Winter Preparedness Plan

October 2021 – March 2022

November 2021

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Introduction

It is important to acknowledge the progress that has been achieved across the health system through the investments made through previous winter plans. The most significant investment was made last winter where the challenges presented by winter combined with the pandemic presented very high levels of risk.

The effect of the pandemic restrictions and the positive response by the public in adhering to same mitigated the risk and ultimately enabled the health services to direct winter investments to respond to the third wave in January 2020.

In the context of a more open economy and society and the high rates of community transmission of the COVID-19 virus presently, it is already clear that this winter will be even more difficult for the health system. Levels of attendance at emergency departments, GPs and other services are significantly increased. Hospitals are seeing a very high rate of admission of COVID and non-COVID cases and a significant number of COVID cases are being admitted to ICU beds.

The HSE Winter Plan 2021/22 will provide for the appropriate, safe and timely care for patients by ensuring, insofar as possible, effective levels of capacity and resources are in place to meet the expected growth in activity levels. The success of this plan will be dependent in part on the continued support of the public in continuing to follow the public health guidance regarding hygiene, social distancing and mask wearing. The public can also support the health services in ensuring that they utilise all other appropriate options of care, including their pharmacy, GP or Minor Injury Unit before opting to attend an emergency department.

Targets are proposed within this document, including an enhanced focus on Patient Experience Times and performance against these targets will be monitored, by integrated oversight teams. This plan endorses a home first approach, enabling and facilitating patients to receive the most appropriate care in their own homes and communities.

Sláintecare underlines this ‘right care, right time, right place’ approach. As part of this integrated plan the HSE will focus on avoidance of hospital admittance unless absolutely essential, patient flow through our hospitals, and safe and timely egress of patients from hospital, as outlined below:

- Continued implementation of agreed patient pathways including our frail elderly and patients with chronic illness;
- A core focus on Infection Prevention and Control (IPC) measures and practices including enhanced measure in the community;
- Supporting GP’s to optimise patient services and access;
- Optimisation of hospital avoidance measures, including GP access to diagnostics and Community Intervention Teams to avoid unnecessary hospital admittance;
- Management of patient flow and egress;
- Enhanced initiatives to prevent unnecessary hospital admissions;
- Demand/capacity management of attend and admit profiles to respond to rising pressures;
- Building community and acute capacity; and
- Maintaining an enhanced focused on service restoration in disability services, mental health, services for older people and social inclusion care groups.

The Winter Plan 2021/22 requires an approach which maintains COVID-19 services, accounts for winter pressures, provides continuity of non COVID-19 services, addresses waiting lists and enhances services in line with Sláintecare. Such an approach requires the design and deployment of new initiatives whilst delivering the outstanding components of the 2020/21 plan. This paper will clearly outline:

- current initiatives that continue to be implemented as part of the National Service Plan (NSP) which will form part of this Winter 2021/22 plan;
- proposed new initiatives to address the challenges outlined and have the potential to positively influence the current context; and
- new services proposed as part of the NSP 2022 process which funding is sought for to accelerate early implementation for winter.

Further context on influenza, COVID-19 demand and the transition from pandemic to endemic is outlined in the appendices.

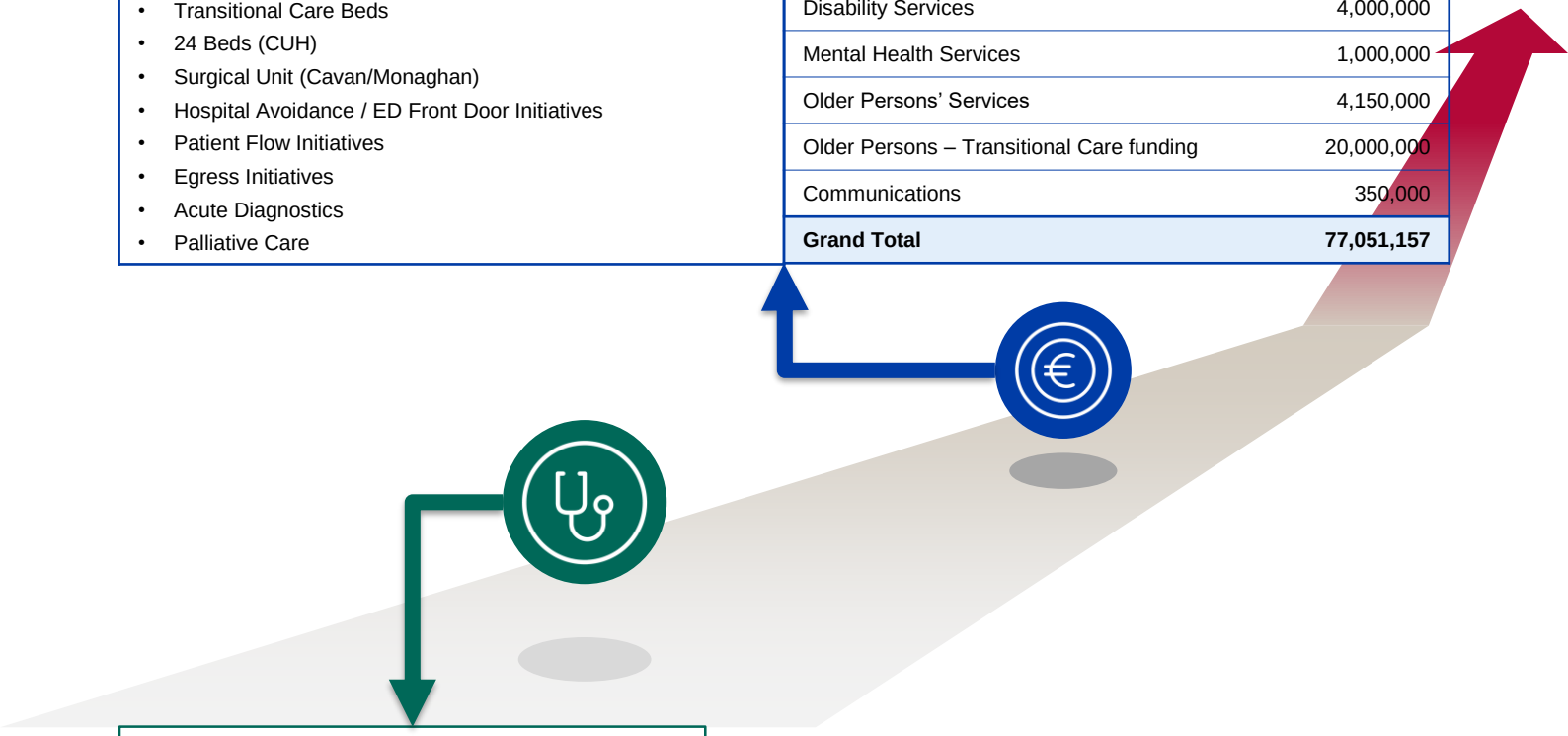
Executive Summary

NSP 2021 supporting Winter 2021-22

2021-22 Winter Plan

- Private Capacity (SafetyNET 4b Agreement)
- NAS PATHFINDER
- Communications
- Aids and Appliances (Primary Care)
- GP and OOH supports (Primary Care)
- Acute Alternative Pathways
- Acute Restart Initiatives
- Social Inclusion
- GP Access to Diagnostics
- Older Persons Hospital Discharge Liaison
- Transitional Care Beds
- 24 Beds (CUH)
- Surgical Unit (Cavan/Monaghan)
- Hospital Avoidance / ED Front Door Initiatives
- Patient Flow Initiatives
- Egress Initiatives
- Acute Diagnostics
- Palliative Care

WINTER PLAN FUNDED INITIATIVES	
	FY 2022 Cost
Acute Services	9,185,777
Acute Services – Private Capacity	20,160,000
National Ambulance Service	5,700,402
Primary Care – GP Supports and OOH	10,000,000
Primary Care – Aids and Appliances	1,854,978
Palliative Care	650,000
Disability Services	4,000,000
Mental Health Services	1,000,000
Older Persons' Services	4,150,000
Older Persons – Transitional Care funding	20,000,000
Communications	350,000
Grand Total	**77,051,157**



2021 Service Plan

- 1,152 Acute Beds (795 open)
- 73 Sub-Acute Beds (All open)
- C. 1,100 private bed days used per week (SafetyNET Agreement)
- 551 Community beds planned (276 open)
- Access to 572 private Community beds (472 currently contracted)
- 96 ECC Networks planned (15 networks in place YTD)
- 85,315 Diagnostics accessed by GPs YTD 2021
- 5 million additional Home Support Hours (2.3 million used YTD)
- Full population coverage for CIT services

Supports to be implemented during Winter 2021-22 from the 2021 Service Plan

- 205 Acute beds
- 1,100 private bed days per week (SafetyNET)
- 275 Community Beds
- 100 additional private Community beds to be accessed
- ECC Programme to be further expanded
- C. 4,000 GP Diagnostics per week
- 2.7m additional home support hours available in the context of pressures caused by unfunded price increases

Winter Preparedness Plan 2021-22

Introduction

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Appendix 1 provides further context on influenza, COVID-19 demand and the transition from pandemic to endemic.

Introduction

Winter 2021/22 Costings

This component of the document outlines the planned winter spend for 2021/22. The Full year 2022 (FY2022) costs where appropriate have also been included for information. The summary table below outlines by area the entire cost of the Winter Plan 2021/22. The Full year 2022 cost of the winter plan will be **€77,051,157.**

The Winter Plan 2021/22 initiatives will be further supported by the significant level of investment made as part of the 2021 service plan and will support the HSE in dealing with the expected winter pressures.

The initiatives identified are mainly service capacity and treatment pathway enhancements that are permanent in nature and where put in place will require full year funding in 2022 and beyond. Where full year funding is required, these initiatives will be clearly identified in the NSP 2022 submissions of which they are a subset. The costs and approach to implementation are outlined below:

Initiative	FY2022 Cost €
Acute Services	29,345,777
Community Services	41,654,978
National Ambulance Service	5,700,402
Communications	350,000
Total	**77,051,157**

The HSE approach to delivering these initiatives will be integrated and patient centered.

Risks

Risks

The Winter Plan is a short term tactical plan which aims to mitigate winter pressures. The Winter Plan must be seen within the overall context of the wider National Service Plan which focuses on continued service restoration in line with the Service Restoration Plan and investments targeted at redesigning and rebuilding services guided by the vision, principles, approach and priorities of Sláintecare. A main aim of both the Winter Plan and the National Service Plan is to shift the services the HSE provides from predominantly hospital environments to community based delivery. As the HSE approaches and plans for winter 2021/22, it is faced with significant challenges and risks in managing potential COVID-19 surges, the co-circulation of seasonal influenza, service restoration, workforce availability, cyber attack recovery and addressing the backlog of care. There are also new risks emerging including the impact of delayed care as a result of the postponement of care and long COVID on service users and associated service demand.

A key underlying risk in implementing this Winter Plan, is the significant risk of not being able to attract and retain the appropriate number and caliber of staff. This is particularly the case in relation to the home care and nursing home sector.

Each initiative has been reviewed and risks have ben identified by the service owner. Engagement with other key stakeholders, including HR, Estates, Finance, OoCIO, Procurement and colleagues in the Department of Health has been ongoing throughout the development of the Service Restoration Plan and Winter Plan. In this context, it is essential that these risks, their mitigation and residual nature are documented and dynamically reviewed throughout the implementation of this plan.

All initiatives were reviewed and risks that are identified have been validated and categorised in a comprehensive risk register. However there are a number of risk types which are common as archetypes across many elements which have been categorised as follows:

Structural Risks

- The ability to address and deliver the necessary physical infrastructure (people, materials, machinery and buildings);
- Premise capacity and configuration to provide safe services in line with IPC and COVID-19 considerations;
- Geographical variation in the availability of both acute and community services; and
- The leadership and governance (clinical and corporate) arrangements to drive and enable implementation including capacity, capabilities, and agreed roadmap.

System and Procedural Risks

- COVID-19 related issues, in particular reoccurrence of COVID surge and waves;
- Ongoing need for both COVID and non COVID-19 pathways in acute services whilst addressing care backlog and delivering service enhancements/initiatives;
- Continual prioritisation, balancing and judgement calls of service capacity according to community need and risk;
- Ongoing need for strict infection prevention control and safe working practices reducing productivity and ‘foot-fall’;
- Increased activity, in both scheduled, unscheduled care and community services;
- Safe delivery of services to unvaccinated sections of the population at high risk of severe disease;
- Meeting the challenging scale of recruitment required, in maintaining existing staffing levels, COVID-19 services and recruitment for new initiatives;
- Reliance on external providers for workforce availability and capacity in some sectors;
- Ongoing need for staff redeployment in testing, tracing, booster vaccination programme and long term care facilities;
- Staff burnout and well-being in the event of further surges;
- Staff absenteeism in the event of symptomatic infection in line with current HPSC guidelines;
- Employee engagement mechanisms to deliver new ways of working;
- Clear communication strategy with all stakeholders and management of expectations;
- Defined well governed mandated care pathways to deliver integrated and safe care; and
- Providing the necessary tools and enablers for change including operations management, project management and data analytical skills and capabilities.

Outcomes/ Key Result Risks

- Ensure clarity on relationship between structural and process indicators and key outcomes required. There is often a need to address the first two before the latter is realised;
- Understanding of context to delivering key outcomes;
- Demand profile remaining stable and predictable; and
- Operation of Performance and Accountability Framework in delivering outcomes.

Winter 2021/22 Context

Winter Plan 2020-21 Initiatives Delivered

Our response in 2020/21

As part of the Winter 2021/22 plan it is important to reflect on performance against the 2020/21 plan. During the winter period 2020/21 the HSE faced unprecedented challenges. Successive COVID-19 surges, the requirement to deliver COVID and non COVID pathways harmoniously and the unanticipated Cyber Attack have negatively impacted 2020/21 delivery. COVID outbreaks and staffing challenges in community facilities have significantly delayed the opening of additional community bed capacity. Continual prioritisation, balancing and judgement calls of service requirements and competing demands to launch new initiatives in line with the 20/21 plan whilst delivering on the restoration of services plan has impacted the delivery timeline, however the HSE remain committed to delivering the NSP 21.

Resilient in the face of these challenges, the HSE delivered very successful vaccination and test & trace programmes. Additional capacity has been added to the system and alternative community based pathways have been successfully launched. Please note the cyber attack has impacted the ability to analyse data for the period of May-July, therefore the infographic below encompasses gaps, and underestimates delivery against the plan.

Winter 2020/21 and NSP 2021 initiatives to date have delivered, as follows:

Acute Beds

795

COVID-19 tests per week

161,917 tests complete
as at week 36 2021

Home Support Hours

>2.3 million Hours out of an
additional 5million NSP Hours

Sub-Acute Beds

73

Repurposed community beds to support home first pathway

299 public & **468** private beds
contracted

Self-isolation bed capacity per day

Average of **101**
occupied each day

GP access to diagnostics

85,315 scans complete to date

Winter 2021/22 Context

Integrated Service Model (ISM)

Integrated Service Model (ISM)

The ISM is a tool that when fully developed will be used for enhancing winter service planning. The ISM is discrete event simulation which replicates core components of the health system for key patient pathways and allows health service performance to be assessed to provide data-driven and evidence based support to HSE strategic planning.

The ISM, when fully operational, will ensure a comprehensive service response by focusing on forecasting demand, benefits tracking and evaluating service outcomes for both COVID-19 and non COVID-19 services. Agreed health service demand profiles on a patient-by-patient, day-by-day, site-by-site and service-by-service level will be applied to the model to simulate and predict likely future performance. Potential interventions and initiatives in acute and community settings can then be applied to the integrated model to simulate and predict likely system performance in response to these changes.

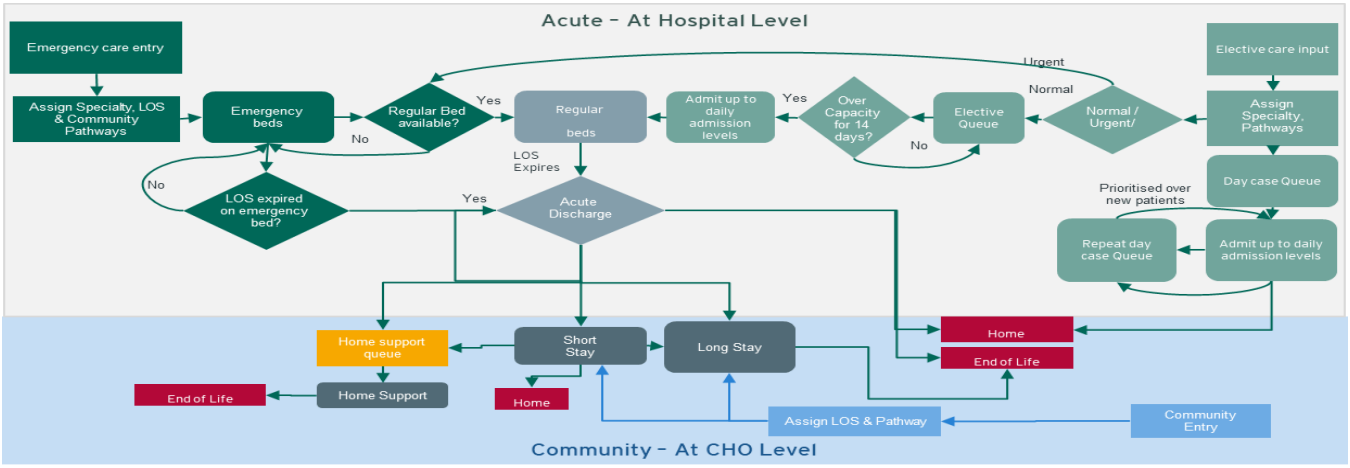
The model build will be open, collaborative and allow for stress-testing and validation using the expertise of HSE operations, strategy and clinical colleagues to ensure the model is authentic and focused on key questions and challenges. ISM will augment, strengthen and make more transparent key service planning discussions and decisions. It will help focus and build specification in planning proposals. It will assist in defining expected benefits and tracking benefit realisation.

ISM Model Flow

A high level visualisation of the ISM model flow is provided below. It outlines both the acute and community settings.

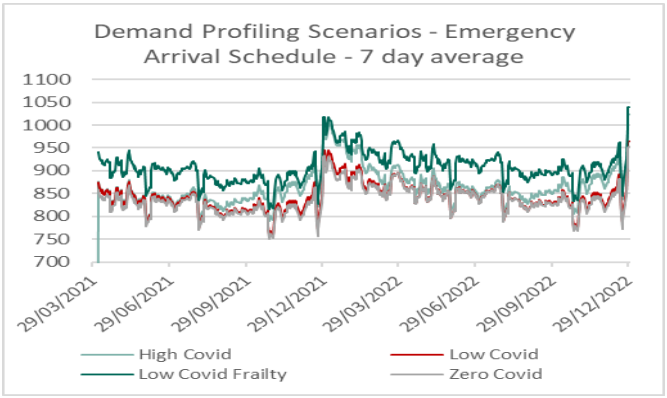
COVID

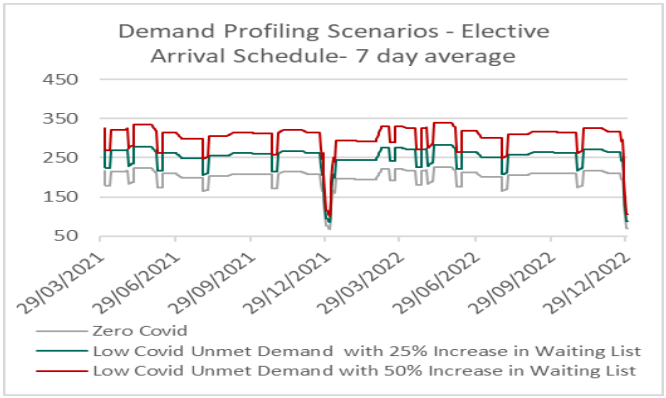
The ISM will model health service performance in response to various demand scenarios. This includes scenarios regarding COVID-19 and there is ongoing interaction with the Irish Epidemiological Modelling Advisory Group (IEMAG) to mobilise its forecasting for HSE planning.



Model Input Illustration – Demand Profiling

The graphs presented below demonstrate the model inputs of ISM. The first graph outlines the demand profiling for the emergency arrival schedule using four critical scenarios, while the second graph outlines same for elective care across three critical scenarios.





Winter 2021/22 Context

COVID-19 Modelling

COVID-19 Demand and Capacity Modelling

Updated COVID-19 modelling has been recently undertaken by the Health Information Unit (HIU) using data transferred from the Irish Epidemiological Modelling Advisory Group (IEMAG) in relation to projected COVID-19 healthcare demand for acute and critical care beds. This modelling indicates the scale of the challenge likely to be faced by the HSE this winter in terms of the high short and medium term demands for general acute and critical care bed demands for COVID-19 patients. Inevitably increased pressures in COVID-19 demands can be extrapolated to pressures being experienced in community services including testing and tracing.

The overall modelling approach is to examine the impact on healthcare demand generated in response to the latest available (26th August) IEMAG scenarios based on age cohorts. These scenarios project the possible case trajectory as a result of the rise to dominance and continued spread of the Delta variant and taking the vaccination impact into account.

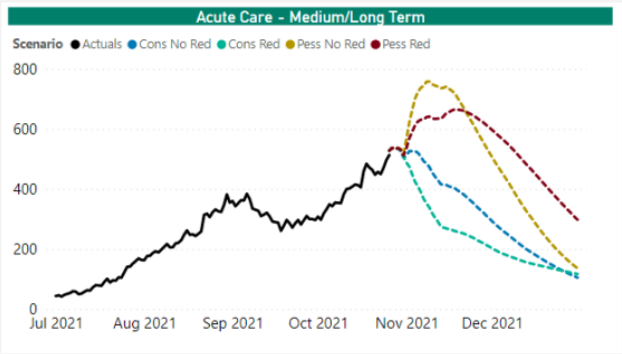
Four scenarios (Conservative No Reduction, Conservative Reduction, Pessimistic No Reduction, and Pessimistic Reduction) are illustrated by IEMAG which show possible COVID-19 daily case growth based on a combination of the adjacent key assumptions:

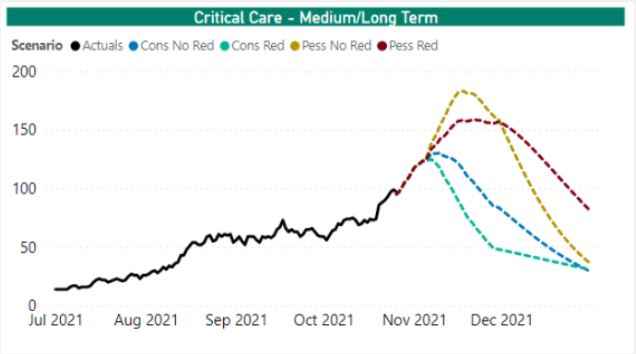
- Delta variant will have an increased transmissibility over both the standard COVID-19 strain and the alpha variant;
- Multiple change points for R number; and
- Population level is lowered by 8.1% to crudely model 50% of the children aged 0-12 years of age being fully immune in the Reduced scenarios.

All scenarios have an upward COVID-19 case trajectory in the medium term, resulting in significant demand across acute and critical care. High level projected long term demand based on the updated model is as follows:

- Critical care: 43-89 beds by the end of Nov 2021 across both Conservative scenarios while 152-164 beds across both Pessimistic scenarios; and
- General acute care: 119-313 beds by the end of Nov 2021 across both Conservative scenarios while 513-615 beds across both Pessimistic scenarios.

Hospital Demand – Medium / Long Term





Cumulative cases

Scenario	Cumulative cases November	Cumulative cases December
Conservative Scenario No Reduction	47,000	14,100
Conservative Scenario Reduction	31,700	21,000
Pessimistic Scenario No Reduction	51,400	8,700
Pessimistic Scenario Reduction	84,100	36,900

Acute care

Scenario	30/11/2021 acute care occupancy	31/12/2021 acute care occupancy
Conservative Scenario No Reduction	303	105
Conservative Scenario Reduction	209	117
Pessimistic Scenario No Reduction	523	136
Pessimistic Scenario Reduction	605	298

Critical care

Scenario	30/11/2021 critical care occupancy	31/12/2021 critical care occupancy
Conservative Scenario No Reduction	84	30
Conservative Scenario Reduction	48	31
Pessimistic Scenario No Reduction	159	37
Pessimistic Scenario Reduction	157	82

Winter 2021/22 Context

Unscheduled Care (USC)

USC Overview

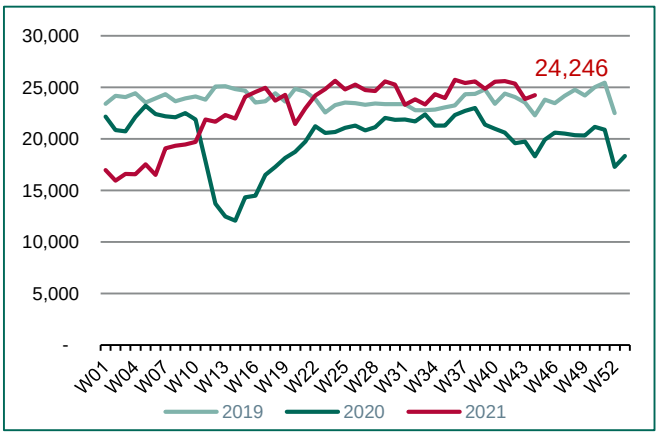
Unscheduled Care demand continues to grow year on year, 24,246 patients attended our EDs last week, this is up 32.4% on the same week last year and up 9% on the same week in 2019.

The greatest challenge to addressing high trolley queues and poor Patient Experience Times (PET) are the delays encountered in accessing acute in-patient beds especially for older people. In order to alleviate ED congestion this plan sets out the requirement to reduce ED attendances and admissions by the delivery of care in the most appropriate clinical level, maximise patient flow from community to hospital and appropriate discharge while maintaining optimal inpatient length of stay and strengthening the existing integrated (hospital & community) approach to patient flow.

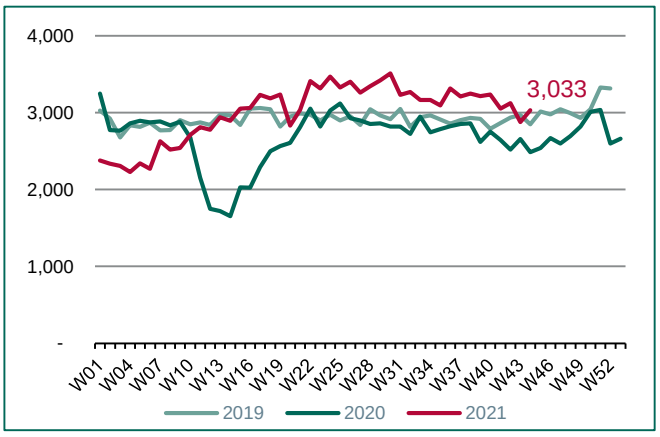
The HSE is experiencing an increased demand for unscheduled care in our acute settings, this demand is both an increase in ambulatory care and delays in accessing care during previous COVID-19 surges. The increased demand in attendances is predominantly in the 16-74 year old cohort.

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

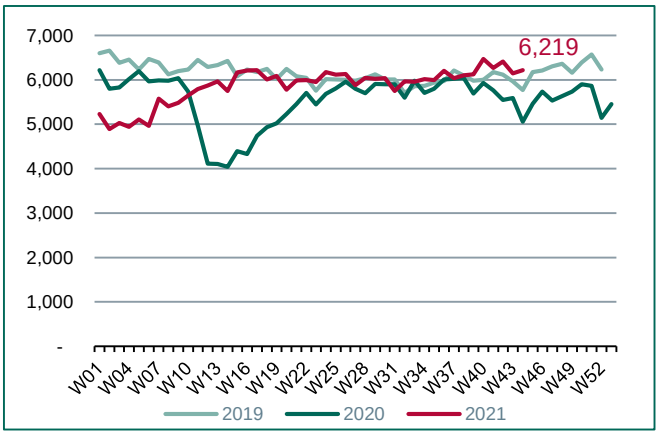
Emergency Department Attendances



Emergency Department Attendances (75+ Years Old)



Emergency Department Admissions



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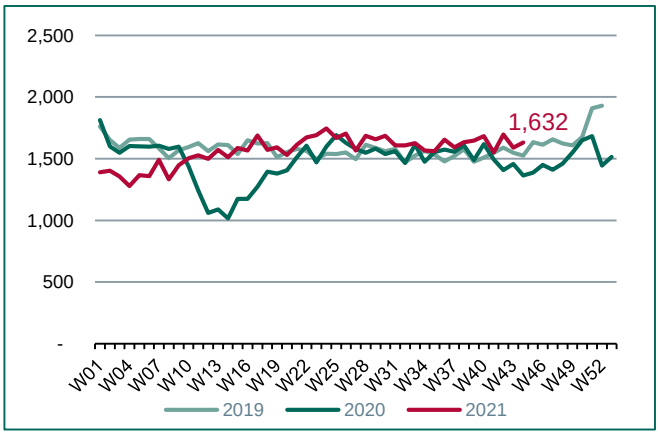


Winter 2021/22 Context

Unscheduled Care (USC)

Within the cohort of challenged sites, there are three discernible groups. The first group are those that are returning zero to very low trolley numbers and sustaining a steady state position performance level.

The second group are those for whom the challenge is of a temporary nature predicated by a temporary mismatch in demand and capacity. Sites predominantly take accelerated actions to address such a mismatch in accordance with the steps outlined in the local site escalation plans.

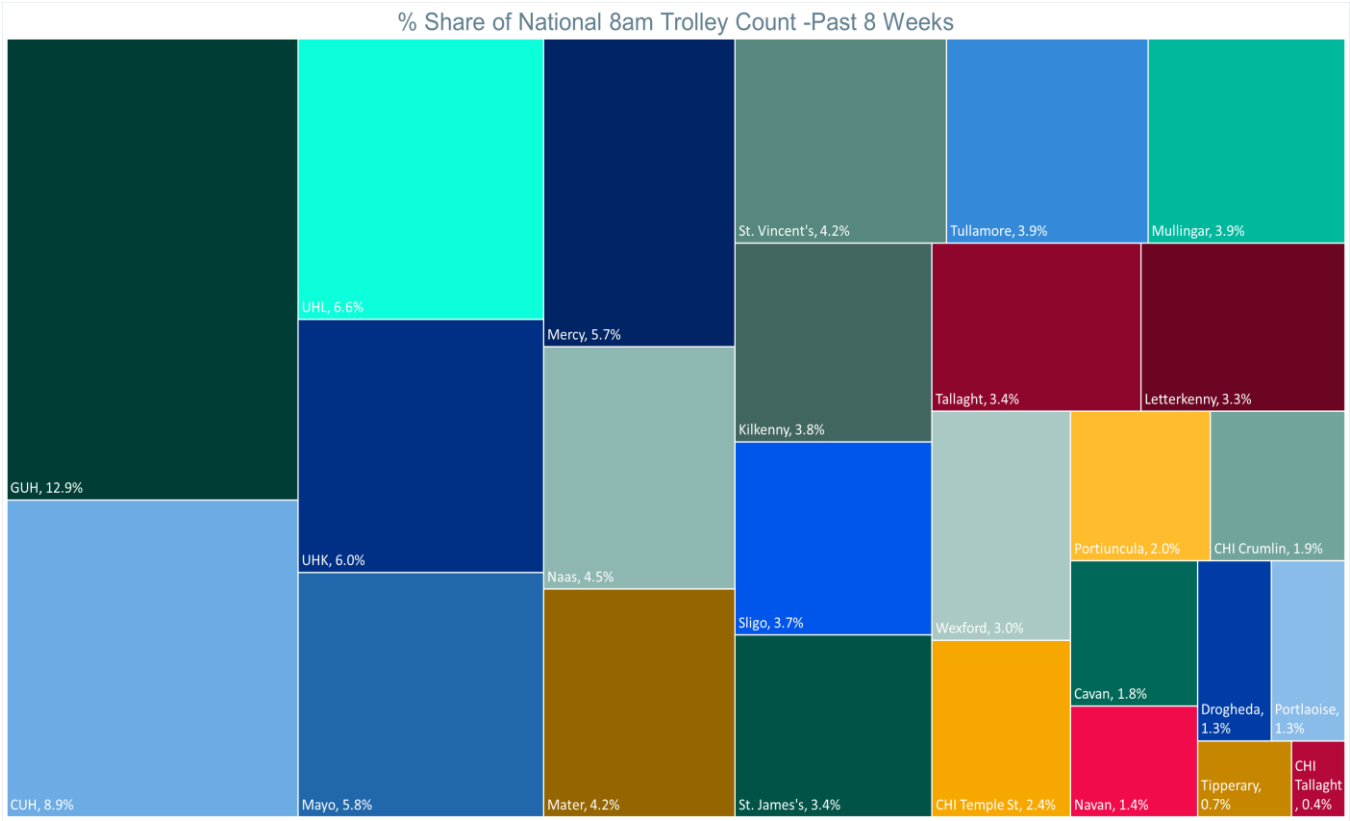
The third cohort of challenged sites relates to those in a prolonged state of escalation where in the main the challenges are more deep rooted and not amenable to a "quick fix". In such cases, sites are often using extraordinary measures to address the increased demand profile. It is unlikely that these sites will improve in the short term as they require a suite of targeted de-escalation measures to re-balance and a review of and attention to the causative factors which gave rise to the continued escalation. This may include some suppression of incoming demand, adding various types of capacity (acute, community, diagnostic) and tightly governing changes to operational systems and processes with strong focused leadership and governance.

As part of the winter plan there will be an enhanced focus on the third cohort of sites. The infographic outlined below presents the percentage share of National 8am trolley count for the period 12/09/21 – 07/11/21.

Specific sites as outlined will remain challenged this winter. The proposed initiatives outlined in this plan are targeted at improving PET and reducing ED congestion. This is not only an acute hospital response, this requires a whole system response.

As part of the Winter Plan 2021/22 there will be an enhanced focus on PET. A specific focus will be on improving 24 hour PET and over 75 PET, by focusing on PET and enhancing compliance with PET targets, this will have a positive impact on the trolley count. The HSE are committed to reporting weekly on PET performance. Furthermore, commitment to the 236 trolley target will be maintained, whilst acknowledging that certain sites as outlined below will remain challenged.

There is no evidence to suggest a direct correlation between delayed transfers of care (DTOC) and trolleys, however, DTOC does impact on the level of surge capacity in use and on average length of stay (AvLOS), particularly those in hospital over 30 days, which does impact on capacity to support access. It is therefore not unreasonable to hypothesise that DTOC can indirectly influence trolleys. Therefore, initiatives implemented as part of the Winter Plan 2021/22 will focus on maintaining the DTOC target of 350.



Winter 2021/22 Context

Governance and Accountability

Governance and Accountability

The HSE's Winter Plan for 2021/22 aims to address the significant combined challenges faced by the health service this winter. The scale of these challenges and the demands that our health system will face requires both a plan and an associated system of governance and accountability. This system will include leadership, governance and operations to reflect the scale of the challenges faced and investments provided. This section of the HSE's Winter Plan sets out the national, area and site level leadership and governance arrangements in place.

To understand health system governance, it is important to recognise the national leadership and governance arrangements as they stand. This includes the roles of:

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 Chief Executive Officer 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.

To provide leadership, governance and oversight, the Chief Operations Officer chairs the Integrated Operational Team Meeting on a weekly basis with defined membership from all relevant services and enabling functions.

Local Perspective

To ensure oversight at a local level, each area has an Integrated Management Team that will provide the system with a strong integrated grip on operations in terms of oversight, management and response. Integrated Management Teams will meet regularly in line with formal terms of reference and focus on key measures to support patient care during the winter months such as supporting appropriate staff rotas and complements of senior decision makers are in place in acute and community settings and drive local communications around out of hours' services and minor injury units.

Winter 2021/22 Context

Governance and Accountability

Monitoring and Reporting

Implementation

Monitoring and reporting of progress of the winter plan will be coordinated and managed by a central Programme Management Office (PMO) who will ensure that programme and project reporting is aligned and integrated and accurately reflects the status of portfolio delivery. The PMO and local implementation teams will utilise the reporting portal, developed for the 2020/21 Winter Pan, to enable the level and frequency of reporting required to support responsive decision-making and robust management practices.

The PMO will report weekly through the Integrated Operations Team on the implementation of initiatives under the plan. These reports will be forwarded to the Department of Health weekly and reviewed as part of the weekly engagement between the Performance Monitoring and Improvement Unit and Department Officials.

Performance

The Performance Monitoring and Improvement Unit (PMIU), part of the Operational Performance and Integration Team, provides monitoring and reporting of performance across unscheduled and scheduled care, 365 days of the year. In addition to resourcing and running the Winter Plan PMO, the PMIU, in collaboration with the Business Information Units for Acute and Community Care, provide focused monitoring and reporting on performance against specific measures pertinent to the specific pressures that are addressed by the Winter Plan. The PMIU, in collaboration with the National Office for Clinical Audit, closely monitors and reports on COVID-19 specific pressures on hospitals and in particular ICU departments. Reports are issued to stakeholders three times daily reflecting COVID-19 hospitalisations, ICU and unscheduled care activity and performance.

Where escalation is required, this is managed initially through engagement by the PMIU with the local site and the relevant National Operations team (i.e. Acute or Community). Where further escalation is required, this is managed through the HSE Performance and Accountability Framework. This Framework is overseen by the National Performance Oversight Group (NPOG) which applies a layered escalation approach to addressing under-performance and ensuring all of the available resources are applied.

Under the Performance and Accountability Framework there is provision for the formal escalation of individual Hospital Groups, CHOs, or other services that are not achieving national performance expectations. Escalation reflects an increased level of concern in relation to performance which requires more intense focus, action and scrutiny in order to bring about improvement.

In the context of the Escalation and Intervention Framework, underperformance also includes performance that:

- Places patients or service users at risk;
- Fails to meet the required standards for that service; and
- Departs from what is considered acceptable practice.

Existing Pressures

2021 has seen an exceptional level of activity in Emergency Departments well before the winter period commences. While further study is under way to identify the underlying causes of the unseasonal levels of attendance, there is some evidence that delayed attendance due to the pandemic and early onset of non-COVID-19 respiratory illnesses in addition to significant levels of COVID-19 infection and subsequent acute illness amongst unvaccinated people are significant contributors to this upsurge in demand for unscheduled care.

There are a number of sites where close observation is in place as a precautionary, pre-escalation measure. These are typically sites that have previously been in escalation and who are experiencing elevated levels of attendance, longer Patient Experience Times and elevated levels of patients awaiting admission on trollies.

Winter 2021/22 Context

Communications

Communications

A complex season ahead calls for continued reliable communications from the HSE.

Our messages over the coming months will focus on what matters to the people in our care and the wider public, our staff, and our partners. Our communications programme will be flexible, evidence-based, and will support and enable the actions and priorities of the HSE and the winter plan.

The HSE will provide guidance and updates about COVID and other respiratory illnesses, how to keep well this winter as we adjust to life beyond the emergency phase of the pandemic. These will include what we need to continue to do – like protective behaviours, and also how to respond when we do feel ill, avoiding work or events, and getting tested as appropriate.

Our communications will also highlight how to get the healthcare you need this winter, with insight-based messaging on urgent care, and choosing the right care across the spectrum from HSE.ie and HSElive, Pharmacy, GP, GPOOH, Injury Units and NAS and EDs. Messages will be tailored to people's location, language, and life stage as needed.

Themes and Topics include:

- COVID – how to protect you and yours, guidance for various settings, protection will cover COVID and other respiratory illnesses;
- COVID vaccines – ongoing programme of information and guidance on vaccine rollout and developments;
- Test and Trace - what to do if you're sick, avoiding work and events to protect others;
- Flu vaccination – campaigns for healthcare teams in local settings, national campaigns for at-risk adults and children 2-17;
- Health services – how they will care for you, signposting, activity updates, crisis response; and
- Keeping Well – self-care for people with common or chronic illnesses, when to get help.

Approach

We will undertake a full programme of communications with both national and local plans.

We will employ all channels based on the message, timing and relevance.

Communications resources will be deployed in an effective, co-ordinated way.

Communications will play a strong supporting role in getting the health service and the public through this complex and challenging season -

here are the six communications elements outlined in the Winter Plan for 2021/2022:

Media Briefings

Regular media briefings, both for Winter and during the pandemic, have proven to be excellent in terms of engaging with the media and the public around key progress and messaging.

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 have should have access to factual, relevant and important information about challenges, performance and initiatives across the health service.

Public Representative Engagement

Continued engagement with local public reps, government, leaders will continue to ensure they are appropriately briefed and to answer the questions and queries of their constituents.

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

Specific and targeted advertising across radio, print and social media on COVID, vaccines, self care, pathways of care and wellbeing.

Winter Priorities 2021/22

Building Capacity

Pathways of Care

Testing and Contract Tracing

Population Health

Vaccinations

Winter Priorities 2021/22

High Level Summary

High Level Summary of Winter 2021/22 Priorities

The table below provides a high level summary of the priority initiatives for winter 2021/22.

Priorities	New Initiatives	Current Initiatives (maintained or enhanced)	Rationale
Building Capacity	• Implement new community based models of care including; respiratory pathways, community response teams and COPD outreach teams; • Capital works to enable flow; • Introduce new roles including: ED phlebotomists, sort and shift triage nurses and CIT co-ordinators; and • Introduce new community based pathways for Older People avoiding transfer to Hospital.	• Continue to fund alternative pathways and acute restart initiatives; • Enhance IP&C measures; • Deliver remaining acute and community beds planned for 2021; • Maintain private community bed capacity; and • Enhance FITT and Home First Teams.	• The response is targeted at optimising and creating capacity at three critical stages in the patient pathway; admission avoidance/alternative pathways, inpatient flow and egress. All initiatives support the Sláintecare vision of 'the right patient in the right place at the right time' and support our aim to build capacity across the health system.
Pathways of Care	• Expand the Pathfinder Frailty model at the most challenged M4 and M3 sites to increase ED avoidance; • Discharge support for people with complex needs – across all care groups; • Access to an additional community based diagnostics for the winter period as required; • Mental Health liaisons will be placed in EDs; and • Additional emergency Placement, Respite and Complex Packages of Care will be provided for people with disabilities.	• Rollout 96 ECC Networks each servicing a population of c.50k; • Continued roll-out of already funded 91 Children's Disability Network Teams (CDNTs); • Provision of 30 Community Specialist Teams that will serve older persons and 30 Community Specialist Teams for chronic disease management; • Deploy Community Paramedics to work in partnership with primary care to increase ED avoidance; and • Stabilise the implementation of Physician led triage of low acuity 999 calls.	• The response is targeted at preventing ED attendances, hospital admissions and facilitating timely hospital discharges. The HSE aims to support individuals and their families/carers to maintain their independence, health and well-being in their communities.

Winter Priorities 2021/22

High Level Summary

High Level Summary of Winter 2021/22 Priorities (cont.)

The table below provides a high level summary of the priority initiatives for winter 2021/22.

Priorities	New Initiatives	Current Initiatives (maintained or enhanced)	Rationale
Testing and Contact Tracing		• Testing and Tracing Surge Strategy (July 2021) is currently activated; • Maintenance of current Testing and Tracing model and standing capacity (25,000 tests per day) to the end of 2021; and • Genomic sequencing to monitor variants of concern.	• The response is focused on delivering timely, efficient, multi-channel access to testing for whom it is clinically indicated. The HSE plans to scale back the model in 2022 with plans to scale up as required.
Population Health		• Community Response Teams (CRTs) to support Long Term Care Residential Facilities (LTCRFs) to prevent and manage outbreaks of COVID-19 and other infections; • Continue with CRTs working with primary care, non governmental organisations (NGOs), social inclusion and public heath; • Continued implementation of the Public Health Pandemic Workforce Plan and Reformed Public Health Model; • Social Inclusion outbreak response support to Public Health; • Capital funding to upgrade equipment and facilities; • Improvement of water, sanitation facilities and hospital infrastructure; and • Procurement of ICT systems, upgrade applications and pay for licensing fees.	• The response is targeted at supporting safe continuity of care and preparing for potential future increases in infectious diseases including COVID-19 while continuing to enhance and reform the Public Health Model.
Vaccinations	• Communication campaign regarding the benefits of COVID-19 vaccination to address concerns of those not yet vaccinated to encourage uptake; and • Identification and targeting of cohorts who have not yet availed of vaccination due to difficulties accessing same or hesitancy.	• Seasonal influenza vaccination campaign; • Continuation of the COVID-19 primary vaccination campaign; • Extended primary vaccination campaign for immunocompromised groups; • COVID-19 booster campaign based on NIAC advice; and • Continue enhanced vaccinations COVID/ Flu on site and mobile clinics.	• The response is to prevent morbidity, mortality and associated disease from influenza and COVID-19 and pressures on the healthcare system. The HSE wishes to maximise vaccination uptake, as much as possible, to protect the public; and • Vaccination uptake in marginalised groups remains low (50-60%) approximately.

Building Capacity

Acute Capacity

Creating Capacity

Our healthcare system will face extreme challenges this winter exacerbated further by a potential increase in COVID presentations and flu presentations, therefore the system response required is complex and multi-faceted.

As part of the Winter Plan 2021/22, the HSE are preparing for the volume of both unscheduled and scheduled activity to return to previous levels. In order to accommodate this demand the HSE will implement new ways of working, open additional capacity and will continue to enhance infection prevention and control measures in our healthcare facilities.

Our response is targeted at optimising and creating capacity at three critical stages in the patient pathway:

Admission Avoidance/ Alternative Pathways

In order to build capacity in the acute setting it is essential that the HSE optimise the use of current admission avoidance models and introduce new models that will positively impact ED attendances. The HSE are committed to maintaining all acute restart and alternative pathways that were introduced as part of winter 2020/21, additional funding is required to support these initiatives. In addition the HSE will introduce the following patient pathways:

- GP Liaison Nurses to manage direct referrals from GP's to ED;
- Geriatric Community Support;
- Enhance and expand FITT models;
- Community Response Teams (nursing and therapies);
- Community respiratory admission avoidance teams;
- COPD outreach teams; and
- A public advice/communication campaign for winter regarding alternative pathways for winter and managing winter viruses.

These proposed initiatives are targeted at preventing ED attendance by optimising alternative more appropriate models of care, subsequently building capacity in the ED setting.

Inpatient Flow

For the foreseeable future, health services will continue to operate and develop pathways to treat both COVID and non-COVID inpatients simultaneously, where vital COVID capacity needs to be available and heightened safety measures need to be rigorously adhered to. There has been a steady increase in demands for both general acute beds and critical care beds since early summer. In response as part of the Winter Plan 2021/22 the HSE will further enhance inpatient capacity to enable patient flow. The HSE will:

- Secure additional private capacity (based on the success of the Safety Net agreement);
- Deliver a further 143 beds by year end 2021 and a further 62 beds by end March 2022 as planned for Winter 2020/21;
- Introduce additional phlebotomy capacity for ED;
- Enhance IP&C measures;
- Invest in capital works to enable flow; and
- Introduce new roles including:
  - Sort and sift pre triages nurses; and
  - ED phlebotomists.

Egress

In line with the Sláintecare vision of ‘the right patient in the right place at the right time’ this winter the HSE will maintain an enhanced focus on Egress and introduce the following initiatives to further enable timely discharge of patients from the acute setting:

- Early supported discharge teams for the elderly;
- Expansion and introduction for ‘Home First’ teams;
- CIT Co-ordinator roles;
- Additional discharge coordinator roles; and
- The introduction of a number of other ‘flow’ specific roles targeted at delivering the Sláintecare vision.

Building Capacity
Community Services

Services for Older People

Services for Older People will continue to deliver and enhance services to support older people to live as independently as possible and receive the best possible care.

Home Care and Reablement

The National Service Plan 2021 provided for 5 million additional Home Support Hours focusing providing additional capacity for Long Term Care Avoidance, Waiting List reduction, Reablement and additional hours.

The allocation of hours will continue to be monitored throughout the course of the winter period and will provide valuable support to the system during the winter pressures.

Community Beds

Ongoing use of community beds will support people during winter with the following options:

- Short-stay care to avoid admission to hospital or step-down from a stay in hospital;
- Respite care; and
- Discharge to Assess.

Intermediate Care capacity in the community was enhanced as part of the 2020/21 Winter Plan. **552** public intermediate care beds will be delivered by Q4. **468** privately contracted intermediate care beds have been delivered year to date. In order to support this capacity during Winter 2021/22 continuing education and training in relation to infection prevent and control measures and support from the COVID-19 Response Teams will be required.

Hospital Discharge Liaison Lead for Older People

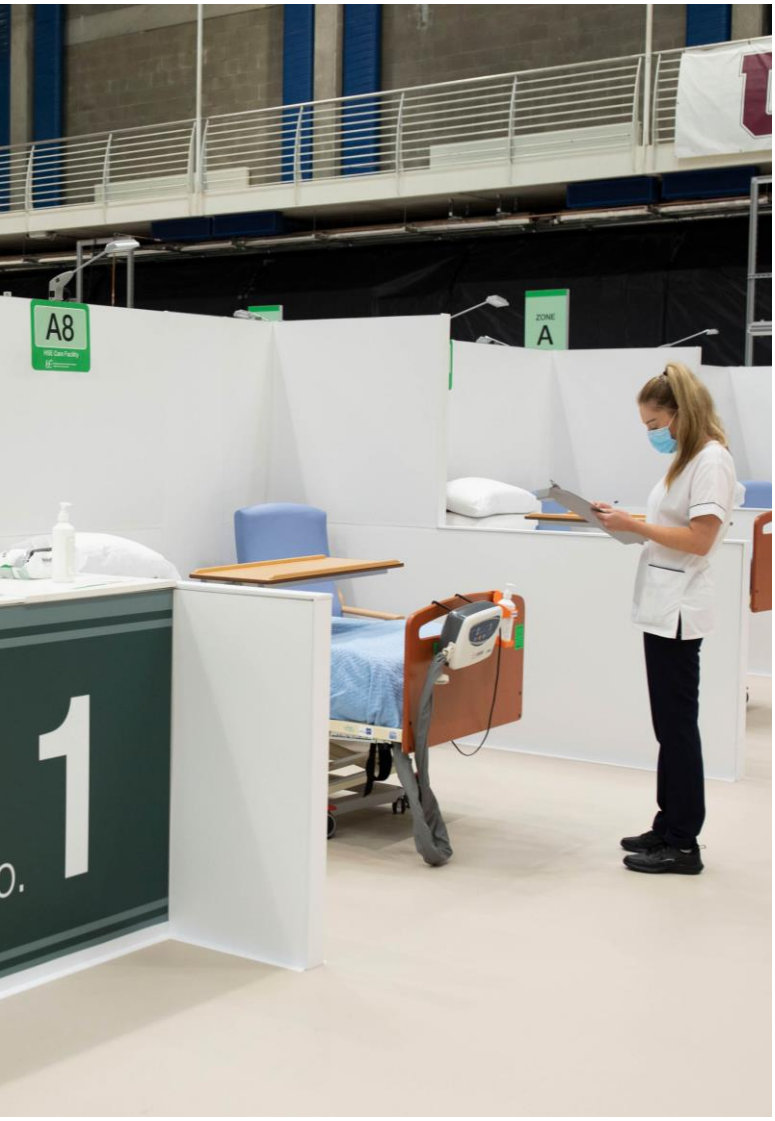
To provide a hospital discharge liaison point of contact for older people in each acute HSE hospital, to be designed by Integrated Management Teams according to local community need and existing service arrangements. The aim of this initiative is to enable egress from the acute setting.

Maximising the use of Community Vaccination Centres (CVCs)

To maximise the use of the CVCs to meet local priority health needs in line with NIAC guidelines. This may include offering school immunisations to maximise uptake and ensure the most efficient use of the skills of the schools vaccination teams in a centralised delivery model. In addition, this approach may relieve the burden of vaccination from GPs to allow them focus on other community needs including seasonal illness or potential further COVID waves.

Pathways of Care

Primary Care Services



Enhanced Community Care Programme

Community health services will be delivered through 96 Community Healthcare Networks (CHNs c.50K). These CHNs will provide the foundation and organisational structure through which integrated care is provided locally at the appropriate level of complexity. GPs, Health and Social Care Professionals (HSCPs) & Nursing leadership will be empowered at a local level to drive integrated care delivery and to support egress in the community. In addition, 30 community specialist teams for older people and 30 community specialist teams for chronic disease management are being established, each supporting three CHNs, c.150K population. This additional community capacity delivered through CHN's and Community Specialist Teams, is essential to increasing capacity within our primary and community care settings. The ECC Programme is in development. The ECC programme has the ability to provide transformative care for those in the community in the long term. It is important to note that the full benefits of this programme will not be realised in 2021/2022, however strong progress will made to operationalise these networks.

CHNs and Community Specialist Teams will work in an integrated way with NAS and acute services to deliver end to end care, keep people out of hospital, enable a 'home first' approach, and ensure people are discharged from hospital without delay. When fully implemented, the CHN's and Community Specialist Teams are aiming to reduce over 75's ED admissions by 20% and reduce acute bed days in hospital services by 10%. Elements of the programme to be delivered during winter 2021/22, which may mitigate the winter challenges facing the HSE, include:

- Implementation of end to end care pathways for older people linked to the Community Specialist Teams and Frailty at the Front Door Teams in our acute hospital services;
- Co-ordination of voluntary and community supports across each CHN leveraging in a structured way the informal supports and volunteerism within local communities; and
- Expansion of Community Intervention Teams/OPAT services nationwide.

Additional primary care initiatives for Winter 2021/22

In order to deliver the Sláintecare vision of the 'right patient, in the right place, at the right time', and to build capacity in the community, in addition to existing services the following services will be implemented:

- Required aids and appliances will be provided in order to support people and promote their independence to avoid an admission to hospital and discharge home in a safe and timely way after a hospital stay. The aids, adaptations and associated similar supports will be determined according to local CHO community need and local service arrangements.

Pathways of Care
Primary Care Services

Palliative Care

Bed Capacity

The commissioning in 2021/2022 of three new Specialist Palliative Care Inpatient Units (IPUs/Hospices) in Wicklow, Mayo and Waterford along with additional beds in Kildare will increase the national inpatient bed capacity in the community by almost 25% (from 221 to 276 beds).

Integrated Working and Community Outreach

The IPU is the hub of integrated palliative care services in an area and supports symptom management and end-of-life care for patients who wish to be cared for and/or to die at home.

Nursing Support at Night

A service providing night nursing support for dying patients and their families is part-funded by the HSE in partnership with two voluntary agencies. These community based services reduce acute hospital admissions and facilitate earlier discharge from hospital. From October to February inclusive (2020/21) specialist palliative care services provided end-of-life care to 3,123 individuals in the community.

End of Life and Bereavement Care

End of Life Care Coordinators and Committees across hospitals organise and promote end of life and bereavement care through our Hospice Friendly Hospital Programme. These Coordinators and Committees will be supported in the Winter Plan by:

- End of Life Winter Plan Implementation Lead to enable good practice across all hospitals;
- End of Life Hospital Group Committees to share learning and experience across hospitals within the group;
- Further development of the HSE Care of the Deceased Guidance;
- Development of the National Bereavement Support Line for patients, families and staff (operated by the Irish Hospice Foundation);
- Further expansion of staff training on end of life issues through the Final Journeys Programme;
- Enhancement of supporting information available for patients and bereaved families;
- Development of the HSE website to provide better signposting to services for bereaved families;
- Review and enhancement of bereavement care services across acute hospitals; and
- Further improvements in facilitating family visiting at end of life.

Pathways of Care
General Practice

General practice

Building on the experience of the pandemic, significant additional supports and associated resources were provided to General Practice in recognition of the impact of the pandemic on their service model and the overall disruption to services. Specific initiatives were implemented last winter taking account of the heightened impact of the pandemic at the time. While it is recognised that GPs played a key role in the successful delivery of the vaccination programme, it is important that some of the most beneficial reforms and learning from the COVID-19 experience are maintained. In this context it is envisaged that a more targeted approach will be required this year with a particular focus on how the surge in capacity over the winter period will bring pressure on single handed practices. Such practices may be impacted by illness or excess demand over the ability to deliver services which in turn could potentially impact patients, acute hospitals, out of hours services and local practices. A range of appropriate measures will be required to ensure the continued provision of local GP and OOH supports.

GP Access to Diagnostics

The aim is to continue the programme of expansion of GP access to diagnostics, which proved very successful last winter and through 2021 to date. It is well established that limited access to diagnostics, such as X-rays, ultrasound, MRI, CT, ECHO & spirometry, results in increased referrals of patients into hospital EDs and outpatients to access diagnostics. Provision of timely direct access to diagnostics to GPs can enable integrated care delivery, reduce ED attendances and facilitate hospital avoidance particularly for the over 75 age group. It is proposed to continue the existing programme for provision of community diagnostics to general practice and will expand the volume available during the winter period as required.

A range of appropriate measures will be provided to ensure the continued provision of local GP supports.

Pathways of Care

Mental Health & Disability Services

Mental Health Services

Mental Health services will continue to deliver and enhance services to support local people to receive the best possible care in their own homes and in local community services.

Acute Mental Health Beds

In addition to existing services, all possible solutions will be explored and implemented to support additional acute mental health bed capacity and to support people currently in acute beds to move onto community-based solutions to meet their needs. This will involve working in partnership with colleagues across the sector to ensure that as much acute bed capacity is available as possible in the run up to and during winter.

Additional support for Winter 2021/22

Additional supports will be in place for winter 2021/22 including online supports, mental health liaisons in EDs and transitional care facilities. Further details are outlined below:

- A number of online supports are in place and are being further developed informed by learning during the pandemic. This includes an Open Social Platform and online support group, being launched on World Mental Health Day on the 10th October. The use of SilverCloud for online sessions continues with an ongoing project for online CBT to increase access to 1000 licences across the breadth of the system including primary care, GPs, voluntary organisations and CMHTs. In addition there is an ongoing Project of Ewell online via SilverCloud for 13-17 year olds and online CBT for people aged over 18 years. Working with NGO partner GROW, the HSE will increase capacity in the delivery of online support groups to ensure that service users are receiving additional community support (online).
- Support will be provided to people who present at ED with mental health difficulties to assess their needs and determine the best pathway of care. This will be modelled in EDs by considering peak demand times and local community needs including target age groups, for example Childhood and Adolescent Mental Health Services (CAMHS).
- Support will be provided for people with mental health difficulties with transitional care or admission avoidance to access step up or step down beds, designed according to local community need, existing local service arrangements and local Integrated Winter Team priorities.
- Further additional supports will be introduced as part of the implementation of the 2021 Psychosocial Framework to meet lower levels of mental health need. This need is arising in the context of increased anxiety in the population associated with COVID-19 and the re-opening of society. These supports will be driven by psychosocial leads and will target priority groups in the population with a view to alleviating pressure on frontline services.

Support for Eating Disorders

There will be investment in the development of early intervention for eating disorders in the form of guided online support. This will be suitable for those presenting with binge eating disorder as well as restrictive eating disorders and is tailored for users from 12 years of age. It will be accessible across services including primary care, GPs, voluntary organisations, CAMHS and general adult Community Mental Health Teams (CMHTs). Support will also be provided to staff in CAMHS and CMHTs in the form of training and up skilling in delivering early intervention services for eating disorders.

Disability Services

Disability services will continue to deliver and enhance services to support local people to receive the best possible care in their own homes and in local community services.

Day Services

The capacity and reach of day services for people with disabilities will be maximised in line with safe operating guidelines. Day services will help to provide a range of health and social supports to people with disabilities and their families during this period. Robust risk assessment and business continuity plans are in place in order to deliver support to as many people as possible in the event of further waves of COVID in the community.

Discharge from Hospital

During winter high levels of management oversight will be ensured to support people with disabilities who are ready to return home after a hospital stay. This will involved working collaboratively with colleagues in acute hospitals and older persons services to utilise the multi-disciplinary hospital discharge pathways to support timely discharge. Engagement with partners, across the disability sector, including the Child and Family Agency, will take place through regular operational engagement to ensure the whole system is focused on individuals who are ready to return home.

Emergency Placement, Respite and Complex Packages of Care

In addition to existing services for adults and children, and based on assessed clinical/social care need, people with disabilities will be provided access to emergency placements, respite or packages of care. This will be designed and utilised according to local community need and existing service arrangements and opportunities.

Pathways of Care
Social Inclusion

Social Inclusion Services

Social Inclusion services will continue to deliver and enhance services to support local people to receive the best possible services to meet their needs.

Homeless Population Service Provision

During Quarter 4 of 2021/22, a number of initiatives by the COVID-19 Homeless Coordination Group continue to provide high quality, accessible and safe care to meet the needs of the homeless population. Additional supports have resulted in outstanding results regarding low COVID-19 infection and death rate among the homeless population as well as higher numbers engaging in harm reduction programs such as Opiate Substitution Therapy.

These services will be continued from the once-off budget for Q4 2021 into Q1 2022. These initiatives include:

- *Temporary Emergency Accommodation Supports* (e.g. additional social workers, nurses, case managers, etc.).
- *Service provision enhancements* (e.g. temporary emergency accommodation provision to regional based urban centres).
- *Expanding GP clinics and increasing GP capacity* To enhance health care supports offered.
- *Continuation of COVID-19 Housing Initiatives* Developed as a result of the pandemic.
- *Homeless Hospital Discharge Programme* Coordinated response toward COVID-19 including Homeless COVID-19 response coordination team, rapid detection of COVID-19 clusters and Tracking, Tracing, Isolating Transport Team.
- *Case Management* Continuation of the enhancement of integrated care service/s to support further coordination and continuity of care.
- *COVID-19 measures* Maintain COVID-19 public health measures for people who are homeless and consolidate improvements in health care delivery.
- *Mental Health Support* Continue to increase access and individual health care plans for all homeless individuals that need one and improve access to mental health services.
- *Chronic Health Needs* Strengthen integrated care pathways for people who are homeless with chronic health needs based on an inclusion health model, to achieve better health outcomes and to reduce the incidence of premature death.
- *Drug or Alcohol Addiction* Expand the case management approach for homeless people living with drug or alcohol addiction and enhance treatment options.
- *Housing First* Target 1,200 new Housing First tenancies from 2022 to 2026 in line with Housing for All housing policy.

Pathways of Care

National Ambulance Service

National Ambulance Service

To respond to rising demand for access to emergency services, including the predicted implications of winter, NAS is focusing its preparedness activities on measures intended to reduce demand on the wider acute system, reduce the need for conveyance and maximse the capacity available to respond to 999 emergencies.

These measures include:

1. In consultation with the Pre-Hospital Emergency Care Council (PHECC) and Trade Union partners, temporarily implement a revised minimum crewing model to leverage existing emergency ambulance and intermediate care capacity (Q4 2021);
2. Engage with Hospital Groups to achieve a reduction in the impact of Arrival to Handover Delays on emergency ambulance capacity (Q4 2021);
3. Deploy six Community Paramedics due to qualify in September 2021 to work in partnership with primary care to increase ED avoidance (Q4 2021);
4. Stabilise the implementation of Physician led triage of low acuity 999 calls in the NAS Clinical Hub and where possible, increase nursing staff (Q4 2021);
5. Deploy Paramedic Interns due to qualify in Q4 2021 to increase emergency ambulance capacity in the core winter months (Q4 2021);
6. Complete the deployment of the Alternative Care Pathway in Cork and Kerry to increase ED avoidance (Q4 2021);
7. Maximising staff availability through supportive attendance management and vaccination (Q4 2021);
8. Eight additional operational managers in position to support Hospital Groups, CHOs in the South and West in relation to winter pressures (Q4 2021).

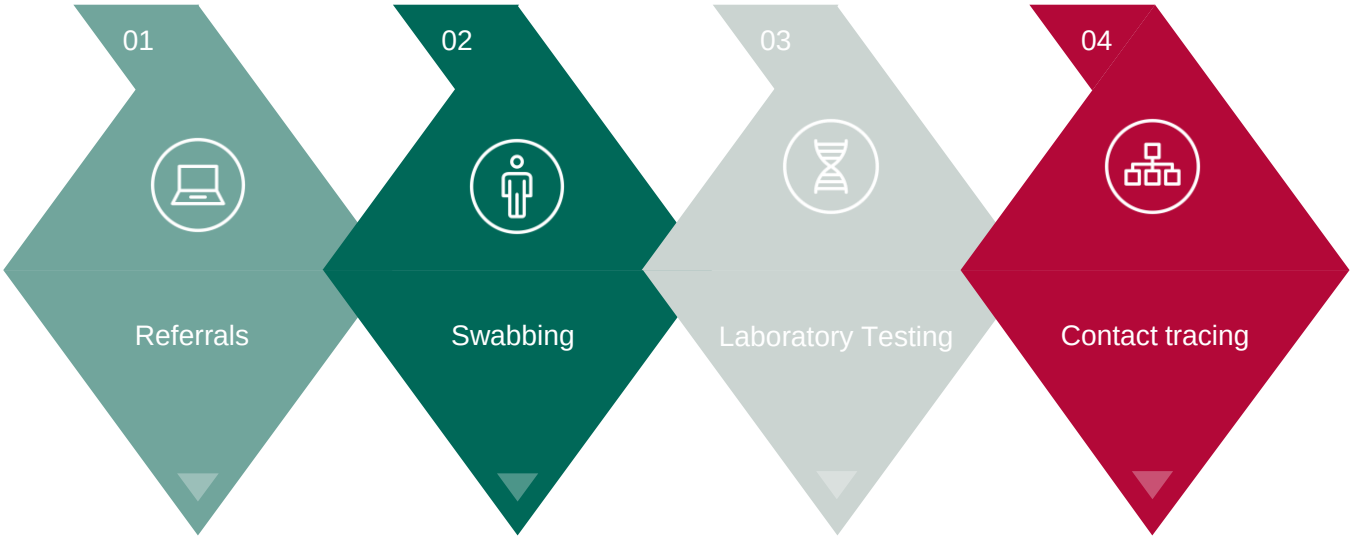
In Q1 2022 NAS will implement the following:

1. Subject to resourcing, scale up and expand the Pathfinder Frailty model at the most challenged M4 and M3 sites to increase ED avoidance- Beaumont, Tallaght Waterford, Cork, Limerick, & Galway (Model 4, 44 WTE). Model 3's Letterkenny, Kilkenny and UHK.(Model 3, 22 WTE). Delivery timeline Q1 2022;
2. Expand the Hear and Treat model focused on managing demand at the point of contact (8 WTEs);
3. Introduce dedicated leadership role to manage COVID19 and Winter Plan response (1 WTE).

Testing and Contact Tracing

Testing and Contact Tracing

The Testing and Tracing function comprises of four core pillars:



The current Testing and Tracing model is focused on delivering timely and efficient, multi-channel access to testing for whom it is indicated, in convenient locations across the country. National standing capacity for Testing and Tracing has been significantly increased over the past year. Standing capacity for swabbing is 25,000 across community and acute, while standing laboratory capacity is 25,000 tests per day. Surge capacity is in place to provide additional capacity across each of these pillars.

The focus of the Testing and Tracing function over the winter period is to manage the continued surge in demand resulting from the Delta variant. The Testing and Tracing Surge Strategy (July 2021) is currently activated, with a number of escalation initiatives in place to increase capacity and control demand across the four pillars.

Over the winter period, high swabbing demand is anticipated as influenza like illnesses (ILIs) become more prevalent and individuals with ILI symptoms present for COVID-19 testing. Combined with increased social mixing due to further easing of restrictions and the return of schools and workplaces, the demand for Testing and Tracing services is expected to be significant.

Therefore, the current Testing and Tracing model and standing and surge capacity will be maintained throughout the winter period. In certain modelling scenarios, surge capacity is projected to be exceeded and, as such, measures such as prioritisation of testing may be required to control demand during this period.

Into 2022, a reconfiguration of the Testing and Tracing operating model will be required as COVID-19 transitions to its endemic phase, in line with the disease indicators and aligned to Public Health intelligence and strategy. Testing will transition away from widespread testing for active cases with minimal or no symptoms towards targeted testing, led by clinical and public health needs. This will help to ensure that the benefit of testing and tracing is realised to provide maximum benefit for the overall health and wellbeing of the population while minimising disruption to the social and economic activities of the country.

Key to the reconfiguration of Test and Trace will be ensuring that:

1. A phased approach is taken to scaling down the pandemic operating model in line with disease indicators and modelling predictions;
2. Public communication regarding updated indications for testing and how to access it needs to remain clear and effective;
3. Contingency planning to enable an operating model for Test and Trace should be developed and form part of HSE emergency preparedness plans.

Population Health

Community Response Teams

In response to the COVID-19 pandemic, COVID-19 Response Teams (CRTs) were established by Local Integrated Working Teams to provide additional support to any Long Term Residential Care Facility (LTRCF) inclusive of older people, intellectual disability and mental health, public or private during this time. The CRTs were a vital component to the management of outbreaks within LTRCFs by working with centres to upskill staff in IPC guidance implementation, PPE provision, public health advice, provision of staff and support with governance. The CRTs, as recommended by the COVID-19 Oireachtas Committee and others, is an imperative CHO support structure. The HSE is required to continue with this support to LTRCFs in preparing them to prevent and manage future outbreaks of COVID-19 and other infections.

Infection Prevention and Control (IPC)

This initiative addresses deficits in IPC within the HSE in both Acute Hospitals and Community Services in order to support the safe continuity of care and prepare for potential future increases in infectious diseases including COVID-19. Progress has been made on addressing these deficits. This includes the establishment of an overarching governance structure to provide oversight for all issues relating to COVID-19 infection prevention and control. This governance structure is aligned to the pre-existing HSE Antimicrobial Resistance and Infection Control (AMRIC) Oversight Group and Implementation Team. The HSE has also been working with the Hospital Groups to implement the NPHET mandated measures across a number of different action areas, in particular governance, risk management, outbreak management, staff symptom declaration, staff segregation and requirements. The proposed investments in this initiative directly support:

- Acute Hospital and Community Services;
- National Support; and
- Occupational Health.

The acute hospital services and community services initiatives will have wide-ranging impacts including:

- All consultant posts will be hospital based but provide 50:50 support to acute and community services;
- Capital funding will be utilised primarily to upgrade equipment and facilities;
- Improvement of water and sanitation facilities and hospital infrastructure to support a clean environment and good hygiene practices including hand hygiene;
- Funding to procure necessary ICT systems, upgrade applications and pay for licensing fees; and
- Education and training supports for IPC nurses and link nurses.

Workforce Planning

It Is vital that the pandemic workforce plan is implemented without delay and the Public Health response is reviewed alongside the capacity to deliver it.

The past year has highlighted the global threat to population health posed by novel infectious agents and the critical importance of a public health workforce sufficient to provide a robust, resilient and responsive health protection response to those threats. Public Health has been at the forefront of our COVID-19 pandemic response, demonstrating considerable leadership, commitment, and professionalism in protecting our communities.

In 2020 permanent resources within Public Health were determined to be insufficient at all levels to respond to the challenges posed by COVID-19 in 2020 and beyond. To help protect our communities and strengthen Departments of Public Health (DPHs), the HSE developed a Public Health Pandemic Workforce Plan to deliver 254 new WTE permanent resources. To date, a significant volume of permanent and temporary resources has been provided to support core teams and surge teams nationally. The core team requirements are in place in each regional department, with additional surge capacity in all DPHs. To complete the recruitment of the remaining permanent multi-disciplinary team resources over 60 campaigns are currently live.

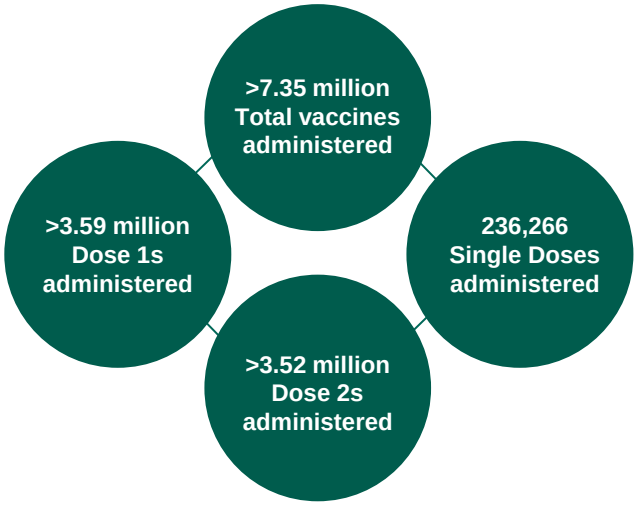
As Ireland emerges from the current set of protective measures and seeks to prevent future escalation in cases, a fast, dynamic, and agile, integrated and intelligence-led population health response, organised at a local level, will be critical to preventing a further resurgence in disease in the medium and long-term. Therefore, the HSE are now implementing an enhanced service delivery model which radically changes the governance and operating structure within Public Health, introducing a more fit-for-purpose National and Regional management structure across the four pillars of Public Health: (1) Health Protection (2) Health and Wellness (3) Health services improvement and (4) Health intelligence. This will allow the implementation of a consultant led ‘hub-and-spoke’ structure as envisaged by the Crowe Horwath Report. Implementation of the new model is being progressed on a phased basis and includes the establishment of the grade of Consultant in Public Health Medicine to provide the strategic leadership for this reformed Public Health Model. 84 Consultants in Public Health Medicine will be recruited by the end of December 2023, with 34 priority posts in place by the end of June 2022. The Phase 1 priority posts will be in the Health Protection pillar and will be allocated to the 6 new areas based on a data driven analysis of population need for each area. The reformed Public Health Model will help to ensure that as Ireland emerges from the pandemic, the HSE will have a significantly enhanced and resourced Public Health service, aligned to International best practice.

Vaccination

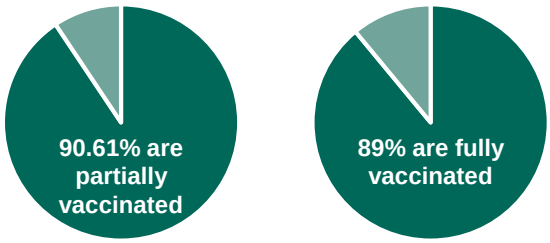
Vaccinations

COVID-19

Since the rollout of the vaccination programme began on December 29th 2020 significant achievements have been made by the HSE. Ireland has one of the highest vaccine uptake rates in the EU. As of 11th November 2021:



As of 11th November 2021, of the eligible population (12+ years of age):



In week 44 (31 October to 06 November 2021) 17,609 vaccinations were administered.

While Ireland has one of the highest vaccination rates in Europe, continued efforts are required to encourage vaccination uptake in the unvaccinated cohort. This has the potential to reduce hospitalisation and ICU admissions significantly. The HSE is focused on communicating with the public regarding the benefits of COVID-19 vaccination and to address any potential concerns that those who have not yet been vaccinated may have. The HSE are now moving into the final phase of the COVID-19 primary vaccination programme and are completing the vaccination of 12 to 15 year olds and planning for extended primary vaccination of the immunocompromised. Based on the current demand for vaccines, the HSE expects to have substantially completed the initial vaccination programme by late September/early October.

In order to ensure ongoing access to vaccination for eligible population cohorts, a significant number of the vaccination centres will remain operational. Approximately 80% of the infrastructural capacity of the original vaccination campaign will be maintained until 31st December 2021. The requirement for vaccination centres will be assessed on an on-going basis and will be informed by any requirements in relation to the booster programme. In addition, discussions are also ongoing with GPs and Pharmacies in relation to their ongoing role in the vaccination programme.

The COVID-19 booster campaign has commenced and those advised to avail of a booster dose are:

- Individuals 60 years or older, or
- A frontline healthcare worker.

Vaccination

HSE Flu Vaccinations

Influenza

The seasonal flu causes significant morbidity and mortality in Ireland; with the potential to have a devastating impact on the health system. In particular, the flu has a significant impact on vulnerable populations such as older adults, those with certain underlying health conditions and pregnant women. To protect the health system, reduce transmission to high-risk groups and to protect themselves additional groups including healthcare workers (HCWs) and children are to be vaccinated. The immunisation guidelines are provided by the National Immunisation Advisory Committee, with policy being decided by the Department of Health and the vaccination programme being implemented by the HSE. Flu vaccines are the best protection available against flu. The Seasonal Influenza Vaccination Programme has multiple components including vaccine procurement and delivery, vaccine administration and flu vaccination promotion.

Injectable flu vaccines for adults

The adult vaccination programme will be delivered by General Practices (GPs), retail pharmacies, Community Healthcare Organisations (CHOs) and Hospital Groups (HGs). Two different adult vaccines will be available for the coming season, the QIV vaccine (Sanofi Pasteur) for those in risk groups and healthcare workers aged under 65 years of age and Fluad Tetra (Seqirus) for those aged 65 years and over.

Additional promotion will be required to explain the new Fluad Tetra vaccine for older people. It is also considered likely that there may be a worse influenza disease season this year due to increased travel and waning immunity due to the lack of circulating influenza in 2020-21. It is unknown whether people will want to take up the influenza vaccine this year compared to the high demand last season. Promotion will be required to encourage vaccination of those in risk groups and those aged over 65 years. Furthermore, it is important that the flu vaccine coverage is high to reduce the incidence of severe flu which may overwhelm the HSE particularly if there is a resurgence in COVID-19 cases.

It is also unknown when boosters of COVID-19 vaccine will be required. The HSE will keep this item under review and will alter plans accordingly if co-administration of COVID-19 boosters and flu vaccine becomes a requirement.

Nasal spray flu vaccine for children

The Fluenz Tetra nasal spray vaccine (AstraZeneca AB) for children was introduced in Ireland for the first-time last season, with the vaccine being available in GP's and pharmacies for those aged 2-12 years old in the first instance, which was extended to those aged 2-17 years later in the season. The uptake was approximately 30% in children aged 2-12 and under 5% for young people aged 13-17 years. The HSE therefore plans to offer the nasal spray flu vaccine to 2-17 year olds through GP's and pharmacies from the start of the season, which should allow for a maximum uptake of 55% if all vaccine is utilised. This uptake would be in line with that obtained in the UK.

In addition, the HSE plans to pilot the nasal spray flu vaccine in primary schools this year through CHOs with a plan to extend further next season if successful.

Vaccine delivery and administration

Vaccines will be delivered from the distributor to various delivery sites that administer the vaccines. This includes GPs, retail pharmacies and hospitals. Additional capacity is required for the 2021/22 season, to expand the delivery to additional sites including direct delivery to several long-term care facilities (building upon the infrastructure put in place in these locations for vaccine storage and administration for COVID-19 vaccines). This will ensure long term care facilities which are at high risk for outbreaks of flu are prioritised for the flu vaccine.

It is assumed that the programme administration will be the same as in previous years, with vaccines for older people and those in risk groups administered by GP's and pharmacies. HCWs will mainly be vaccinated through their employing organisation (CHOs and HGs), but can also attend GP's and pharmacies.

Workforce Planning

Workforce planning

A critical dependency for the Health Service to deliver on the outstanding planned activities for winter 2020/21 and for future initiatives proposed for 2021/22 is the availability of health workforce supply.

Year on year the Health Service has demonstrated capacity to deliver on average an additional 3,500 WTE whilst also maintaining existing employment levels notwithstanding an underlying average of 6% staff turnover rate. This, on average requires a minimum of 8,000 WTE simply to manage turnover at this rate.

16,000 WTE

Under NSP 2021 alone, an additional **16,000+ WTE** was approved, beyond December 2019 reported employment levels, for a comprehensive range of new initiatives. This however **excluded** any additional workforce requirements to manage a national vaccination rollout, a criminal cyber attack, and a further COVID-19 surge beyond level 3 measures, all of which came to fruition in this period with a required resourcing response. Consequently, in the context of the planned recruitment for the NSP initiatives, the health service has undertaken a review of its planned recruitment target for 2021, with a revised reduced projection to year end, taking account of the impact of the above factors.

10,716 WTE

In our combined response to resourcing the new initiatives, a national vaccination rollout, our continued response to COVID-19, including a 3rd surge, alongside the criminal cyber attack, our health employment levels have grown by **10,716 WTE** (+6,357 WTE in 2020; +4,359 WTE year to date 2021), alongside an additional 3,200 staff recruited through external partners for vaccination and contact tracing. This is in addition to the average turnover rate of a minimum 6%. The sustainability of this growth, and ability to redirect this growth is significantly complex in the context of its potential for future winter planning.

The sustainability of the current growth levels, alongside the ability to redirect this growth is significantly complex in the context of its potential for future winter planning. The resourcing for the vaccination programme is a key example of the sustainability factor of our workforce coupled with demonstrating the challenge of cross-programme/initiative distribution for reasons set out below.

Vaccination programme demands

The staffing requirements required to support the vaccination programme will roll forward into winter 2021/22, however the following needs to be considered:

- This workforce in the main, is a blend of HSE employed staff that have increased their hours, or are undertaking additional hours for this programme, alongside retired staff, and staff from other sectors outside of the public health system;
- The programme type is one which lends itself to being attractive, as it is a planned programme delivery in a structured/ predictable environment in the context of intensity and complexity;
- The likelihood of those staff currently delivering on the vaccination programme, moving to winter initiatives is less likely; and
- Winter Planning initiatives, for example, include additional in-patient bed capacity, with often complex medical/ surgical cohorts that are unpredictable and require a greater depth and suite of skills and competencies, coupled with the likelihood of working in a significantly more pressurised/demanding healthcare environment.

Winter 2021/22

Undoubtedly the factors related to an unpredictable environmental context both nationally and internationally, its impact on labour market forces and the broader complexities/ practicalities of workforce deployment present multifaceted resourcing challenges.

These are taking place in a context whereby we will be focusing on the delivery of current initiatives that continue to be implemented as part of the National Service Plan (NSP) which will form as part of this Winter 2021/22 plan; and proposed new initiatives that can address the challenges outlined and are deemed as having the potential to positively influence the current context. The scale of this in resourcing terms, cannot be underestimated or understated.

Consequently, the risks to delivery are substantial, notwithstanding unprecedented deployment of resourcing strategies, and for which will in all likelihood demand a fine balance to be struck at key intervals, to prioritise both available and new workforce supply to meet the demands of both. Continuous review, re-balancing/refresh and re-profiling are all likely requirements under this plan, due to the current availability/stability of both domestic and international supply.

Appendices

Appendix 1

Additional Winter 2021/22 Context

Appendix 1

Additional Winter 2021/22 Context

Projected Service Implications of COVID-19 in the Acute Hospital Setting

At present it is anticipated that Ireland will progress toward a return to normal in terms of general social and economic terms over the coming months. The consensus of expert opinion is increasingly that elimination of the virus is unlikely to be achieved. This means that the resolution of the public health emergency will be based on mitigation of harm in the context of continuing circulation of the virus. The key driver of the harm reduction for the general public is the development of a substantial degree of acquired immunity in the population as a result of the vaccination programme and recovery from infection. The continued circulation of the virus however means that there will be an ongoing risk for some time to come for high risk sections of the population who do not benefit or benefit only partially from acquired immunity. These sections of the population are generally highly dependent on HSE services. This means that the HSE needs to anticipate that circulation of the virus will continue to have implications on the demand for and delivery of health and social services long after wider society has largely reverted to pre-pandemic norms.

Demand for COVID-19

It is likely that there will be continuing demand for care, including acute hospital care, related to SARS-CoV-2 infection in 2022 primarily from those sections of the population who decline vaccination, those who do not benefit from vaccination to the same degree as others because they have poor response and those in whom the benefit of vaccination may decline over time.

In the most optimistic scenario extended primary vaccination courses and potentially booster doses (subject to NIAC recommendation) may reduce this impact but will not eliminate it. However, while hospitalisation for COVID-19 may decline from current levels, it remains possible that hospitalisation could continue to range from 5,000 to 10,000 beds per month for the foreseeable future and approximately 10% of these day being ICU days. There will continue to be significant additional costs associated with these bed days, ongoing need for PPE and drug costs if if new agents are licensed for therapeutics or prophylaxis.

Implications for Delivery of General Hospital Care of Managing the risk of Healthcare Associated COVID-19

Many of those who require hospital services are likely to be disproportionately at risk of severe disease from COVID-19 even if the general population have a high degree of protection from severe disease because of vaccination and natural infection. This means that general hospital care for non-COVID-19 related conditions will need to continue to be delivered in ways that manage the risk of hospital acquired COVID-19 for these high risk patients. This means that for some time the following measures are likely to be required.

It is very difficult to determine at this point a timetable for stepping down or eliminating some of the following and some will be required indefinitely because they are needed not just for control of spread of SARS-CoV-2 but also for control of other hospital acquired infection risks.

Reduced Bed Numbers

The minimum space of 1 metre between bed spaces, trolleys and treatment chairs (side to side and end to end) will be required indefinitely. Where bed numbers were reduced in hospitals rooms to achieve this minimum during the pandemic this should be considered as a non-reversible measure. This will impact on costs per bed-day as a reduction in bed numbers on a ward of 5% to 10% to meet this requirement does not support a reduction in staff numbers on that ward.

Streaming to COVID and non-COVID stream

For the immediate future there will be a continuing requirement to stream non-scheduled patients on admission into those with suspected or confirmed COVID-19 and those in whom COVID-19 is not suspected. This results in increased costs related to the need to support the operation of partially or completely discrete teams on a 24-7 basis to minimise movement of staff between COVID-19 and non-COVID-19 work streams. The risk associated with staff movement between COVID-19 and non COVID-19 streams is much less in the context of vaccination of most staff and patients. However, vaccinated staff can get infected and can infect others in some circumstances therefore a general move to a common stream for unscheduled care may not be possible until well into 2022.

Consumption of Personal Protective Equipment (PPE)

From an Infection Prevention and Control (IPC) perspective PPE is used in two contexts, one is to support standard precautions and the other is transmission based precautions. Standard precautions apply to all patients at all times. In this setting certain items of PPE are required when performing certain tasks that involved contact with blood and body fluids. These requirements, as per guidelines have changed in only one respect since the onset of the pandemic. This change is the policy requirement that healthcare workers should wear surgical masks at all times when within 2 metres of a patient or within 2 metres of another healthcare worker. This has resulted in a massive increase in use of surgical masks in acute hospital. There is no immediate indication that this policy requirement will change therefore at this point it is necessary to anticipate that this cost will continue into 2022. Although guidance on use of other items of PPE (gloves, aprons, gowns and eye protection) required for certain tasks by standard precautions has not changed, the increased awareness of PPE appear to have contributed to greater use of PPE in practice.

Appendix 1

Additional Winter 2021/22 Context

Consumption of Personal Protective Equipment (PPE) (cont.)

In part, this reflects underuse pre pandemic. IPC training will seek to encourage continued use of PPE at appropriate levels indefinitely. Sustained appropriate use of PPE will be associated with increased costs even in the event that the direction on mask use is wholly or partially reversed.

Transmission based precautions apply to people with certain suspected of confirmed infections and those colonised with certain antimicrobial resistant bacteria. COVID-19 is one indication for use of additional PPE to comply with IPC guidance but there any many others. PPE demands for transmission-based precautions specifically related to COVID-19 will depend on the frequency with which patients with suspected or confirmed COVID-19 present to acute hospitals. This is difficult to predict but it must be anticipated that this will continue at a significant level in 2022. In addition to the direct impact of COVID-19, it is expected that IPC awareness in the context of COVID-19 has increased compliance with PPE use to meet guidance on transmission based precautions for other pathogens. IPC training will seek to encourage continued use of PPE at appropriate levels indefinitely. Sustained appropriate use of PPE will be associated with increased costs even if COVID-19 specific demands decline.

COVID-19 related staff absence

Staff absence related to exposure to COVID-19 (contacts), clinically suspected COVID-19 (symptoms) or laboratory confirmed COVID-19 (positive test) has resulted in very significant staff absence with costs associated with replacement staffing. Although the general guidance now is that healthcare workers who are fully vaccinated do not require exclusion from work as a routine, there are many situations in which the risk assessment in acute hospital settings may result in exclusion. There is a very clear public health message that fully vaccinated healthcare workers who have symptoms of viral respiratory tract infection must stay away from work at a minimum until 48 hours after acute symptoms have resolved and for much longer if they test positive for SARS-CoV-2. It is apparent that healthcare workers who are fully vaccinated become infected with SARS-CoV-2 frequently although the infection is generally very mild. It is expected that this will continue into 2022 with continuing costs for the acute hospital system. Pre pandemic all healthcare workers were advised to stay off work until 48 hours after resolution of acute symptoms of any viral respiratory tract infection however it is widely accepted that this was frequently not observed.

IPC training will continue to encourage better adherence to this guidance even if SARS-CoV-2 abates as it is important to prevent hospital spread of other viruses (influenza, parainfluenza, RSV and many others). If successful, this will result in an enduring increase in appropriate staff absence related to respiratory virus infection with implications for costs.

Testing

Acute hospitals are performing approximately 5,000 COVID-19 tests per day. A very small minority of these are on patients admitted with clinically suspected COVID-19. By far the greater part of this testing is related to surveillance testing. Current guidance points to scope to reduce surveillance testing in the context of fully vaccinated patients and staff however change in practice in this regard will be very gradual in the context of local risk assessments (outbreaks and alerts), poor infrastructure and very high risk patients with potentially poor acquired immunity. As other respiratory viruses have begun to circulate again it is possible that the volume of testing for SARS-CoV-2 in acute hospitals will increase in the early part of 2022 since any patient presenting with symptoms of any respiratory tract infection will now be tested for SARS-CoV-2. It is expected that there will also be increased testing for other respiratory viruses compared to pre-pandemic practice. Because SARS-CoV-2 tests are not always positive in people with COVID-19 it is good practice to continue to suspect SARS-CoV-2 until an alternative diagnosis has been established. Whereas pre-pandemic testing was usually limited to testing for Influenza A and B there is now much greater clinical demand for testing for a wider panel or respiratory viruses to support an alternative (non COVID-19 diagnosis).

Summary

Although the impacts of SARS-CoV-2 on wider society are expected to diminish significantly before the end of 2021, the pandemic will continue to impact extensively on the acute hospital system for the remainder of 2021 both in relation to direct impacts of SARS-CoV-2 and most likely also in relation to changes in practice informed by the experience of SARS-CoV-2. This is based on a conservative assumption that Ireland will not have to deal with a variant that substantially escapes acquired immune protection between now and end of 2022. If that were to happen the scale of the impact is difficult to predict.

Appendix 1

Additional Winter 2021/22 Context

Influenza Season 2021/22

In previous winters, the health system experienced the impact of Flu and RSV, almost inevitably these will now be joined independently or simultaneously by COVID-19 this winter. The influenza vaccination programme in winter 2020/21 was one of the most successful to date with high levels of uptake among eligible groups including healthcare workers. The co-circulation of seasonal influenza and SARS-CoV-2 has the potential to add substantially to the winter challenges faced by the HSE. Seasonal influenza could impact acute pathways including throughput in Emergency Departments (EDs) as those presenting with influenza will likely progress through COVID-19 pathways and require isolation. It also has the potential to significantly impact general practice if high numbers of patients are presenting to GPs resulting in difficulties accessing GP care. Additionally, residential services, their residents and staffing capacity could be further impacted by influenza outbreaks. In winter 2019/20, HPSC surveillance data reported high levels of influenza activity contributing to general and critical care hospital admissions. It is difficult to anticipate what the 2021/22 influenza season will look like. There were historically low levels of influenza activity worldwide for the 2020-21 season. The public health measures introduced to curb SARS-CoV-2 transmission have had a positive effect on reducing transmission of other respiratory viruses, including influenza. The World Health Organisation (WHO) continues to report that globally influenza activity remained at lower levels than expected for this time of the year. Influenza season 2021/22 could be similar to 2020-21 or there might be a return to a more typical season, with ongoing SARS-CoV-2 circulation. Public health restrictions are due to be fully lifted on the 22nd October. It is difficult to predict the extent to which this will result in influenza returning to its previous levels. However, as measures are eased, people are travelling between countries again and larger groups will be able to gather, potentially increasing the risk of seeding events for influenza outbreaks and spread. The Joint Committee on Vaccination and Immunisation (JCVI) (UK) is anticipating lower population immunity against influenza with modelling predicting the influenza season in the UK could be 50% larger than typically seen and begin earlier than usual.

Respiratory syncytial virus (RSV)

There are early indications of the re-emergence of RSV in Ireland. This of particular concern as increasing cases could lead to hospitalisations in younger children and older adults. As with influenza, RSV largely disappeared in 2020 due to the public health measures taken because of the COVID-19 pandemic. Since March, the Centre for Disease Control (CDC) in the US is observing increasing RSV rates above usual inter-seasonal levels. Increased inter-seasonal RSV circulation has also been reported in parts of Australia during late 2020 and in South Africa in early 2021. Latest weekly national influenza and COVID-19 surveillance data from Public Health England reports increasing RSV rates and hospital admissions in particular for children aged under 5 years of age. A recent pre-print modelling study in the US has suggested that the easing of public health measures and build-up of susceptibility may lead to an earlier onset and more severe RSV season in 2021/22 and an increase in lower respiratory track infections and hospitalisations. A recent report by the Academy of Medical Sciences in the UK presented modelling suggesting that a reasonable worst-case scenario for RSV would entail case numbers somewhere in the region of 1.5-2 times greater than during a typical year. This presents particular challenges given that younger children susceptible to RSV are also unvaccinated against COVID-19 and may increase demands on both COVID-19 testing, general practices and EDs as parents seek to determine the cause and access treatment for these viruses. It is important that parents are provided with advice and support about how to provide self-care for children with mild respiratory symptoms at home.

Key Considerations

- First winter with potential **co-circulation of both SARS-CoV-2 , influenza and other respiratory viruses.**
- This may add to **demands for testing for COVID-19 and other respiratory viruses.**
- Evidence of **increasing RSV rates in children** over the summer months internationally.
- Increased **susceptibility and decreased immune response** in individuals to winter viruses due to lack of exposure since start of the COVID-19 pandemic.
- Easing of public health measures and lower levels of population immunity may lead to an **earlier onset and more severe influenza season** than previous winters including **potential for outbreaks in healthcare settings**.

Proposed Initiatives

- **Testing for respiratory viruses should be clinically directed and indicated.**
- **Flu vaccination programme**
- **Public advice/communication campaign** to minimise impact of COVID-19 and other viruses and provide education on how to self-care for mild respiratory symptoms at home.

Appendix 1

Additional Winter 2021/22 Context

Transitioning from Pandemic to Endemic

The Table below presents an overview of the operation of the health system in Ireland from the pandemic state, current transition and finally proposals for an endemic state.

	Pandemic state	Current Transition State	Endemic State
Modelling/ Planning	• Daily reporting of cases, hospital admissions and ICU numbers. • Weekly modelling of cases, hospital admissions and ICU numbers. • HPSC surveillance.	• Daily reporting of cases, hospital admissions and ICU numbers. • Weekly modelling of cases, hospital admissions and ICU numbers. • HPSC surveillance.	• ISM modelling COVID-19 impact on acute and community services including age and burden profiles to help improve response preparedness. • HPSC surveillance of COVID-19 outbreaks, seasonal viruses and other infectious diseases.
Acute Services	• Restriction in delivery of non COVID-19 services to essential services. • Use of remote service delivery. • Redeployment of staff to COVID-19 services.	• Gradual service restoration in line with service restoration plan. • Monitoring capacity in the event of outbreaks. • Maintenance of COVID and non COVID-19 pathways. • Ongoing use of IPC and public health measures.	• Full service restoration. • Monitoring capacity in the event of outbreaks. • Use of respiratory and non respiratory pathways. • Ongoing use of IPC measures, transmission based precautions, enhanced measures/protocols during outbreaks in line with other viruses/infectious diseases.
Community Service	• Restriction in delivery of non COVID-19 services to essential services. • Use of remote service delivery. • Redeployment of staff to COVID-19 services.	• Service restoration in line with service restoration plan. • Monitoring capacity in the event of outbreaks. • Ongoing use of IPC and public health measures. • Restarting information systems and reporting post cyber attack.	• Full service restoration • Ongoing use of IPC measures with enhanced measures/protocols for vulnerable populations (LTCF, older people, young children)
Population Health	• Strict public health measures and lockdowns.	• Slow easing of public health measures, further easing for those fully vaccinated.	• Continued public health investment and reform. • Focus on communicating to the public regarding self-care and public health measures to mitigate the spread or respiratory viruses.
Testing	• Extensive testing and comprehensive coverage. • Genomic sequencing. • Prioritisation of testing in times of high demand for healthcare workers and vulnerable groups. • Serial testing programme for vulnerable groups.	• Ongoing testing including walk in testing for symptomatic individuals. • Genomic sequencing. • Testing recommended for vaccinated individuals only if symptomatic. • Serial testing programme for vulnerable groups.	• Scaled back Testing model with ability to increase capacity in the event of new variant or surge • Prioritisation of high-quality clinically appropriate testing deploying antigen testing and nucleic acid amplification testing as appropriate • Genomic sequencing. • Clinically directed testing of people who are symptomatic will remain essential to guide patient care, surveillance and infection prevention and control.
Contact Tracing	• Aiming for contact tracing of individual cases with isolation periods for all close contacts. • Use of COVID Tracker App to support contact tracing.	• Aiming for contact tracing of individual cases with isolation periods for all close contacts. • Use of COVID Tracker App. • Ongoing individual contact tracing with adaption of isolation/testing depending on vaccination, prior infection or weakened immune system.	• Scaled back Tracing model with ability to increase capacity in the event of new variant or surge. • Reduce contact tracing around individual cases to focus on outbreak investigation and management particularly for high-risk settings.
Vaccination	• Focus on priority cohorts initially, followed by achieving broad population coverage.	• High uptake generally. Focus now on targeting hard to reach groups.	• Maintain vaccine protection, consider COVID-19 booster vaccinations where relevant based on evidence. • Annual delivery of vaccination programme