HSE Urgent and Emergency Care Operational Plan 2023

July 2023

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Executive Summary

Introduction

Significant investment has been received through Winter Planning and National Service Plans (NSPs) over the past three years. This investment has enabled the Health Service Executive (HSE) to respond to the sustained and record urgent and emergency care (UEC) pressures which are now being experienced throughout the year and beyond the winter period.

In order to respond to this challenge, a new approach is required and underway to improve UEC performance on an incremental and sustained basis. The approach will involve the delivery of the HSE 3-Year Multi-annual Urgent and Emergency Care Plan.

In the interim, the HSE recognises the need to plan to support UEC delivery and performance for the remainder of 2023 given the high UEC demand and pressures experienced. The HSE UEC Operational Plan 2023 has been developed and outlines the measures and initiatives which will be delivered to support UEC delivery and performance until year end 2023. The sole purpose of this plan is to set out the key points of focus, the redirection of resources where appropriate, the necessary actions for senior management and the Chief Executive Officer (CEO) approved additionality of measures in high pressure regions. This plan encompasses four key pillars:

- Hospital Avoidance Operations;
- ED Operations;
- In Hospital Operations; and
- Discharge Operations.

Urgent and Emergency Care Context 2023

Emergency Departments (EDs) continue to experience high levels of demand this year. These sustained and record UEC pressures are being experienced beyond the winter period where pressures are typically associated with surges in respiratory illness. The pressures now being experienced are the result of historical and newly emerging challenges including a growing and ageing population, chronic disease, bed capacity, acute hospital structural issues, scheduled care demands, staff capacity and the need for the integration of acute and community services. These pressures and issues were culminating in high levels of UEC activity, overcrowding in EDs and high occupancy rates in our acute services prior to the COVID-19 pandemic.

Urgent and Emergency Care Operational Plan 2023

This plan encompasses targeted actions and associated Key Performance Indicators (KPIs) aligned to the four key pillars under the following areas:

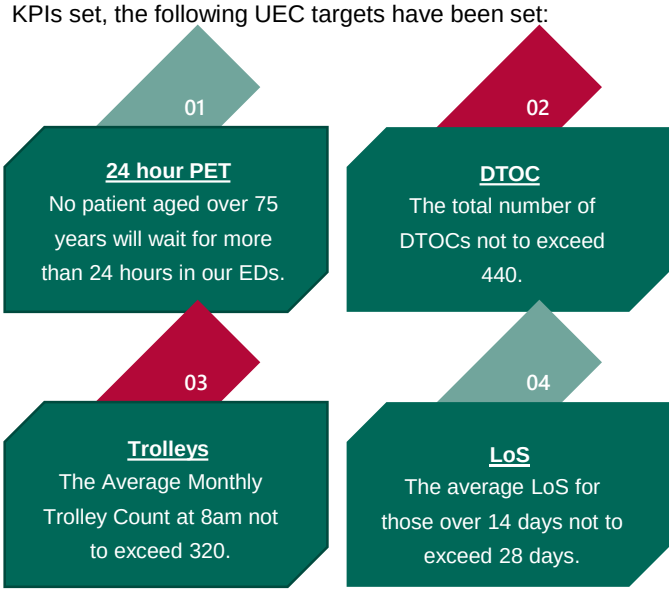
Integrated operations: This encompasses specified actions to be implemented nationally and locally to support integrated operational grip of UEC and instil a culture of continuous improvement. Hospital Groups (HGs) and Community Healthcare Organisations (CHOs) are also working on initiatives that will positively impact on UEC performance within existing resources and funding allocations this year. As part of these plans, sites have been set incremental achievable KPIs targets, taking NSP targets into consideration.

Surge measures: These measures have been developed to respond to and mitigate patient safety risks associated with high UEC activity and congestion. Some measures will be in place prior to the winter period whilst others will be triggered by agreed indicators.

National Service Plan (NSP): Initiatives to support UEC funded through NSP 2023 and outstanding initiatives from previous NSP/Winter plans will be progressed by year end.

Key Performance Indicators

KPIs for UEC activity remain below those established as part of the NSP. An immediate focus on improving these KPIs is required. Hospital sites and associated CHOs will work towards realistic and achievable in-year improvement targets to be achieved prior to year end. It should be noted that there is variation in KPIs between sites, with some sites performing well despite similar challenges. Notwithstanding the NSP KPIs set, the following UEC targets have been set:



UEC Actions 2023

Hospital Avoidance

Injury Unit (IU) expansion*
IU hours will be expanded and standardised in line with the IU Review.

Medical Assessment Unit (MAU) expansion*
Maximise the level of patients attending MAUs with expansion of criteria appropriate patient pathways for National Ambulance Service (NAS) referrals.

Nursing Home Conveyances
Expand mobile X-Ray service to Southeast and Galway/Mayo Roscommon.

Nursing Home Conveyances
Flex Enhanced Community Care (ECC) model to provide an interface with both public and private nursing homes to improve hospital avoidance and to support post-hospital discharge.

Communications
Deliver national and local communications campaigns to provide information on alternative pathways, keeping well, vaccinations and respiratory illnesses.

Community Intervention Teams (CIT)
Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients

Extended General Practitioner (GP) Hours
Extend GP Direct Access to community diagnostics for GP out-of-hours (OOH) Co-Ops.

Emergency Department (ED) Operations

Escalation Framework
Escalation plans will be actioned in all sites in line with the Escalation Framework and the implementation of Full Capacity Protocol (FCP).

Ambulance turnaround improvement*
Hospital Ambulance Liaison Person (HALP) service to be permanently deployed in all Model 3 and 4 hospitals.

NAS Private Capacity
Additional capacity will be in place through voluntary and private ambulance services to improve egress and general flow.

Patient Flow
Additional and extended hours for senior decision makers, staff integral to patient flow and in EDs. All patients at 8am on a trolley will be rounded to expedite patient flow.

Integrated operations Surge measures

*Proposed funding through Year 1 Multi-annual UEC Plan – requires recurrent investment.

UEC Actions 2023

In Hospital Operations

Patient Flow
Patient flow processes to be enhanced with additional staff resources prioritised to fulfil critical roles.

Staff Patient Flow Targets
Key staff involved in the patient pathway are to be clear on their expected targets per day (Discharges before 1100hrs, PDDs).

Predicted Date of Discharge
All patients will have a Predicted Date of Discharge (PDDs) with sites and CHO specific targeted weekly discharges.

Length of Stay (LoS)
All sites will adhere to an integrated weekly review of all patients with a LoS greater than >14 days.

Extended Diagnostics
Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid delays in flow.

6/7 Day Operations
In parallel to the 7 day programme, extended hours for senior decision makers, patient flow and Health and Social Care Professionals (HSCPs) across all services to be optimised.

Discharge Operations

Integrated Operations Hubs
All regional areas (sites and CHOs) will have integrated operational hubs and action teams on site. Meetings are to be timely, focused and target driven.

Transfer non acute patients to appropriate alternative care
All clinically appropriate patients in Model 3 and Model 4s to transfer to alternative care settings including Model 2s, Rehabilitation Beds and Transitional Care Beds (TCBs).

Transitional Care Funding (TCF)
All patients awaiting Nursing Home Support Scheme (NHSS) funding to be transferred to private Residential Care Facilities (RCFs) using TCF.

Long Term Care (LTC)
All patients awaiting LTC placement to be transferred to private RCFs using TCF or public RCFs.

Integrated operations Surge measures

Detailed Actions By Operational Pillar

Pillar 1: Hospital Avoidance Operations

Introduction

Avoidance operations encompasses the activities undertaken to support patients to avoid attending EDs (ED avoidance) and the need to be admitted to inpatient services (admission avoidance). The table below defines the targeted actions required under specific focus areas on ED and admission avoidance to support the achievement of the four key targets set out in this document.

Ref.	Focus area	Targeted action	KPI(s)
Integrated Operations			
1.1	GP OOHs	Continued support of GP OOHs.	• ED avoidance
1.2	IU Expansion	IU hours will be expanded and standardised.	• ED avoidance
1.3	MAU Expansion	Increase the level of patients attending MAUs with the expansion of criteria appropriate patient pathways for NAS referrals.	• Admission avoidance
1.4	Nursing Home Conveyances	Deliver ECC led primary care services in all public and private Nursing Homes	• ED avoidance
1.5	Nursing Home Conveyances	Expand Mobile X-Ray services to Southeast and Galway/Mayo Roscommon.	• ED avoidance
1.6	Communication	Deliver national and local communications campaigns to provide information on alternative pathways, keeping well, vaccinations and respiratory illnesses.	• ED avoidance
Surge Measures			
1.7	GPs	Extend GP Direct Access to Community Diagnostics for GP OOH Co-Ops. Test Model to provide additional Diagnostic and IU Capacity to certain OOH locations through the use of Private Injury Unit Capacity.	• ED avoidance
1.8	Patient Flow	CHOs to roster additional and extended hours for staff to support patients at risk of hospital admission.	• ED avoidance
1.9	CIT	Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients.	• ED avoidance
NSP Initiatives			
1.10	NAS	A further four Pathfinder teams (Galway, Kerry, Navan and Tullamore) will be in place prior to year end.	• ED avoidance
1.11	NAS	NAS Clinical Hub will be strengthened and the Out of Hospital Cardiac Arrest Strategy will be implemented.	• ED avoidance
1.12	Vaccination	Develop and deliver a programme plan for administration of COVID-19 vaccines in line with recommendations. Implement the seasonal influenza vaccination programme to improve uptake amongst healthcare workers as well as promoting uptake amongst at-risk vulnerable groups.	• ED avoidance • Admission avoidance

Pillar 2: ED Operations

Introduction

ED operations encompass the activities undertaken to deliver safe and timely care to patients attending EDs, and to support flow. The table below calls out targeted actions required under specific focus areas on ED to support the achievement of the four key targets set out in this document.

Ref.	Focus area	Targeted action	KPI(s)
Integrated Operations			
2.1	Admitted patients	No admitted patient aged over 75 years to wait 24 hours for an inpatient bed.	• 24 hour 75 years PET • Trolley Count
2.2	Admitted patients	The Average Monthly Trolley Count at 8am not to exceed 320.	• 24 hour 75 years PET • Trolley Count
2.3	Escalation	Escalation plans will be actioned in all sites in line with the Escalation Framework and the implementation of the FCP.	• Trolley Count
2.4	Triage	All patients to be seen in accordance to Manchester Triage times.	• 24 hour 75 years PET • Trolley Count
2.5	Turnaround Times	HALP service to remain operational.	• NAS Turnaround Times
2.6	Patient Flow	Daily rounding to include 8am assessment of every patient on a trolley with a view to expedite patient flow.	• 24 hour 75 years PET • Trolley Count
Surge Measures			
2.7	Patient Flow	Additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs in EDs.	• Conversion rate • 24 hour 75 years PET • Trolley Count
2.8	NAS Response	Additional capacity will be in place through voluntary and private ambulance services.	• NAS Response Times

Pillar 3: In Hospital Operations

Introduction

In hospital operations encompass the activities undertaken to deliver safe and timely care to acute hospital inpatients and to drive the freeing up of capacity and patient flow. The table below identifies targeted actions required under specific focus areas in hospital to support the achievement of the four key targets set out in this document.

Ref.	Focus area	Targeted action	KPI(s)
Integrated Operations			
3.1	Rostering	Operational teams will roster staff to maintain patient flow on a 7//7 basis.	• 24 hour 75 years PET • Trolley Count • LoS
3.2	Diagnostics	Expansion of inpatient diagnostics to meet UEC demand.	• 24 hour 75 years PET • Trolley Count • LoS
3.3	Rounding	As part of the SAFER patient flow bundle, daily rounding by patients' own Consultants (or delegated by agreement) to expedite decisions and treatment.	• 24 hour 75 years PET • Trolley Count • LoS
3.4	Patient Flow	Patient flow processes to be enhanced with additional staff resources prioritised to fulfil critical roles.	• 24 hour 75 years PET • Trolley Count • LoS
3.5	Patient Flow	Key staff involved in the patient pathway are to be clear on their expected targets per day (eg. discharges before 11, PDDs, TCBs, Rehabilitation Beds and LTC RCF Beds required) in both the Hospital and CHO.	• 24 hour 75 years PET • Trolley Count • LoS
3.6	Patient Flow	All patients will have a PDD with sites and CHO specific targeted weekly discharges.	• LoS • DTOC
3.7	Patient Flow	All sites will adhere to an integrated weekly review of all patients with a LoS greater than >14 days.	• LoS • DTOC
3.8	Patient Flow	Full adherence to the National System Wide Escalation Framework and implementation of the FCP.	• 24 hour 75 years PET • Trolley Count
Surge Measures			
3.9	Private Capacity	All sites to utilise all available contracted private hospital bed capacity to support time sensitive and/or medical patient care.	• 24 hour 75 years PET • Trolley Count
3.10	Patient Flow	All sites and CHOs to roster additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs across acute and community services.	• 24 hour 75 years PET • Trolley Count • LoS
3.11	Diagnostics	Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid weekend and post weekend delays in flow.	• 24 hour 75 years PET • Trolley Count • LoS
NSP Initiatives			
3.12	Acute Capacity	An additional 182 acute beds to be delivered by year end.	• 24 hour 75 years PET • Trolley Count
3.13	Critical Care Capacity	An additional 28 critical care beds to be delivered by year end.	

Pillar 4: Discharge Operations

Introduction

Discharge operations encompass the activities undertaken to discharge patients in a safe and timely way to drive the freeing up of capacity and patient flow. The table below calls out targeted actions required under specific focus areas on discharge to support the achievement of the four key targets set out in this document.

Ref.	Focus area	Targeted action	Targets
Integrated Operations			
4.1	Discharges	All regional areas (sites and CHOs) will have integrated operational hubs and action teams on site. Meetings are to be timely, focused and target driven.	• LoS • DTOC
4.2	Discharges	Focused community multi-disciplinary initiatives/services will increase discharges and occupancy of all short-term and long-term public and private beds including rehabilitation, LTC and TCF.	• LoS • DTOC • Occupancy rate
4.3	DTOCs “Ons”	Reduction of DTOCs to specified site targets for each site. All DTOC “ons” should be validated to confirm patients are ready for discharge.	• DTOC
4.4	DTOCs “Ons”	All patients will have a PDD with sites and CHO specific targeted weekly discharges.	• LoS • DTOC
4.5	Bed Capacity	All clinically appropriate patients in Model 3 and Model 4s will transfer to alternative care settings including Model 2s and short-term and long-term public and private beds including Rehabilitation, LTC and Transitional Care (TC).	• LoS • DTOC • Occupancy rate
4.6	Community Bed Capacity	All acute sites and CHOs to utilise all available bed capacity across sites. Weekly community bed capacity report to be utilised and inform timely discharges as part of integrated operations.	• DTOC
Surge Measures			
4.7	TCF	All patients awaiting NHSS funding to be transferred to private nursing home beds using TCF.	• LoS • DTOC
4.8	Community Private Capacity	Additional community private capacity to be stepped up if all available community bed capacity has been maximised.	• LoS • DTOC
4.9	Residential Care Facilities (RCF)	All patients awaiting LTC placement to be moved to a LTC facility.	• LoS • DTOC
4.10	Community Intervention Teams	Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients.	• LoS • DTOC
NSP Initiatives			
4.11	Community Bed Capacity	An additional 27 community beds will be delivered by year end.	• LoS • DTOC • Occupancy rate
4.12	ECC	Increase Integrated Care Programme (ICPOP) Community Specialist Team (CST) Monthly Patient Contacts from April 2023 Target of 6K to 10K by Year-End Increase Chronic Disease Management (CDM) CST Monthly Patient Contacts from April 2023 Target of 10K to 30K by Year-End.	• LoS • DTOC • Occupancy rate

Governance and Reporting

Governance and Reporting

Governance and Reporting

The HSE UEC Operational Plan 2023 aims to support the delivery and management of UEC until year end by establishing clear integrated operational actions and targets for senior management alongside the approved additionality of surge measures to mitigate the risks associated with high UEC pressures.

This operational plan will lead into year one of the multi-annual UEC plan and will align with the governance structure of the overarching multi-annual UEC plan. In order to support the delivery of both plans, an associated integrated system of governance and accountability is required to ensure ongoing monitoring, delivery and reporting.

National Governance

Nationally, the HSE Board will, through its Performance and Delivery Committee, seek assurance on the implementation of the HSE UEC Operational Plan 2023 from the CEO and his Executive Management Team (EMT).

The Chief Operations Officer (COO) will chair the UEC Oversight Group (formerly known as the Winter Oversight Group) supported by other members of the EMT. The COO is responsible for the execution of the UEC Operational Plan 2023.

Local Governance

A key recommendation from the After Action Review (AAR) of the escalation period in Winter 2022/23 was the need for the standardisation of the membership and structure of integrated operational structures to avoid variation and ensure operational grip.

As part of the 2023 UEC Operational Plan, operational leadership staff in associated acute sites and community services will be mandated to ensure key local integrated governance structures including integrated operational hubs, meetings and steering groups are in place. Local integrated operational meetings must be regularly convened, with appropriate senior acute and community leadership and representation to enhance operational grip through the initiation and monitoring of accountable actions.

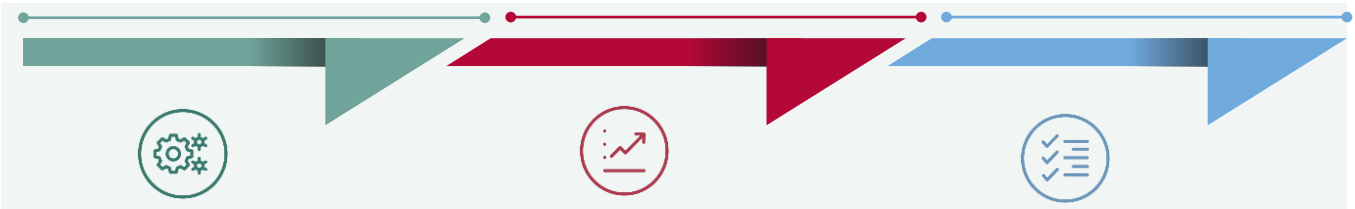
Reporting and monitoring

Regular oversight at national and local levels will be provided to support the implementation of the operational plan, support operational grip and performance in relation to UEC KPIs. The Performance Management and Improvement Unit (PMIU) will closely monitor and report on the implementation of the plan and UEC KPI performance.

Monitoring of the implementation of the Operational Plan

Monitoring and reporting of progress against the Operational Plan will be coordinated and managed by the National Programme Management Office (PMO) in the PMIU. The PMO will ensure reporting is aligned, integrated and reflects the status of projects and measures delivered as specified in this UEC Operational Plan 2023. Each Hospital and CHO will ensure monitoring and reporting arrangements are in place to provide timely updates to the National PMO. A PMO report will be shared with the UEC Oversight Group and with the Department of Health (DoH), as part of weekly pulse meetings, to review and monitor the plan's implementation.

The progress of the Operational Plan 2023 will be monitored through the UEC Oversight Group.



Integrated Operations

The implementation of actions supporting integrated operations will be monitored and assured as part of status updates, performance reviews and UEC KPI monitoring.

Surge Measures

Progress updates and activity/KPI reporting related to the initiation and implementation of surge measures will be provided on a weekly/monthly basis via the PMO report.

NSP

Progress updates and activity/KPI reporting associated with the initiatives funded through the NSP and Operational Plan will be reported on a weekly/monthly basis via the PMO report.

UEC Operational Plan 2023

Governance and Reporting

UEC KPI performance monitoring

Ongoing regular reporting and monitoring is provided by the PMIU on UEC activity and performance to inform data driven actions on a national and site level basis. Clear national and site level targets have been established to be achieved by Q3 2023. Individual site targets for the key focus KPIs has been set, however all sites should aim to sustain below these maximum levels. These target KPIs will function alongside the full suite of KPIs in the HSE NSP.

Each action established under the four key pillars of i) hospital avoidance operations, ii) ED operations, iii) in hospital operations and iv) discharge operations, are associated with UEC KPIs. Progress in relation to the national and site level Q3 and end of year UEC KPI targets will be reported regularly. In tandem to the PMO report, regular UEC performance monitoring on a national and site level basis, will monitor and provide assurance in line with the targets set. These reports include:

- daily basis UEC situational analysis reports distributed by the PMIU to National Operations and the DoH which include acute ED demands, general acute and critical care bed demand and availability including capacity and capability; and
- weekly and monthly UEC reports which are collated and updated to provide data on a national and site level basis and compares activity and performance in relation to previous weeks and years.

These UEC reports will be provided to the DoH weekly and reviewed as part of the weekly pulse meetings with representatives of the UEC Oversight Group.

Focus UEC KPIs

24hr Patient Experience Time (PET) > 75 years

- **As part of the Operational Plan, 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. There is a particular focus on 24 hour PET for this age cohort to mitigate the patient safety risks associated with extended wait times.

8am Trolley Count

- The HSE continues to work toward ensuring that the maximum monthly 8am trolley average does not exceed 320 patients. There will be an enhanced focus on reduction of trolley numbers for the remainder of the year. Measures and projects are being progressed to target reduced congestion including a focus on sites facing challenges in KPI performance.

Delayed Transfers of Care (DTOC)

- As part of the operational plan, measures will be progressed to decrease the DTOC figure and ensure there are no more than 440 weekly DTOC. There is a requirement to focus on this KPI to improve patient outcomes and enhance patient flow. A reduction in DTOCs can ultimately increase bed availability for acutely unwell patients, reduce ambulance delays and decrease admitted PETs.

Length of Stay (LoS)

- Reducing LoS for those patients with a LoS >28 days, will improve operational outcomes in addressing demand-capacity mismatches for both UEC and elective admissions. Decreasing LoS is important for patient outcomes in reducing Health Care Associated Infections (HCAIs) and maintaining functional independence.

Data Intelligence

There are a suite of reports provided to and reviewed as part of the UEC Oversight Group to aid and inform decision making regarding the risk of respiratory surges and potential UEC scenarios as outlined below:

Health Protection Surveillance Centre (HPSC) reporting

The HPSC provides weekly surveillance reporting for notifiable infectious diseases including COVID-19, influenza and Respiratory Syncytial Virus (RSV) and others. The HPSC reports will continue to inform actions to mitigate risks associated with the increasing circulation of multiple respiratory and other viruses and surges in UEC activity.

Integrated Service Model (ISM) reporting

The ISM is a patient-by-patient, site-by-site and day-by-day simulation of hospital and community services. The ISM will project health service performance in response to a range of potential demand scenarios. The ISM has completed preliminary work on the outlook for UEC until Spring 2024 which will continue to be refined over the summer. These outlooks will inform planning.

Surge Measures

Surge Measures

Introduction

Surges in UEC may be driven by surges in COVID-19 caused by emergent variants and/or seasonal rises in influenza and RSV associated with winter and/or other viral or bacterial infections (e.g. invasive Group A Streptococcal infection [iGAS]) and disordered epidemiology post pandemic impacting on the normal ecology of infectious diseases and their experience in the population.

Surge periods of exceptionally high UEC activity levels are being anticipated for the remainder of 2023. In order to respond to and mitigate the patient safety risks associated with such high UEC activity and resultant congestion, surge measures have been planned. These measures have been informed by the lessons learnt as part of the AAR of the escalation period in Winter 2022/23.

These surge measures recognise the complexity and whole-system nature that is UEC, and that accordingly an integrated response across acute and community services is required to reduce pressures and mitigate associated patient safety risks. These surge measures will be triggered based on agreed appropriate indicators.

Surge period outlook – Winter 2023/24

A multi-pathogenic winter (similar to winter 2022/23) is anticipated due to the co-circulation of SARS-CoV-2, influenza and RSV. These viruses may peak concurrently or in sequential waves with a resultant high impact and demand on services over an extended period.

In line with the most recent winter seasons (2021/22 and 2022/23), it is possible that there will be an early RSV season with increased activity from August/September onward, peaking in November/early December. As a result, paediatric related UEC and GP pressures are likely to be experienced at an earlier point of the winter period than that experienced in adult services.

Seasonal surges of influenza and COVID-19 are expected in mid-late winter. This is likely to lead to simultaneous and sequential outbreaks of COVID-19, influenza and RSV in health and social care settings. With increased virus circulation in the community, subsequent elevated invasive bacterial infections late winter/early Spring is expected e.g. iGAS, Invasive Pneumococcal Disease (IPD) and Invasive Meningocal Disease (IMD).

Particular consideration is required for those in medical risk groups, vulnerable populations/settings and those aged ≥65 years and ≤4 years (in particular ≤1 year) who are at highest risk of severe disease during surge periods.

Surge measure categories

The HSE recognises the need to adapt and respond appropriately to periods of surge during winter 2023/24 as part of the UEC Operational Plan. A flexible approach will be required to the implementation of surge measures which recognises the need for some measures to be progressed and in place in advance of the winter period. Other surge measures will require initiation and scaling based on evidence based indicators of increasing respiratory viruses, UEC congestion and potential patient safety risks. Other indicators will support the cessation of surge measures. Accordingly two categories of surge initiatives have been developed:

- *Category 1* - Mitigating measures put in place in advance of surge pressures to support UEC pressures; and
- *Category 2* – Surge specific measures, triggered by indicators and implemented for an agreed period of time, to improve patient flow and mitigate patient safety risks in response to escalating UEC pressures.

The surge measures and associated categorisation are detailed overleaf.

Category 1

Mitigating measures put in place in advance of surge pressures to support the management of UEC pressures.

Category 2

Surge specific measures, triggered by indicators and implemented for an agreed period of time, to improve patient flow and mitigate patient safety risks in response to escalating UEC pressures.

Surge Measures

Surge measures

Surge measures for the UEC Operational Plan have been based on the learnings from the AAR. These measures, while requiring funding and investment, are non-recurring, are not dependent on recruiting Whole Time Equivalent (WTE) and are feasible for delivery in 2023.

Category	Surge Measure	Descriptor	Recurring/ Non recurring	Cost
Hospital Avoidance				
Category 2	GPs	Extended GP hours over out of hour (OOH) periods and weekends will be delivered.	Non-recurring	€3,080,000
Category 2	Patient Flow	CHOs to roster additional and extended hours for staff to support patients at risk of hospital admission.	Non-recurring	*See extended hours*
ED Operations				
Category 2	NAS Response	Additional capacity will be in place through voluntary and private ambulance services.	Non-recurring	€1,000,000
In Hospital Operations				
Category 2	Private Capacity*	All sites to utilise all available contracted private hospital bed capacity to support time sensitive and/or medical patient care.	Non-recurring	TBC
Category 2	Patient Flow	All sites and CHOs to roster additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs across acute and community services.	Non-recurring	*See extended hours*
Category 2	Diagnostics	Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid weekend and post weekend delays in flow.	Non-recurring	€1,145,000
Discharge Operations				
Category 2	TCF	All patients awaiting NHSS funding or requiring convalescent care to be transferred to private nursing home beds using TCF.	Non-recurring	€2,333,333
Category 2	Community Private Capacity*	Additional community private capacity to be stepped up if all available community bed capacity has been maximised.	Non-recurring	TBC
Category 2	RCFs	All patients awaiting LTC placement to be moved to a LTC facility	N/A	N/A
Category 2	CIT	Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients.	Non-recurring	*See extended hours*
Additional/Extended Hours				
Category 2	Additional/ Extended hours:	Patient Flow (Hospital Avoidance and In Hospital Operations) and CIT (Discharge Operations)	Non-recurring	€150,000
Total Cost				€7,708,333

**Private capacity funding requirements not included as this will extend beyond the surge period.*

Surge Measures

Surge measure indicators and triggers

The surge indicators outlined in the table below are to inform decision making and support the triggering of Category 2 surge measures. These indicators will support pre-emptive action to respond to increasing UEC pressures and mitigate associated patient safety risks. These indicators have been developed with and will be further refined and agreed with the UEC Oversight Group in consultation with Public Health, the National Health Protection Service, HPSC and the ISM.

Sample Metrics and Triggers

	Initiation of surge measures	Cessation of surge measures

Indicators	• Weekly surveillance data indicates respiratory related hospitalisations (for COVID-19, influenza or RSV) in excess of previous seasonal means or thresholds (based on historical data over several seasons) for that week.
	• Sentinel GP influenza-like illness (ILI) consultation rate is above baseline threshold and increased significantly (e.g. rate has doubled - overall or in age specific groups) compared to previous week(s).
	• Waste water surveillance indicates rising levels of infection in the community.
	• An increased trend in the number of laboratory confirmed COVID-19/influenza Intensive Care Unit (ICU) cases over 2-3 weeks (or over a single week if the increase is very significant).
	• An increased trend in the number of respiratory virus outbreaks in health and social care settings over 2-3 weeks (a trend that can't be explained by way of change in surveillance processes/testing/policy).
	• Observed actuals are in excess of and/or in advance of modelled ISM pessimistic scenarios for any of the following:
	  ○ Occupancy
	  ○ Trolleys
	  ○ Admitted patients on emergency beds.
	• Significant sustained upward trend in UEC demand in relation to attendances and admissions over 3 successive weeks.
		• Sustained downward trend over two weeks of Acute Respiratory Infection (ARI) hospitalisation should trigger review with de-escalation of interventions should it be sustained for a further week.
		• Sentinel GP ILI consultation rate has decreased for three weeks in succession.
		• Significant sustained downward trend in UEC demand in relation to attendances and admissions over three successive weeks.
		• Reduction in outbreaks in hospitals and care homes sustained for two successive weeks.
		• Reduction in signal from waste water surveillance for two successive weeks.
		• High coverage of vaccines in vulnerable people and healthcare staff.

Trigger	• At least one of the conditions met.	• Triggering condition reversed or substantially reduced.

Appendix 1: Abbreviations

Abbreviations

Abbreviation	Meaning
AAR	After Action Review
ARI	Acute Respiratory Infection
CEO	Chief Executive Officer
CDM	Chronic Disease Management
CHO	Community Healthcare Organisation
CIT	Community Intervention Team
COO	Chief Operations Officer
COVID-19	Coronavirus Disease 2019 aka Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
CST	Community Specialist Team
DoH	Department of Health
DTOC	Delayed Transfers Of Care
ECC	Enhanced Community Care
ED	Emergency Department
EMT	Executive Management Team
FCP	Full Capacity Protocol
GP	General Practitioner
HALP	Hospital Ambulance Liaison Person
HCAI	Health Care Associated Infections
HCW	Healthcare Worker
HG	Hospital Group
HPSC	Health Protection Surveillance Centre
HSCP	Health & Social Care Professional
HSE	Health Service Executive
ICPOP	Integrated Care Programme for Older Persons
ICU	Intensive Care Unit
iGAS	invasive Group A Streptococcal infection
ILI	Influenza-like Illness
IPD	Invasive Pneumococcal Disease
IMD	Invasive Meningocal Disease
ISM	Integrated Service Model
IU	Injury Unit
KPIs	Key Performance Indicators
LoS	Length of Stay
LTC	Long Term Care
MAU	Medical Assessment Unit
N/A	Not applicable
NAS	National Ambulance Service
NHSS	Nursing Home Support Scheme
NSP	National Service Plan
OOH	Out-Of-Hours
PDD	Predicted Date of Discharge
PET	Patient Experience Time
PMIU	Performance Management Improvement Unit
PMO	Project Management Office
RCF	Residential Care Facilities
RSV	Respiratory Syncytial Virus
SAFER	Senior, All Patients, Flow of Patients, Early Discharge, Review
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
TBC	To Be Confirmed
TC	Transitional Care
TCB	Transitional Care Bed
TCF	Transitional Care Funding
UEC	Urgent and Emergency Care
WTE	Whole Time Equivalent

End