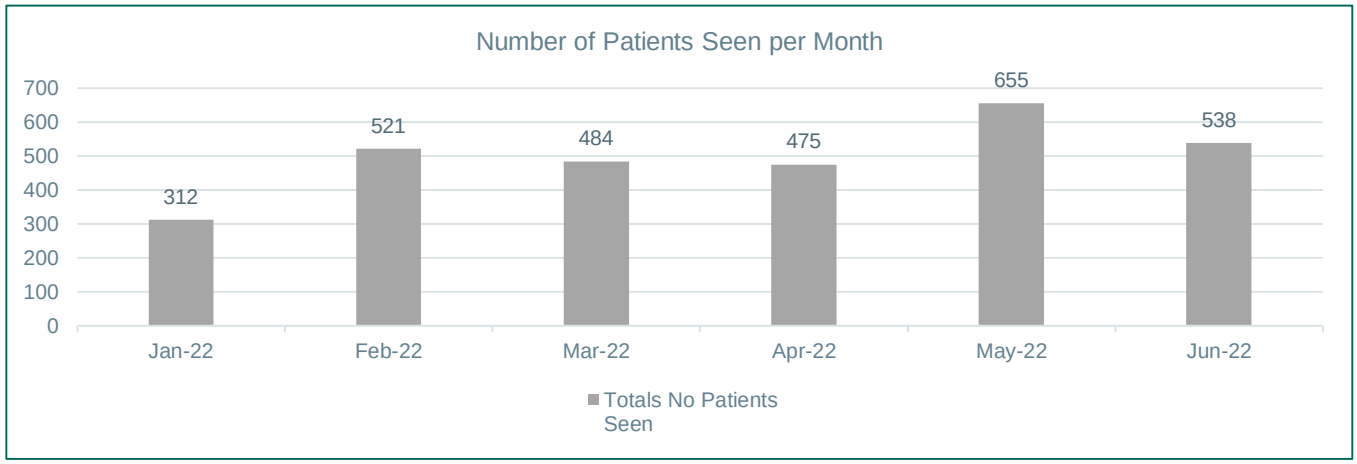


Figure 22: *Average wait times*

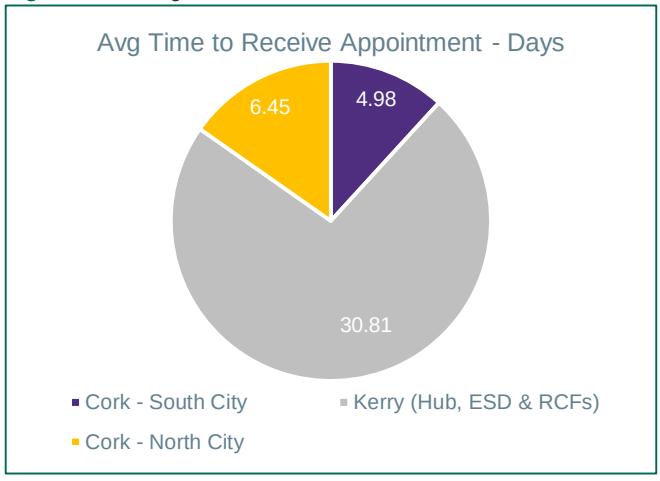
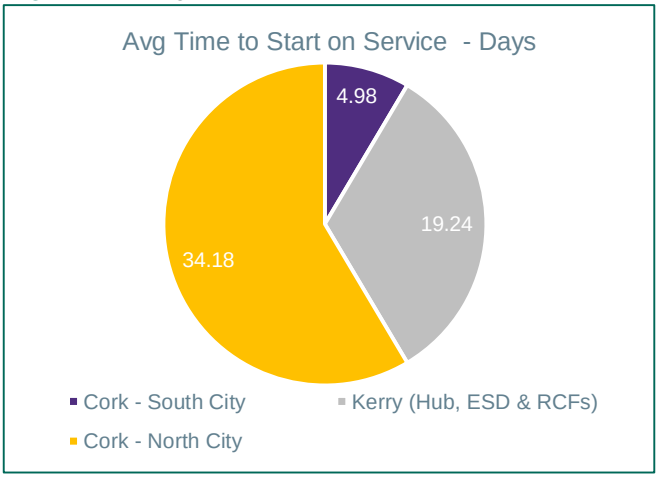


Figure 23: *Average time to start times*



ECC Activity (CKCH)

Figure 24: *Services overview*

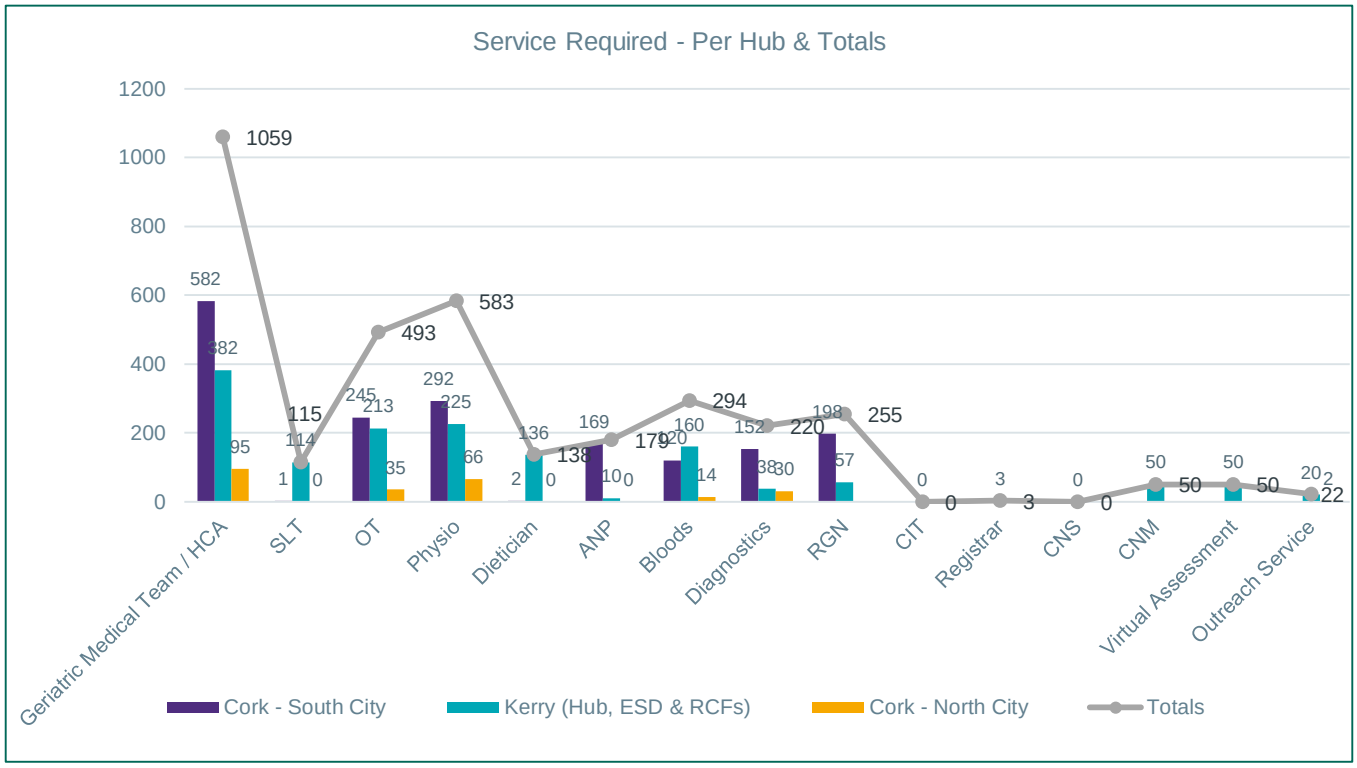
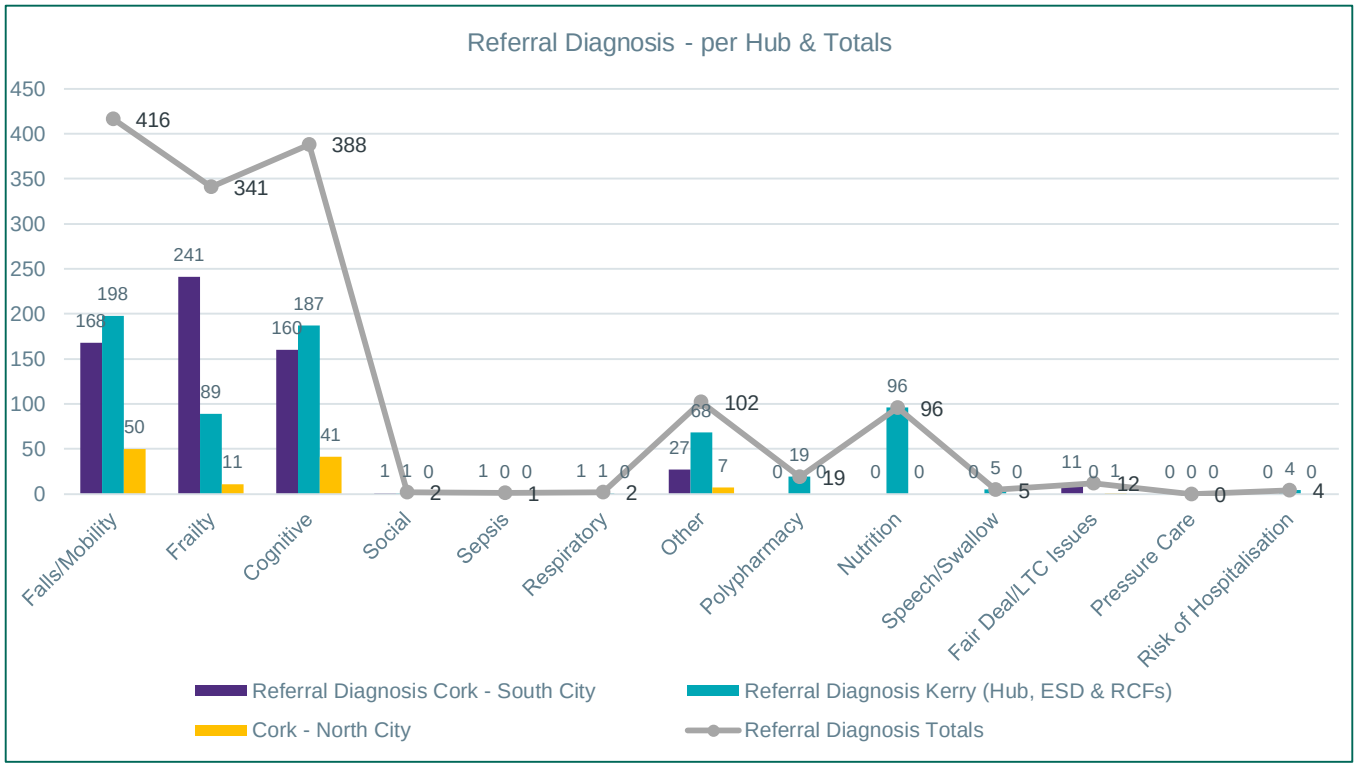


Figure 25: *Referral diagnosis*



Appendix 4: Abbreviations

Abbreviations

Table 13: *List of abbreviations*

Abbreviation	Meaning
AMAU	Acute Medical Assessment Unit
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
CDM	Chronic Disease Management
CEO	Chief Executive Officer
CHI	Children's Health Ireland
CHN	Community Health Network
CHO	Community Healthcare Organisation
CIT	Community Intervention Team
CKCH	Cork Kerry Community Healthcare
CMP	Contact Management Programme
COVID-19	Coronavirus Disease 2019 aka Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
CSO	Central Statistics Office
CST	Community Support Team
CT Scan	Computed Tomography Scan
CTM	Clinical Team Meeting
CVC	COVID-19 Vaccination Centre
Dexa Scan	Dual Energy X-ray Absorptiometry Scan
DoH	Department of Health
DTOC	Delayed Transfers Of Care
ECC	Enhanced Community Care
ED	Emergency Department
ESD	Early Supported Discharge
FITT	Frailty Intervention Therapy Team
GP	General Practitioner
HCAI	Health Care Associated Infection
HCW	Healthcare Worker
HDU	High Dependency Unit
HPSC	Health Protection Surveillance Centre
HSCP	Health & Social Care Professional
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
ICPCDM	Integrated Care Programme for Chronic Disease Management
ICPOP	Integrated Care Programme for Older Persons
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IEHG	Ireland East Hospital Group
IMO	Irish Medical Organisation
interRAI	International Resident Assessment Instrument
IP&C	Infection Prevention & Control
IGPNA	Irish General Practice Nurses Association
IPU	Irish Pharmacy Union

Abbreviations

Table 13: *List of abbreviations (cont'd)*

Abbreviation	Meaning
ISM	Integrated Service Model
KPIs	Key Performance Indicators
LICC	Local Integrated Care Committee
LIU	Local Injury Unit
LoS	Length of Stay
LTC	Long Term Care
MDT	Multi-Disciplinary Team
MOH	Medical Office of Health
MRI	Magnetic Resonance Imaging
mRNA	messenger RiboNucleic Acid
NAS	National Ambulance Service
NHpPD	Nursing Hours per Patient Day
NIAC	National Immunisation Advisory Committee
NSP	National Service Plan
OoCIO	Office of the Chief Information Officer
OOH	Out-Of-Hours
OPAT	Outpatient Parenteral Antibiotic Therapy
OPD	Outpatient Department
PCR	Polymerase Chain Reaction
PCT	Primary Care Team
PET	Patient Experience Time
PMIU	Performance Management Improvement Unit
PMO	Project Management Office
Rapid HO	Rapid Handover
RCF	Residential Care Facilities
SAFER	Senior, All Patients, Flow of Patients, Early Discharge, Review
SARI	Severe Acute Respiratory Infection
SAU	Surgical Assessment Unit
SI	Statutory Instrument
TCB	Transitional Care Bed
USC	Unscheduled Care
WTE	Whole Time Equivalent