

Winter Planning within the COVID-19 Pandemic

October 2020 – April 2021

September 2020





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Introduction

COVID-19 has and continues to challenge the overall capacity and capability of the health service in a way that we have not experienced in living memory. The COVID-19 pandemic has led to unprecedented interruption to normal healthcare activity, with both community and acute settings affected. Not only have existing services been significantly impacted, but new services have had to be rapidly developed and deployed. For example, Testing and Contact Tracing has become a vital component in the health systems' management of COVID-19, and preventing onward transmission of the virus.

Protecting and caring for the most vulnerable people in our society must be a key priority in our plans and actions. Of equal importance is the need to ensure that we focus on the health and wellbeing of all of our staff whom have experienced unprecedented challenges in the nature of the work we undertake on behalf of the public we serve.

In the first phases of the pandemic, the anticipated high-volume surge in COVID-19 patients within acute hospitals was mitigated by close adherence by the public in response to Public Health advice, the increasing of capacity of the public and private health and social care system and the deferral of elective activity. Robust public health measures remain in place and are frequently updated based on the advice of NPHET and other stakeholders in order to mitigate a second significant spike in COVID-19 transmission.

***In the context of COVID-19,
Winter 2020/21 will be the most
challenging winter for our
services in living memory.***

Notwithstanding the foregoing, it is increasingly evident that we can expect, and should therefore plan and be prepared for, subsequent waves of COVID-19, in so far as practically possible.

Until such time as there is a vaccine or cure, healthcare delivery will occur in a high risk environment where outbreak and surge could ensue at any time. In this context, Winter 2020/21 will be the most challenging winter for our services in living memory.

Winter planning is predicated on learning lessons from previous years. However, in this current environment, we are preparing for the expected winter pressures in conjunction with planning for service delivery in the context of the continued prevalence of COVID-19. Planning must also incorporate an approach to address the backlog of non-COVID care following the unprecedented interruption of routine services during the COVID-19 pandemic.

The health and social care system must be prepared to respond comprehensively to surge and create an environment that does not result in outbreaks. This environment, by its very nature, is also a higher risk for disease transmission and thus high standards are required to mitigate those risks. Key to meeting these challenges is the provision of additional capacity. The 2018 Department of Health Capacity Review and Sláintecare acknowledge the appropriate capacity of the health service in terms of both beds and community based services. This plan is not intended to achieve that level but is intended to be the first major steps towards achieving such a level.

A key symptom of the long term capacity challenges of the health service is ED overcrowding. In the context of working in a COVID-19 environment, we need to adopt a zero tolerance for overcrowding in all of our care environments. This has been a particular focus of our planning efforts in terms of how our patients access acute care and how patient flow is managed efficiently across the full patient care continuum to avoid any such overcrowding.

To support our capacity requirements, this plan will also seek to leverage private acute facilities in a number of ways including engaging these facilities to maintain continuity of elective procedures allowing for maximum unscheduled emergency care to take precedence in our public acute hospitals. In the event that a significant surge occurs, the engagement of capacity from the acute private sector will be required. As this is difficult to predict with any certainty, it will need to be provided for separately.

Introduction



The Strategic Framework for Delivery of Service Continuity in a COVID Environment (HSE, June 2020), focusses on restoring our services in a prioritised manner with investments targeted at rebuilding services guided by the principles and priorities of Sláintecare. A Community First approach to the delivery of care will be central to delivering safe, efficient and effective services through winter and beyond. Service delivery will be re-oriented towards general practice, primary care and community-based services. By 'shifting services left' and prioritising Primary Care and Community Services, we will advance the goals of Sláintecare and mitigate the impact of COVID-19. The enhancement of community services will allow people to remain at home, prioritising older people and those with chronic conditions.

This plan has been formulated within the context of an increasing demand for unscheduled care, the need to support service continuity and resumption of services and delivering essential healthcare in a COVID-19 context. The plan comprises of targeted initiatives to address population health needs which combine the needs to shift care to home and ambulatory care environments especially for high risk cohorts of patients such as the elderly and those with chronic enduring illnesses.

Initiatives included in this plan are primarily funded up to April 2021 and will be prioritised on the geographical integrated response required to meet local service needs. It is important that further services and initiatives as outlined in the HSE's wider Pandemic Plan, "Planning for Health Services Delivery in the COVID-19 Pandemic – Winter 2020 to End 2021" be considered and included in HSE estimates process for 2021. In addition, while this plan outlines work streams relating to PPE, testing and contact tracing, the funding for these initiatives are not within this winter plan.

The primary investments targeted at winter surge and envisaged in this plan are;

- Additional acute bed capacity;
- Additional home support packages;
- Additional HSE procured private bed capacity;
- Additional intermediate care beds, proposals for acute hospital egress; and
- Additional Community Healthcare Networks, Community Specialist Teams (Older Persons and Chronic Disease).

This plan requires the HSE and funded bodies to sustain the drive and expedience that served the nation well in the first phase of the pandemic. Early clarity on the approval of this plan will be crucial to enable our workforce, estates teams and teams of clinical and support staff to deliver the plan. It will require a recruitment campaign, both domestic and international, of a scale that has not been done before. It will require facilities and IT systems to be developed and commissioned at pace. Given the demographic pressures, combined with significant effects of the pandemic, this plan can and must proceed.

KEY OBJECTIVES OF THE PLAN

- *Improvement on Patient Experience Times in ED*
- *Reduction of 30% on previous year's Trolley count*
- *Maximum of 450 Delayed Transfers of Care*
- *Completion of over 20,000 additional Elective Procedures*
- *Establish 20 functioning Community Assessment Hubs*

Introduction

Key Outputs of the Winter Plan 2020/21

892

Acute Beds (409 now in place)

484

sub-Acute Beds (395 now in place)

631

Additional rehabilitation beds

530

Repurposed community beds to support home first pathway

47

Specialist Teams

500

self-isolation beds capacity each day

100k

COVID-19 tests per week

>33k

additional activity identified (In-patient Day cases, OPD, Endoscopy, Diagnostics)

>4.7 million

additional home support hours by the end of April 2021

>79k

GP access to diagnostics sessions

** Further work ongoing between Community Healthcare Organisations and Hospital Groups in relation to staging of bed openings.*

Introduction

Winter Plan 2020/21 Cost Summary

| Initiative / Sub Initiative | 2020 Cost € | 2021 Cost € | Total Cost € |
|--|----------------|----------------|-----------------|
| Private Hospitals | 0 | 58,961,549 | 58,961,549 |
| Acute Beds | 30,731,745 | 50,740,849 | 81,472,594 |
| Acute Service Continuity / "Restart" (Basic) | 18,327,166 | 13,753,859 | 32,081,025 |
| Alternative Pathway | 8,785,082 | 12,223,304 | 21,008,386 |
| Sub Acute (NEW) | 7,416,683 | 5,068,467 | 12,485,150 |
| Community Beds (Intermediate Care) | 45,394,979 | 41,774,207 | 87,169,186 |
| Community Health Networks | 6,590,955 | 9,381,429 | 15,972,384 |
| ICPOP | 0 | 9,064,900 | 9,064,900 |
| ICPCDM | 0 | 15,093,257 | 15,093,257 |
| Community Intervention Teams (CIT) | 2,450,000 | 2,266,667 | 4,716,667 |
| Dementia | 830,000 | 0 | 830,000 |
| Gp Structured Access To Diagnostics | 9,115,064 | 9,608,091 | 18,723,155 |
| Home Supports and Home First | 0 | 138,043,887 | 138,043,887 |
| Community Hubs | 0 | 5,612,796 | 5,612,796 |
| QPS HOS | 0 | 341,102 | 341,102 |
| Homelessness | 3,036,451 | 2,512,901 | 5,549,352 |
| Primary Care (NEW) | 5,895,751 | 3,846,835 | 9,742,586 |
| OPAT | 250,000 | 500,000 | 750,000 |
| WAITING LISTS / SCHEDULED CARE | 0 | 4,374,522 | 4,374,522 |
| CANCER RESTART | 0 | 2,352,970 | 2,352,970 |
| Vaccination | 55,163,875 | 818,500 | 55,982,375 |
| Flu Leads | 176,573 | 213,286 | 389,859 |
| Staff Health And Well Being | 1,100,000 | 1,000,000 | 2,100,000 |
| Accommodation - Vulnerable Persons | 0 | 3,740,990 | 3,740,990 |
| Accommodation - Staff | -60,960 | -81,280 | -142,240 |
| Health Analytics | 409,690 | 741,760 | 1,151,450 |
| Health Visualisation | 1,602,913 | 2,309,439 | 3,912,352 |
| Planning & Modelling | 155,828 | 167,708 | 323,536 |
| eHealth | 1,046,223 | 7,174,140 | 8,220,364 |
| NEOC Clinical Hub | 512,142 | 682,856 | 1,194,998 |
| Community Paramedicine | 258,258 | 344,344 | 602,602 |
| Critical Care Retrieval | 86,088 | 114,784 | 200,872 |
| Pathfinder | 628,425 | 837,900 | 1,466,325 |
| Telemedicine Expansion | 500,000 | 0 | 500,000 |
| 1813 Medical Helpline | 132,756 | 51,008 | 183,764 |
| | 200,535,688 | 403,637,026 | 604,172,714 |

Risks

This plan must be seen within the overall context of the wider Pandemic Plan, “Planning for Health Services Delivery in the COVID-19 Pandemic – Winter 2020 to End 2021”. The wider Pandemic Plan is focused on restoring our services in a prioritised manner with investments targeted at redesigning and rebuilding services guided by the vision, principles, approach and priorities of Sláintecare. A main aim is to shift the services we provide from predominantly hospital environments to community based delivery. This “shift left” principle also underpins to this Winter Plan.

It is important to note that this winter plan is a shorter term tactical plan which will prioritise initiatives within the broader Pandemic Plan. The Pandemic Plan remains the optimal integrated plan to address the combined challenges of a) mitigating winter pressures, b) safely restoring health and social care services and c) building integrated, patient centred capacity in line with Sláintecare

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 in the event that key posts, of which there is a significant number required, cannot be offered on a permanent basis.

Each initiative has been reviewed by the service owner and risks identified. 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 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 need for **early** agreement on targeted funding over a defined timeframe and schedule;
- The ability to address and deliver the necessary physical infrastructure (people, materials, machinery and buildings); and
- The leadership and governance (clinical and corporate) arrangements to drive and enable implementation including capacity, capabilities, and agreed roadmap.

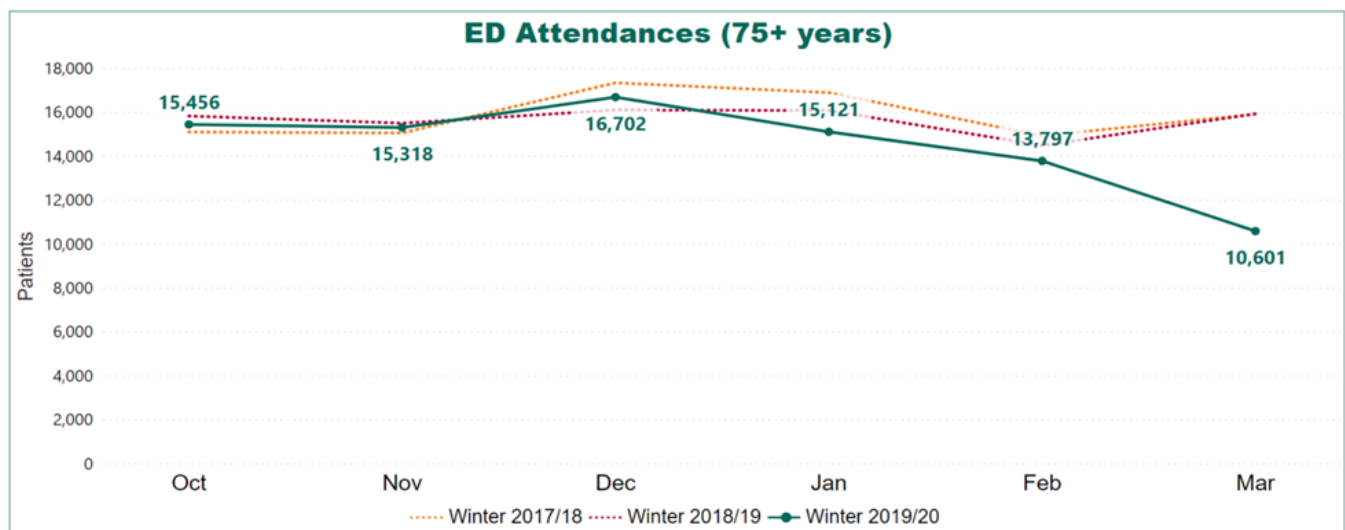
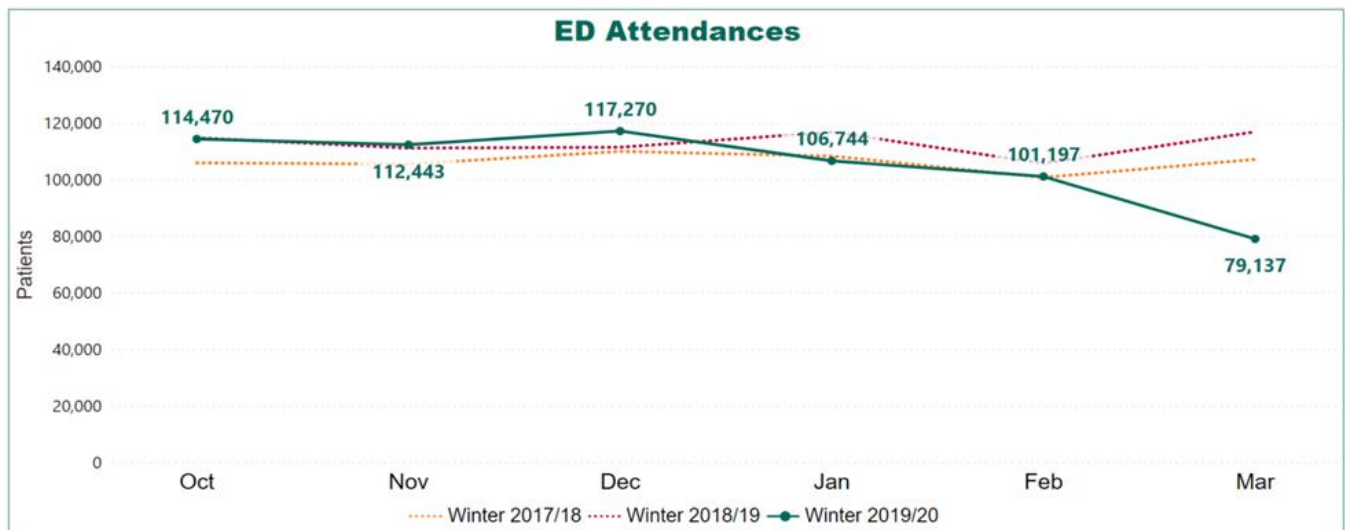
System and Procedural Risks

- COVID-19 related Issues, in particular reoccurrence of COVID surge and waves;
- Increased activity, in both scheduled and unscheduled care;
- Defined well governed mandated care pathways to deliver integrated and safe care;
- Meeting the challenging scale of recruitment required, in particular where roles cannot be deemed to be permanent;
- Employee engagement mechanisms to deliver new ways of working;
- Clear communication strategy with all stakeholders and management of expectations;
- Providing the necessary tools and enablers for change including operations management, project management and data analytical skills and capabilities; and
- Developing integrated ways of working and optimising potential for all workers to work to the limit of their professional scope of practice.

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 realized;
- Understanding of context to delivering key outcomes;
- Demand profile remaining stable and predictable; and
- Operation of Performance and Accountability Framework in delivering outcomes.

Overview of Winter Performance 2017/18 - 2019/20



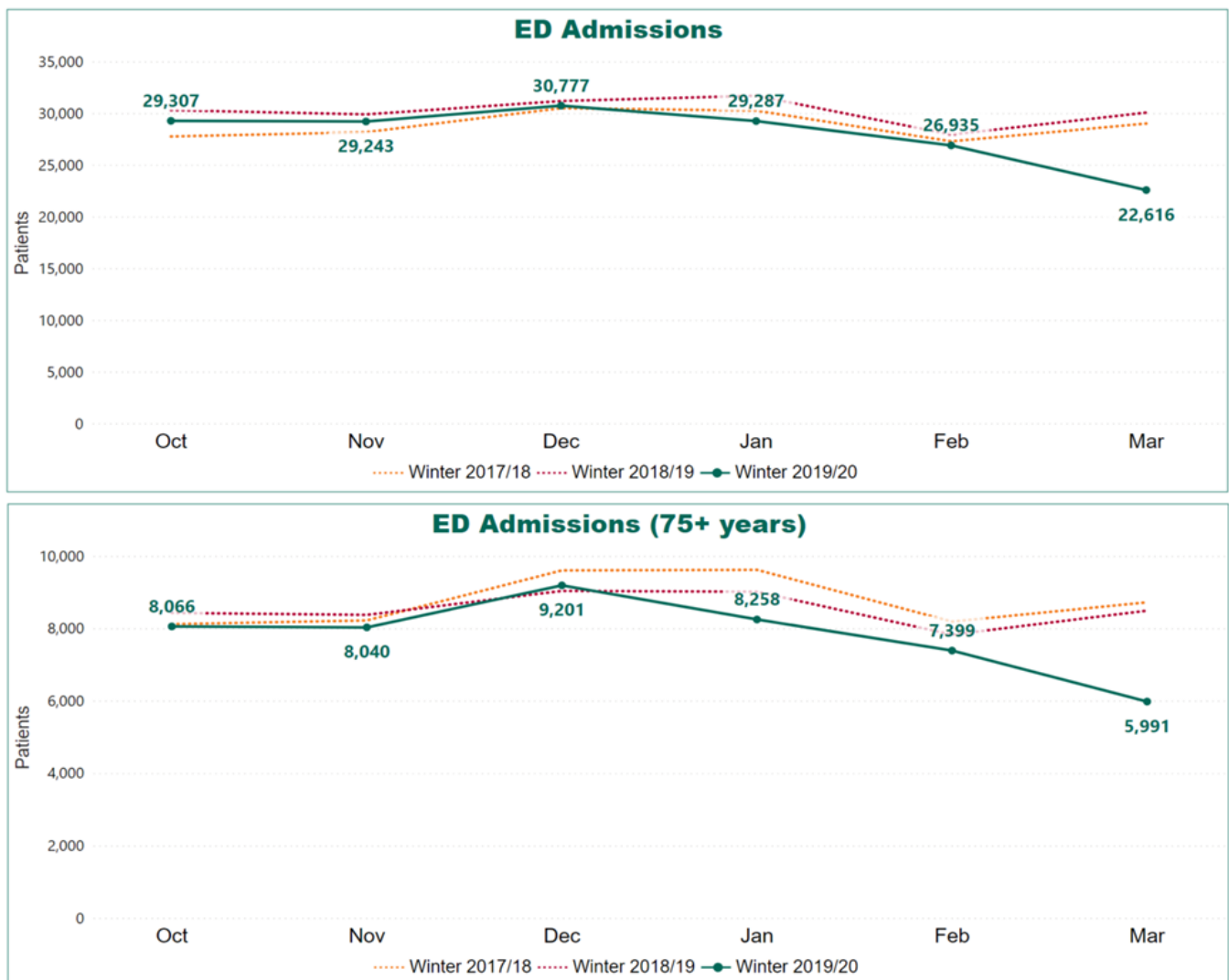
ED Attendances

When comparing the 2019/20 and 2018/19 winter periods, an overall reduction in ED attendances of 6.8% is observed, however comparing winter 2019/20 to winter 2017/18 records a reduction of only 1.1%. When March data is excluded, the difference between winter 2019/20 and 2018/19 becomes a reduction of 1.5%, while the difference between winter 2019/20 and 2017/18 becomes an increase of 4.0%. This displays relatively minor variability in winter ED attendances in recent years as demonstrated in the chart above, however we can see that January and February 2020 were lower than the previous year, followed by a sudden drop in March due to COVID-19. Based on the previous 3 years it would be expected that the 2020/21 winter ED attendances would be in a similar monthly range, excluding any potential significant impact due to COVID-19.

ED Attendances (75+)

The over 75+ years ED attendance pattern is not greatly dissimilar to the overall comparison between 2019/20 and 2018/19 winter periods with a reduction of 7.5% for Oct-Mar and a reduction of 2.1% with March excluded, however there is a more significant decrease when comparing 2019/20 and 2018/19 winter periods with a reduction of 8.7% for Oct-Mar and a reduction of 3.8% with March excluded. This demonstrates, at least for the last 3 years, a decreasing trend in the average 75+ years ED attendances during winter. Similar to the overall trend we see a relatively slight reduction in January and February with a sudden drop in March due to COVID-19.

Overview of Winter Performance 2017/18 - 2019/20



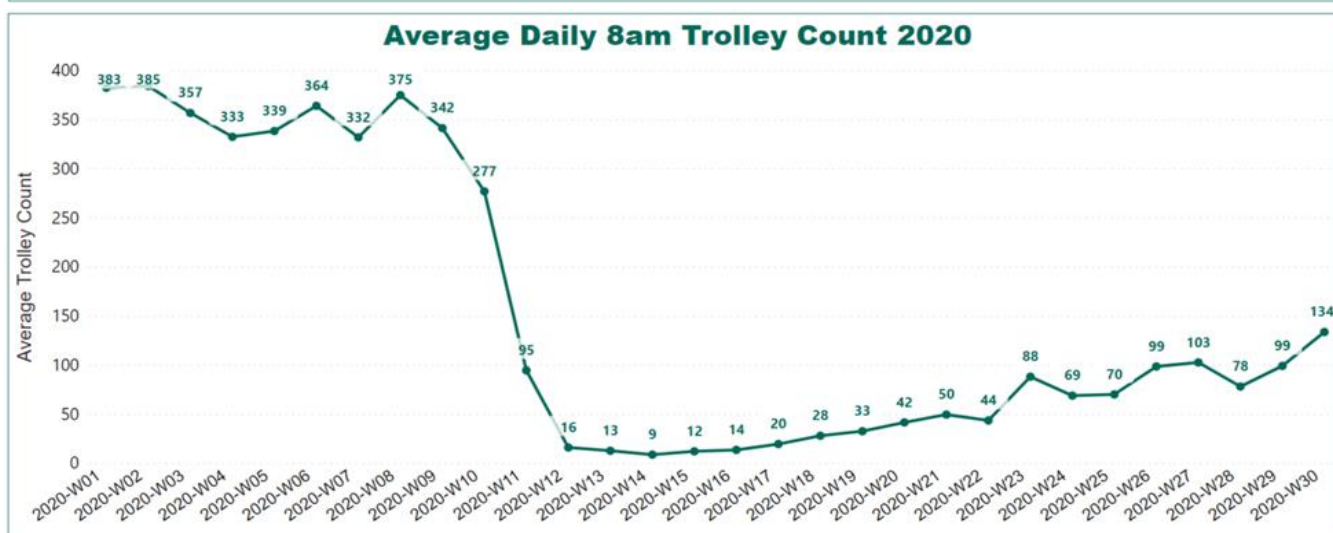
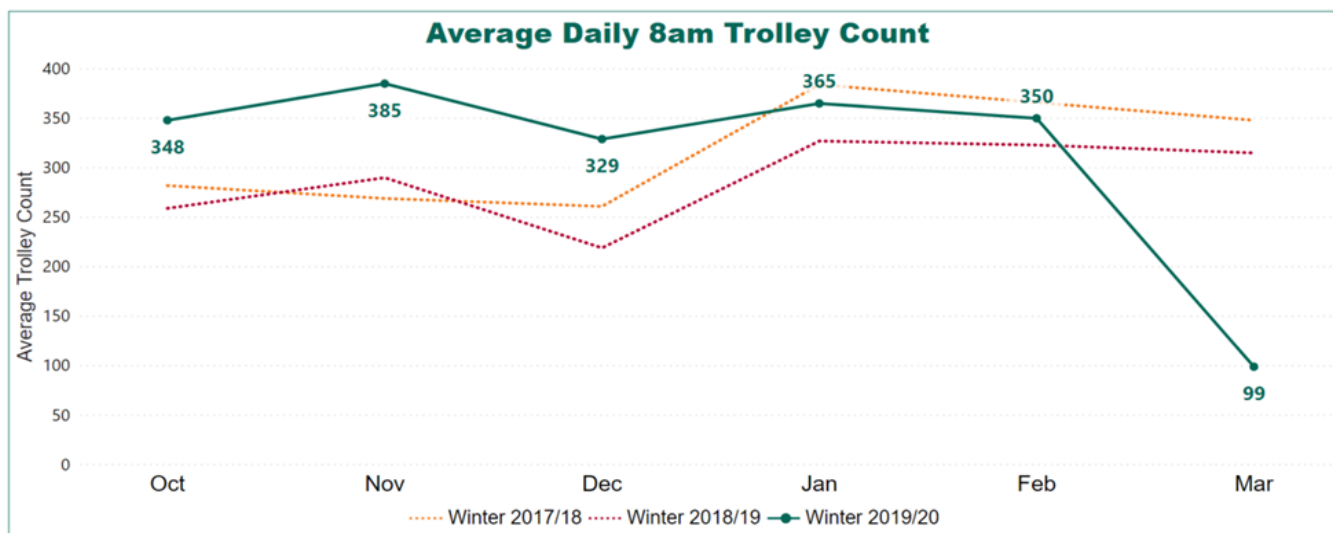
ED Admissions

When comparing the 2019/20 and 2018/19 winter periods, an overall reduction in ED admissions of 7.3% is observed, however comparing winter 2019/20 to winter 2017/18 records a reduction of just 2.9%. When March data is excluded, the difference between winter 2019/20 and 2018/19 becomes a reduction of 3.7%, while the difference between winter 2019/20 and 2017/18 is actually an increase of 1.0%. This shows that there is some relatively minor variability in winter ED admissions in recent years, as demonstrated in the chart above, however we can see that January and February 2020 were lower than the previous year, followed by a sudden drop in March due to COVID-19. Based on the previous 3 years it would be expected that the 2020/21 winter ED attendances would be in a similar monthly range, excluding any potential significant impact due to COVID-19.

ED Admissions (75+)

The over 75+ years ED admissions pattern is not greatly dissimilar to the overall comparison between 2019/20 and 2018/19 winter periods with a reduction of 8.4% for Oct-Mar and a reduction of 4.2% with March excluded, however there is a more significant decrease when comparing 2019/20 and 2018/19 winter periods with a reduction of 10.6% for Oct-Mar and a reduction of 6.5% with March excluded. This demonstrates, at least for the last 3 years, a decreasing trend in the average 75+ years ED admissions during winter. Similar to the overall trend we see a relatively slight reduction in January and February with a sudden drop in March due to COVID-19.

Overview of Winter Performance 2017/18 - 2019/20



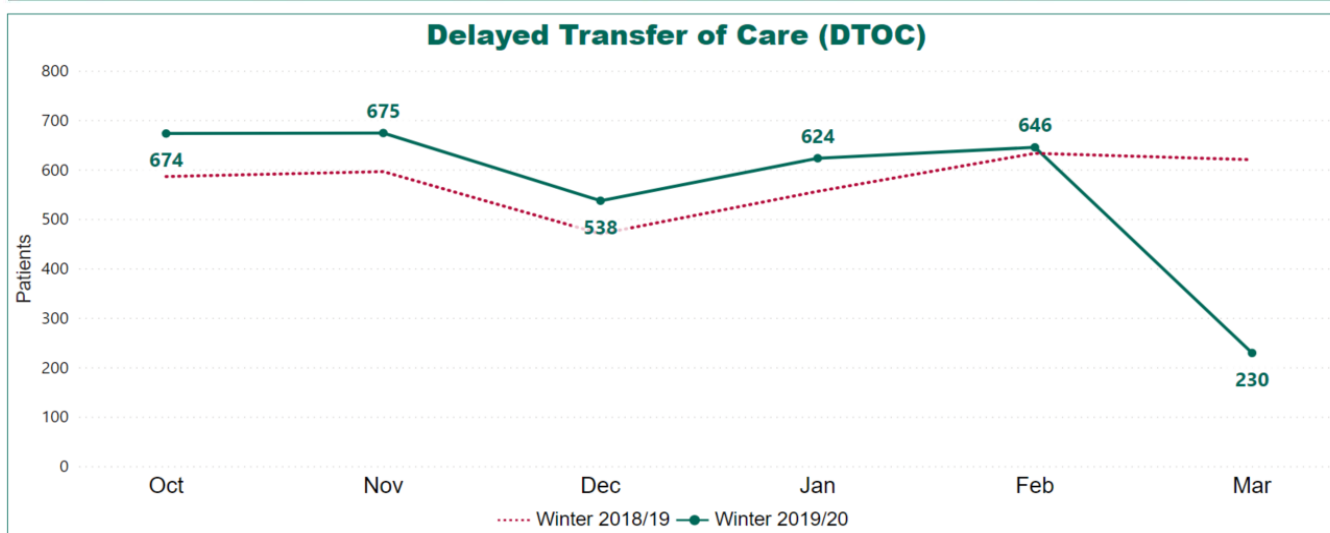
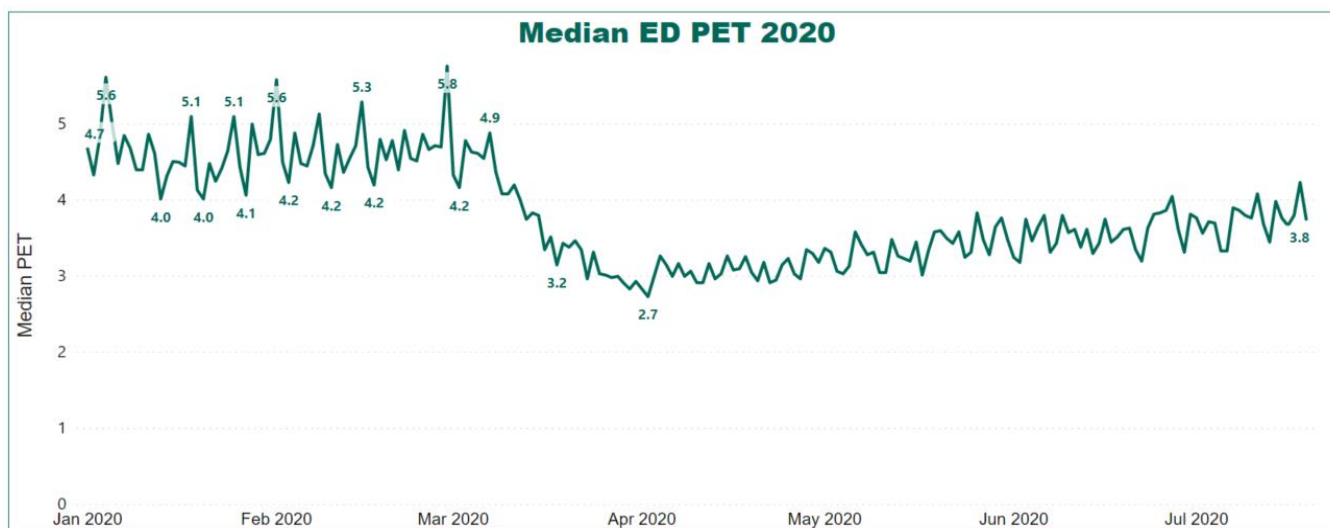
Winter 8am Trolley Count by Month

The average (mean) daily 8am trolley count figures for winter 2019/20 were considerably higher in Q4 2019 than the previous two years, but more consistent overall through the winter period in contrast to the sudden spike in averages for Jan-Mar in winters 2017/18 and 2018/19. As expected there is a sudden drop in the average daily 8am trolley count in March 2020.

8am trolley Count by Week 2020

The second chart shows the average daily 8am trolley count by week number in 2020 (data provided up to 20/07/2020). We can see the sudden drop off in March coming into April, which is then followed by a steady increase in May, June and July. Although it is not possible to predict the impact of COVID-19 on trolley count figures for winter 2020/21 based on the data available, there is an overall pattern of increase in trolley count year on year from 2016 to 2019.

Overview of Winter Performance 2017/18 - 2019/20



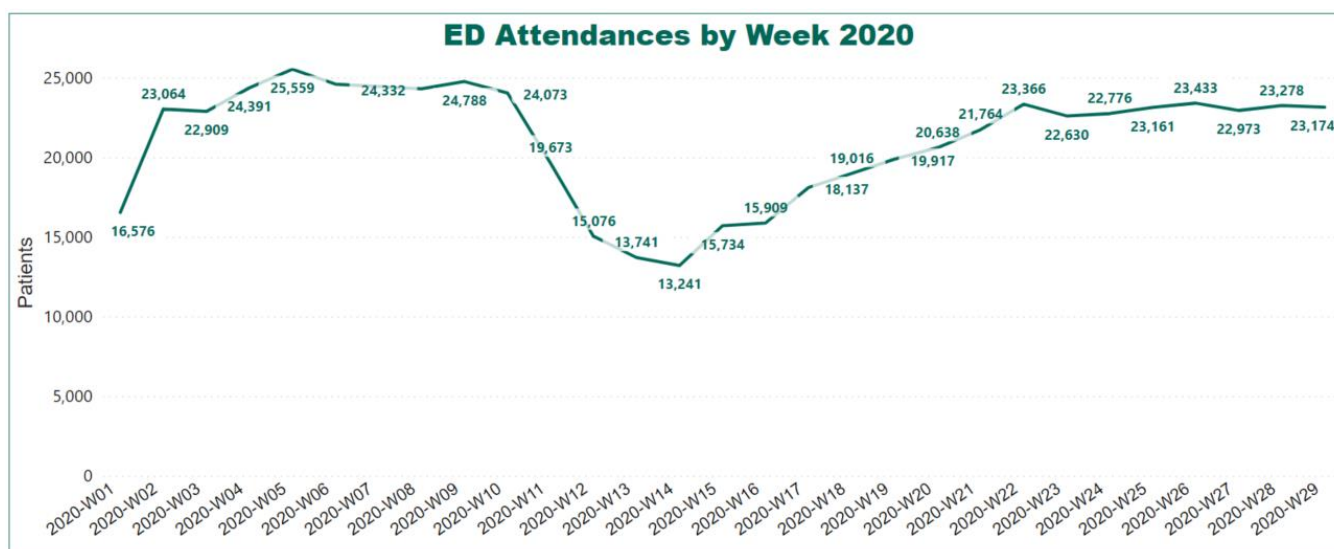
Median ED PET 2020

The Median ED PET (Patient Experience Time) fell during March 2020 from the 4-5.8hrs range formed in January and February to a low of 2.7hrs by the start of April, however the PET has been steadily rising since then to circ. 4hr by the end of July. This means that we are seeing a return to a pre-Covid level of attendance duration for Emergency Departments on an aggregated national level.

Delay Transfer of Care (DTOC)

During the Winter Period 2019/20, a 2.2% reduction in delayed transfers of care was experienced when compared to winter 2018/19. However, with the exclusion of March statistics, a 10.9% increase is realised. The statistics for the delayed transfers of care in 2019/20 move in a similar way as the previous winter period, therefore it can be inferred that while a reduction in delayed transfers of care may occur in December, there may be an increase in the months following this.

Overview of Winter Performance 2017/18 - 2019/20



ED Attendances 2020

The above chart shows the weekly total ED attendances by week number in 2020 (data provided up to end of week 29). We can see the sudden drop off in March / April due to COVID-19, which is then followed by a very steady increase and a return to the previous levels of activity from around the end of May onwards. While there is an element of attendance to ED that is in appropriate and is reflected in the reduced attendance due to COVID-19, there is a risk inherent in such non-attendance where patients who should attend choose not to and deteriorate as a result. The provision of alternative pathways of care will reduce this risk and help to ensure the most appropriate care is provided.

Winter Planning in the COVID-19 Pandemic (October 2020 to April 2021)



The HSE's Winter Plan for 2020-2021 aims to mitigate the extraordinary challenges brought about by the COVID-19 pandemic. The scale of the challenges and demands that our health system will face requires a plan and associated investment of unprecedented proportions.

In this context, the system of accountability, including leadership, governance and operational grip must reflect the scale of the investment and the challenges faced. 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 the Minister for Health, the Department of Health, the HSE, it's Hospital Groups and Community Health Organisations, the statutory versus the voluntary system, the place of private versus public healthcare and the presence or absence of hospital boards of management.

From a national perspective, the HSE Board, will, through it's Performance and Delivery Committee, seek assurance on the implementation from the Chief Executive Officer and his Executive Management Team. The Chief Executive Officer chairs the Executive Management Team and the National Crisis Management Team which meets regularly and more often as circumstances dictate. 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.

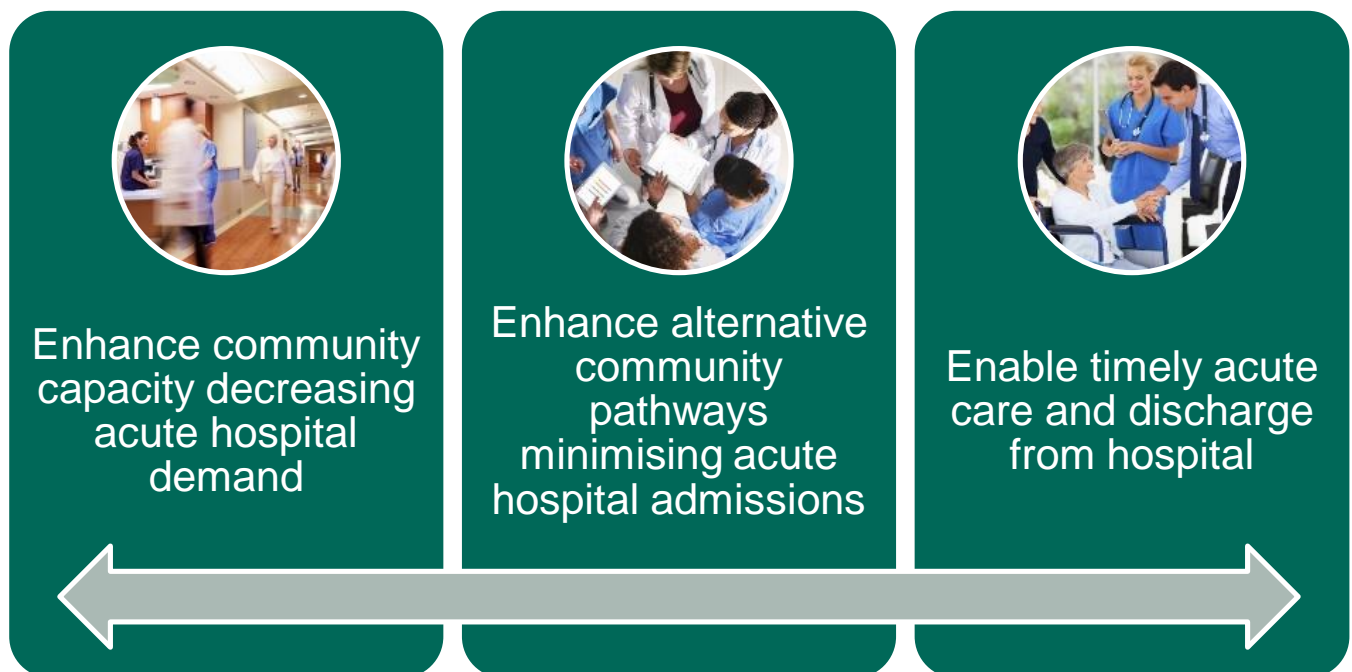
To provide leadership, governance and oversight, the Chief Operations Officer has established the Integrated National Operations Hub (INOH) with defined membership from all relevant service and enabling functions with a clear Terms of Reference. For the purposes of coordinating the response to COVID-19, each geographical area has an Area Crisis Management Team (ACMT) which has replaced the Winter Action Team (WAT) established during the 2018-19 season. This will provide the system with a strong integrated grip on operations in terms of oversight, management and response.

With the prevalence of COVID-19 during Winter 2020/2021, the INOH overseeing the nine ACMTs, will provide clarity on leadership and governance to the implementation of the HSE's Winter Plan during what is expected to be an extraordinary period. This process will be co-ordinated by the National Services Division of the HSE.

Winter Planning in the COVID-19 Pandemic (October 2020 to April 2021)



Initiatives to Support Winter Planning in the COVID-19 Pandemic (October 2020 to April 2021)



The aim is to ensure that service providers are prepared for the additional external pressures associated with the winter period and doing so in the new COVID environment. The increased pressures include the requirement for separate pathways for COVID and non-COVID demand, with the added pressure of operating normal services within a COVID environment. Therefore, it has been necessary to consider specific strategies to meet the expected demand. The plan will feature a number of initiatives designed to establish new and strengthen existing capability in the acute hospital and community sector.

Building Capacity



Acute beds

The emerging clinical evidence in relation to operating in a Covid environment points to a large number of significant necessary changes that will affect the patient flow, available health system capacity and will impact on productivity. Put simply, the implementation of these necessary changes will mean that we will deliver less activity for the current capacity. The impact of operating at 85% occupancy on annual activity levels is significant. It is estimated that this will displace up to 100,000 in-patient cases from our total workload of 660,000 cases. This initiative centres on the provision of additional acute beds to mitigate the reductions in acute capacity and productivity as result of the requirement to operate within the context of capacity challenges outlined below:

- The need to reduce acute sector occupancy rates from 95% average to 85% in line with clinical guidance on safe practice for patients and staff alike;
- Impact on efficiency levels because of new ways of working (30%-40%);
- Increased demand due to displaced and deferred activity;
- The reduction in available beds due to impact of changes to physical layout of facilities (e.g. Nightingale wards); and
- The potential impact of HSPC guidance on Nursing Home transfers are extremely significant. We have set out the overall estimated additional acute inpatient bed requirement which results from these combined effects in the table below.

It is proposed to open an additional 251 Acute beds and 89 Sub Acute beds in Q4 2020 and an additional 232 Acute beds in Q1 2021.

Community Beds

This initiative is in place to provide Intermediate Care capacity in the community to reduce hospital admission and facilitate timely discharge from acute settings for older persons. It includes expanding Intermediate Care capacity by:

- Repurposing some existing centres through refurbishments and extensions;
- The conversion of existing beds to Rehabilitation beds;
- Developing an Intermediate Care Rehabilitation Outreach services to support home-based Intermediate care; and
- Gradually reconfiguring public NHSS beds to Intermediate care beds; as well as obtaining private capacity, either from private hospitals or private nursing units to help meet demand.

A total of 530 repurposed/ new rehabilitation beds, including 631 rehabilitation outreach places will be operational up to April 2021, 868 new WTE are needed to staff this initiative.

The impact of this initiative will be a 15% reduction on acute bed days used by the >75 years population when implemented in full. Two drivers to this initiative will be the reduction in ED admissions and a reduction in length of stay for this cohort of patients.

The impact on Delayed Transfers of Care (DTOC) are captured in the overall reduction in bed days.

19,975 bed days will be saved over Q4 of 2020 and 30,267 beds days saved in Q1 2021. An additional 10,625 people will be cared for in Intermediate Care beds allowing them to either avoid hospital admission in the first place or facilitate timely discharge from the acute hospitals.

Building Capacity

Building
Capacity

Private Hospitals

The HSE entered into arrangement with Private Hospitals to secure access to their facilities and capacity to meet the challenges of the Pandemic. During the period of the agreement (30th March – 30th June), the following activity was undertaken; 13,000 inpatient discharges, 54,000 day cases, 86,000 diagnostics, and 52,000 OPD attendances.

The arrangement facilitated the transfer of critical time dependent and complex services that otherwise would have had to be deferred during the period of surge predominantly cancer surgery, chemotherapy, cardiothoracic surgery, transplant surgery and cardiology.

The HSE are negotiating a new arrangement with the Private Hospitals as follows:

- Access to private Hospital capacity in the event of a surge in COVID-19 cases and separately (Safety Net);
- Access to Private Hospital services to address the HSE priority needs in providing essential ongoing care; and
- Ability to address elective care for public patients experiencing delays and the growth in waiting lists. This is to be done in collaboration with the NTPF. (Procurement Process).

Aims of Initiative

10,000 OPD appointments

2,879 in-patient procedures

17,930 day-case procedures

2,935 GI scopes

Home First

A targeted work programme to double the existing home support hours to fully support those with high and moderate levels of frailty, including people with dementia, will be implemented, which will include the roll out of a single assessment tool.

This will support the Department of Health with the establishment of an interim Home Support Scheme this Winter in advance of legislation. Clinicians will have three pathways to support patient discharge back to the community utilising a discharge to assess model with a philosophy of home first underpinning all discharge decisions.

1. Home with community support and package of care (Home Support);
2. Home with reablement package of care;
3. Extensive Home Support packages for those with complex assessment of care needs in order to avoid Long Term Care; and
4. Increase Home Support hours provided to existing clients.

Local placement forums in the community which have existing governance structures in place will be redesigned to become long term care decision making forums with autonomy to commission community services to support rapid discharge of patients back home. These decision making forums will have the decision making and coordinating role for all patients leaving hospital who require community supports.

Initiatives 1-3 will be implemented over the period Q1 to Q3 2021 to deliver increased and enhanced Home Support hours.

Aims of Initiative

A total of 4,76 million additional home support hours (above NSP 2020 target) by April 2021

Service Continuity



The planning for winter 2020/21 and beyond must incorporate an approach to address the backlog of non-COVID care following the unprecedented interruption of routine clinical care during the COVID-19 pandemic. As the volume of both unscheduled and scheduled activity increases, health services will need to continue to adapt to new ways of working which should be done using a formal programmatic approach. There is an urgent need to re-conceptualise how we deliver care to both COVID and non-COVID patients simultaneously.

A restoration of services in the community is necessary for the continuation of support to people in maintaining health and wellbeing, and avoid activity being directed to acute settings.

Appropriate information technology solutions are required to enable real-time communication. Retaining and maintaining some of the innovations which were implemented as part of the COVID response will be a key enabler of timely service provision.

Acute Service Continuity / Restart

Review of the experience in other jurisdiction points to a phased re-introduction of scheduled care services and Ireland has adopted a similar approach. In parallel with the phased increase in scheduled services activity, current data indicates that unscheduled presentations to ED and emergency admissions to acute settings are rapidly approaching pre COVID-19 levels.

In preparation for the volume of both unscheduled and scheduled activity to return to previous levels, we have begun to implement new ways of working and revised infection prevention and control measures in our healthcare facilities. The steps that have been taken already and those proposed to enable re-start of activity, which has increased post-COVID, require further support and enablement so that current activity can be maintained and increased.

Health service capacity needs to expand to address the inherent deficits and health services will also have to operate and develop pathways to treat both COVID and non-COVID patients simultaneously where vital COVID capacity needs to be available and heightened safety measures need to be rigorously adhered to.

Community Service Continuity/ Restart

Enhanced Quality and Patient Safety Capacity in Community

A key learning during the COVID-19 pandemic was the requirement for enhanced capacity to respond to the challenges presented by the pandemic. The purpose of this initiative is to strengthen QPS leadership, governance and management structures to ensure an adequate response to the anticipated surge in activity during the winter months across community services.

Homeless Population Service Provision Enhancements

This initiative is concerned with the provision of high quality, accessible and safe care that meets the needs of the homeless population. Services for Homelessness are currently delivered by multiple providers including Statutory Services, Non-Government Organisations (NGOs) and charitable organisations, however, given the complexity of homeless services and the number of services, the system can be difficult for service users and service providers to navigate. The COVID-19 Homeless Coordination Group embarked on various initiatives i.e. Prevention, Triage & Testing, Self-Isolation to support this population group some of which are proposed to be continued or further enhanced as part of the Winter Planning process.

Initiatives include:

- Additional financial supports to the Homeless Hospital Discharge Programme.
- Service provision enhancements (i.e. additional GP hours and temporary emergency accommodation provision to regional based urban centres,
- Expanding GP Practice to enhance health care supports offered to vulnerable groups; and
- Continuation of Covid-19 Housing Initiatives which was developed as a result of the pandemic.

Pathways of Care



Community Assessment Hubs

This initiative relates to the ongoing provision of COVID-19 Community Assessment Hubs and the extension of these to incorporate the treatment of acute respiratory illness via Acute Respiratory Assessment & Treatment Hubs. In order to significantly reduce the requirement for individuals to attend Acute Emergency Departments (EDs) and General Practices (GPs) a planned community approach to winter 2020/21 in responding to COVID-19 and non COVID-19 acute respiratory illness is essential.

The initiative will continue to allow individuals with COVID-19 who become unwell in the community to be referred by their GP to attend a scheduled appointment at the Community Assessment Hub for further clinical assessment and appropriate management. Additionally this initiative will accept referrals from GPs for individuals from the community requiring assessment for non COVID-19 acute respiratory illness. Individuals requiring specialist respiratory disease multidisciplinary team input would not be accepted for assessment.

Aims of Initiative

Allow GP practices to continue to effectively manage the demand for non COVID-19 services which have been significantly compromised since the start of the pandemic.

Manage any increase of acute respiratory infections including potential COVID-19 uptick(s). Several GP surgeries do not have the infrastructure for streaming high volumes of COVID-19 and non COVID individuals in line with national recommendations.

Provide an alternative facility for community level assessment and treatment of individuals with acute respiratory infections thereby minimising pressure on EDs (from data we know that CAH D/C home 80%)

There are currently 7 Community Assessment Hubs operation within 5 Community Healthcare Organisations with a further 3 on standby to open should demand increase. The plan is to have 20 hubs in total available from January to April 2021.

Community Networks / Specialist Teams

Community health services will be delivered through Community Healthcare Networks (CHNs), providing the foundation and organisational structure through which integrated care is provided locally at the appropriate level of complexity, with GP, HSCP & Nursing leadership, empowered at a local level to drive integrated care delivery and supporting egress in the community. Additional community capacity delivered through CHN's and Community specialist teams, is essential to increasing capacity within our primary and community care settings.

CHN's and Community specialist teams will work in an integrated way with NAS and acute services to deliver end to end care, keeping people out of hospital, enable a 'home first' approach, and ensure people are discharged from hospital without delay, with a 20% reduction in over 75's ED admissions and 10% reduction in acute bed days in hospitals service by CHN's and Community specialist teams once fully implemented. Self-management support and alone type voluntary model will be in place linked to COVID-19 Community Call Programme.

The aim is to accelerate the implementation of this change programme which is included in the HSE Corporate Plan. This includes:

- Establishment Community Healthcare Networks and Specialist Teams in the community.
- Phase 1 (Winter 2020/21) will target the 11 challenged hospitals and associated CHN catchments;
- Implement a structured programme for chronic disease management and prevention, with an anticipated 75% uptake;
- Implement end to end care pathways for older people. These include enhancing existing and accelerating additional ICP OP MDTs and Frailty at the Front Door Teams to cover 57 CHNs.
- Expand Community Diagnostics; and
- Complete national coverage of CIT.

Pathways of Care



GP Access to Diagnostics

The aim is to increase GP access to diagnostics. Limited access to diagnostics results in patients being referred into hospital EDs and outpatients to access diagnostics.

Since the COVID-19 pandemic, GPs are reporting difficulty in accessing all radiology services within a hospital setting including chest x-rays and plain film x-rays. There is now an even more urgent requirement to provide GPs with direct access to diagnostics and in a primary care location to facilitate hospital avoidance.

Timely direct access as a priority to X-rays and ultrasound and MRI, CT, ECHO & spirometry will be provided to GP's and Community Specialist Teams, enabling integrated care delivery in the community, with an expected decrease of 20% in the number of over 75's attending ED's.

It is proposed to provide an additional 33,950 diagnostics in Q4 2020 and an additional 45,267 diagnostics up to April 2021.

General Practice Support

It is well recognised that general practice provision is insufficient with a credible risk of localised failures (DoH Capacity review, HSE Workforce planning). The surge in activity over the winter will bring particular pressure on single handed, two-doctor practices and those practices of older GPs. Failure of individual practices due to the illness of core personnel or an excess in demand over ability to deliver services will lead to knock-on impacts into emergency departments, the out of hours services and other stressed local practices.

Temporary crisis supports are required to ensure the continued provision of local GP services to patients.

- Each area crisis management team will develop and govern a capacity to respond to actual or impending failures in local practices or out-of-hours services;

- Crisis intervention capacity includes GP, nursing and administrative supports; and
- Funding will be provided to the Area Crisis Management Teams for provision of staff, indemnity insurance and other necessary infrastructure and expenses.

These supports are essential to ensure that single-handed and two-doctor practices, of which make up 15% and 24% of GPs respectively, do not experience practice failure and / or GP burn out.

Acute Alternative Pathways

During the first surge of COVID-19, acute hospitals implemented separate streams of ED pathways for COVID-19 and non-COVID presentations. Senior decision makers at the front door were paramount to determine these pathways.

With guidance, new processes, and infrastructure, it is anticipated that 70% of pre-COVID productivity could be achieved. Managing the volume of demand will require increased senior decision makers who can complete episodes of care.

During low incidence periods, the infrastructure for the COVID pathway may consist of 1 or 2 identified isolation rooms for assessment and testing and streaming through self-identification of symptoms and remote triage by the GP and prudent infection prevention and control practices. During higher incidence periods (>20/100,000) formal forward triage and separated infra-structure are recommended. These delivery systems need to be organised a priori so they can be deployed on demand. As COVID-19 cannot be diagnosed clinically, infection prevention and control strategies, in particular access to PPE and isolation areas are key to preventing spread. Forward triage and separated pathways is associated with reduced healthcare staff acquisition of COVID-19.

Pathways of Care



Acute Alternative Pathways (cont'd)

| Aims of Initiative |
|--|
| Expansion of senior decision making and Consultant delivered care |
| The use of alternative technologies e.g. Capsule Endoscopy |
| Development of satellite renal units |
| Compliance with COVID-19 clinical guidance and staff risk reductions (e.g. 12 videoscopes for ENT units) |

Waiting lists and Scheduled Care

The numbers of patients waiting for scheduled care assessment and/or treatment and the length of time they are waiting are now at record levels, with many thousands of patients having to wait for years from initial GP referral to definitive treatment. While waiting to access services, patients will often be in pain, they and their families may be anxious, they are likely to be in frequent contact with their GP and hospital, and their condition may deteriorate, sometimes to such an extent that they are required to present as an emergency. In the context of the ongoing pandemic and its operational consequences, decisive action is now required to prevent the current, already hugely challenged position, from deteriorating further.

While small improvements had been observed in the total numbers waiting over the past 12 months, they were still unacceptably high. As a result of the COVID-19 Pandemic, the situation has worsened significantly. The current Waiting Lists, as of June 2020, is 704,500 in total.

In order to effectively tackle the complex challenge of Scheduled Care waiting times and manage growing waiting lists, with the reduction in activity due to COVID-19, the following five initiatives have been identified:

- To accelerate the appropriate pathway, all patients waiting will go through an active clinical triage process carried out by a consultant or senior decision maker;
- Procurement of additional activity from the private sector for specific specialties; and
- Expansion of non-invasive capsule endoscopy diagnostic services (PillCam) to a further 10 hospitals to reduce the lengthening waitlist due to a 42% reduction in activity due to COVID-19 restrictions.

Cancer Services

During the COVID-19 crisis period, cancer services in the state were requested to prioritise activity across the patient pathway in line with national clinical guidance. This ensured emergency, time critical and symptomatic services for cancer (diagnostics, surgery, chemotherapy and radiotherapy) were delivered appropriately and that patients continued to be seen in a timely way. It also protected vulnerable cancer patients from exposure to COVID-19 during the crisis period. However, the impact of “slowing” cancer services has been significant with the centres now struggling to deliver to a pre-COVID level.

Pathways of Care



Cancer Services (cont'd)

These impacts include:

- Reduced capacity within the service with a growing backlog of patients waiting for access, care and treatment;
- Backlogs experienced in the symptomatic breast and prostate services;
- Prior to COVID-19, cancer services were working at full capacity and there was no resilience within the services due to serial under-investment over the past number of years;
- The use of the private sector contract to facilitate cancer surgeries in a protected environment exposed the lack of resilience in the centres particularly for the surgical part of the cancer pathway; and
- Other areas such as Radiology diagnostics/ surveillance and investigative/ diagnostic scoping/ biopsies are pinch points in cancer patients journey to treatment.

This initiative is about increasing the provision of cancer services in public health care settings in the context of this growing backlog and to create resilience in key parts of the pathway to minimise delayed diagnosis and protect against future COVID-19 outbreaks. It includes proposals to:

- Improve cancer access / follow up for outpatients (via Telehealth/ IT);
- Create resilience within the designated cancer centres / surgery/ early diagnosis/ diagnostics; and
- Streamline the chemotherapy pathway. Ongoing roll out of the National Cancer Information System (NCIS) to the 26 SACT Units.

It is expected that additional resourcing will increase patient attendance across Breast, Lung and Prostate Rapid Access Clinics. It will also assist in addressing the COVID-19 backlog of patients and the impact of COVID-19 restrictions have on capacity across cancer services. It will enable on average an estimated 15% increase in the current maximum capacity (Covid restrictions) for attendances within target access times.

This is projected to achieve a maximum capacity level in 2021 of approximately 95% of pre Covid capacity levels. The Service Planning for cancer services for 2021 will further address the needed capacity and resilience of cancer services, within the context of furthering the objectives of the National Cancer Strategy 2017-2026.

Additional staff (across Medical & Dental, Nursing, HSCP, Pharmacy, Management/ Admin and Support) are identified as required through to the end of 2020.

The resources underpin recovery from the disruption to cancer cancers including Screening, Prevention, Access, Treatment and Support for patients, and are aimed at restoring capacity and performance.

National Ambulance Service

The National Ambulance Service operates at the interface between hospital services and the public. Community-based care options will expand with Sláintecare implementation meaning transport to hospital may not be necessary or appropriate, and the evolution of the 'mobile medical' role of NAS will accelerate. Building on the model of patient care and clinical initiatives that were developed as a result of the NAS Strategy Vision 2020, the NAS has the potential to play a significant role in relieving the pressure on hospitals and aiding the reorientation of healthcare as envisaged in Sláintecare. The NAS will aim to ensure that the patient care we provide is aligned with Sláintecare goals.

For the upcoming winter period, NAS will be focusing on maintaining service delivery whilst giving support to the wider healthcare delivery system both at the community and acute levels. As this approach requires different pathways, these pathways form an integral part of the system that is required to deliver pre hospital care. As such, the NAS is focusing in relation to hospital avoidance initiatives and outreach programmes.

PPE, Testing and Contact Tracing



Testing and Contact Tracing

The HSE is in the process of developing a sustainable COVID-19 Test & Trace service. The new service model being developed will strengthen underpinning processes (technology, logistics, workforce planning, and quality assurance) to ensure the service is sustainable and of a high quality into the winter months and beyond. While significant progress has been made on scoping service options, examining international developments and implementing shorter-term process and service improvements, the detailed design for the final model is still a work in progress. To support cost estimation for this plan, however, high-level costs, informed from the design process undertaken to date, have been estimated.

This programme of work is about developing and implementing an enduring and robust end-to-end Test and Trace service for COVID-19. This service includes referrals for testing, swabbing of patients in various settings, laboratory testing of samples, test result communication, contact tracing and outbreak management. A key assumption underpinning the development and implementation of a sustainable service model is to meet a service demand of 100,000 COVID-19 tests per week.

It is important to understand that from a workforce perspective, direct staff costs incurred to date for swabbing and contact tracing are non-existent due to the fact that services were delivered by HSE staff redeployed from other health and social care services (paused due to COVID-19 epidemic), or by volunteers. One of the reasons that a new service model is now required is that these staff are required to revert to their substantive roles and resume normal services for patients.

A number of key assumptions exist within this initiative, including:

- Year to Date staff costs assumed to be zero, as all staff have been redeployed from elsewhere within the HSE / Public Sector;
- New staff are assumed to be ramped up to 20% of baseline levels in September, 70% in October and to 100% of baseline level by November 2020;

- 100,000 tests per week is based on current NPHE testing strategy and does not include any potential changes in swab type for particular cohorts e.g. testing of children;
- Proposed model assumes 10,000 tests daily in community (9,000 via GP referral and 1,000 via central clinically governed team) and 5,000 in acute settings. €30 per GP consultation;
- Positivity rate of 5% of the 10,000 community referrals is assumed, which requires a GP follow up, at a cost of €30 per consultation; and
- Proposed model includes 21 test centres, mix of drive-through and walk-in and combination.

The transition from existing redeployed staff / volunteers to the new service model is expected to occur over time, with a ramp-up of new staff taking place between September and November 2020.

Personal Protective Equipment (PPE)

This initiative centres on the effective management and supply of PPE. This requires a coordinated approach for implementing a national supply chain strategy for PPE, including encouraging indigenous manufacturing. This proposal is based on the HSE's PPE Distribution Operating Model, which has been designed to support the provision and distribution of PPE in compliance with established clinical guidelines. It will ensure a long-term sustainable approach to managing the increased sourcing and distribution activity relating to PPE including additional storage capacity to meet requirements.

A forecasting algorithm is being developed in conjunction with Department of Health. At pandemic pricing levels, this algorithm calculates that an additional requirement to the value of €415 million PPE related funding will be required by year end 2020, with a further amount to the value of €1,155 million in for the full year of 2021. It is expected that HSE will realise some price reductions as markets soften.

This forward-looking strategic procurement approach to PPE is based on leading international practice and is critical to supporting the Irish health service.

Public Health



Community Response Teams

In response to the COVID-19 pandemic, COVID-19 Response Teams (CRTs) were established by Area Crisis Management Teams (ACMTs) to provide additional support to any Long Term Residential Care Facility (LTRCF) inclusive of older adult, intellectual disability and mental health, public or private during this time. The CRTs were a vital component to the management of outbreaks within LTCFs 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 and the HSE is required to continue with this support to LTCFs in preparing them for future outbreaks and in managing any potential COVID-19 outbreaks throughout the coming months.

Vaccinations

Influenza

This initiative surrounds maximising the provision of seasonal influenza vaccine to at-risk groups including healthcare workers, and the expansion of the seasonal influenza programme to include children aged 2-12 years. This initiative is required in order to prevent morbidity / mortality from influenza and prevent the associated outbreaks that would place significant stress on health services in a COVID environment.

The major element of this initiative is providing influenza vaccination to children. It is proposed to vaccinate children aged 2-12 years (n=750,000) for this influenza season. The vaccination of children has not been provided previously and will be a new programme, and therefore requires:

- The development of training for vaccinators;
- Changes to PCRS systems;
- Information and communication campaigns for parents; and
- Development of systems to record uptake levels.

COVID-19

It is yet unclear when, and at what cost, a vaccine for COVID-19 will become widely available. Once an effective vaccine is identified, it will require large-scale manufacturing, production and distribution capacity, as well as a mass vaccination campaign which could last 3-6 months. We will remain abreast to the cost involved in this large-scale vaccination programme

Infection Prevention and Control (IPC)

This initiative concerns 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 spikes in cases of 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 HSE 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 adoption of social distancing guidelines.

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 clean hygiene practices including hand washing and cleaning practices;
- Funding to procure necessary ICT systems, upgrade applications and pay for licensing fees; and
- Education and training funds for IPC nurses and link nurses.

Public Health



Wider Public Health

This initiative is about the provision of additional resources for the Department of Public Health (DPH), including medical and non-medical requirements. It includes a breakdown of resource requirements per HSE resource team. This initiative excludes role and responsibility description per resource team.

The additional investment is an essential response to pre-existing capacity constraints that have been exacerbated by COVID-19. The number of resources within the DPH during COVID-19 (May 2020) increased by 214% compared to January 2020 (pre-COVID-19). The increased demand was met by redeploying staff from across the DPH, Department of Health (DoH) and external agencies to DPH Health Protection services. It is reasonable to assume that the core number of staff sitting within the DPH since January 2020 has remained at 254.

This proposal is focused on the targeted recruitment of 158 permanent WTE to respond to the resourcing requirements associated with COVID-19. The additional resources will be allocated to services across DPH, the majority will be allocated to in DPH Health Protection in order to:

- Establish a National Coordination Department Health Protection (NCDHP);
- Strengthen the HPSC pandemic workstream;
- Enable the restructure of the DPH East into 3 Dublin DPH's; and
- Increase capacity on a permanent basis within pandemic workstreams across each DPH.

Communications

The learning from previous Winter Plan implementations and from COVID-19 pandemic communications will guide our approach to winter 2020/2021. There will be six key elements to the communications plan that will come together to support the overall operational system in its management of the winter seasonal pressures in the context of a continuing pandemic scenario.

These communications plan elements are as follows:

Weekly Media Briefings

Over the course of the past two winter seasons and the entire COVID-19 pandemic, the weekly media briefings have proven to be excellent in terms of engaging with the media and the public around key progress and messaging.

Trained Spokespersons

The addition of trained spokespersons, in particular from our clinical staff, over last winter and during the pandemic, both at a local level and a national level has been particularly helpful in engaging the public, media and public representatives.

Staff Communications

The adoption of technology in reaching our many thousands of staff across the country has been invaluable in ensuring that our staff have access to factual, relevant and important information about the challenges, performance and initiatives across the health service.

Public Representative Engagement

COVID-19 and the regular winter pressures are worrying for our population and they will reach out to their political representatives for information and assurance. Continued engagement with government, leaders will continue to ensure they are appropriately briefed and to answer the questions and queries of their constituents.

Performance Reporting

Building on the experience of the previous winters where we have on a weekly basis published our key performance data pertaining to unscheduled care and patient flow in our hospitals and communities, we have over the course of the COVID-19 pandemic issued daily updates on key performance and capacity data.

Advertising

Specific and targeted advertising pertaining to winter initiatives, e.g. vaccination, alternative pathways, hand and respiratory hygiene etc. will be procured across radio, print and social media.

Public Health



Industrial Relations

Early engagement with staff representative bodies will be important in the implementation of service restoration and winter planning 2020/21. There are a number of flexibilities within successive National agreements since 2010, regarding issues including rostering, early starts/late finishes, weekend attendances, redeployment, skill-mix, among others, which will be maximised over winter 2020-21. The roll out of the plan will require an overarching National engagement process, with subsets of this process at Hospital group and CHO level.

Health & Wellbeing

Recent events have highlighted the critical importance of supporting healthcare workers in their efforts to prevent and treat patients, not only in current straitened circumstances but in the midst of a pandemic. Throughout the winter period, we will continue to support our health care staff to mitigate all risks associated with the delivery of care by our employees. This includes all hazards including physical, chemical, biological and psychosocial. This winter, there will be challenges faced by staff, in addition to the existing pressures associated with flu. The additional challenges of COVID-19 outbreaks, sick employees, fatigued employees and the safe return of workers to their workplace will be significant. Over the upcoming winter period, we will continue to provide a comprehensive strategy and workforce plan to mitigate these effects.

Maximisation of the uptake of the flu vaccine amongst health care workers is an absolute priority for the upcoming autumn period. This will necessitate an 'all of health' approach, during the short period involved, with a requirement for an enhanced pro-active involvement from staff representative bodies.

Workforce Planning

The workforce requirement is under ongoing review in response to government decisions regarding COVID-19 and subsequent HSE operational and strategic service delivery decisions. The HSE will remain responsive in terms of workforce requirements and deployment, in the context of COVID-19 challenges, with service responses encompassing both a COVID and non-COVID approach. Our workforce planning will require the appropriate 'shift left' approach, in alignment with Sláintecare priorities.

Given the high demand for FETAC Level 5 cohort of staff within this plan, a triangulated approach between the HSE, private providers and Educational Institutions is required to ensure an appropriate level and flow of such staff. New ways to ensure this flow will be explored, such as an Apprenticeship model.

Recruitment

HBS Recruit has capacity to manage 5,000 appointments annually with an average time to hire of 19-23 wks. During COVID-19, HBS Recruit increased volume output significantly using a scaled back recruitment process with standard job specifications, shorter application forms, reduced timeframes and reduction in clearance requirements prior to appointment. It's expected that recruitment activity levels will continue to rise as the HSE implements this plan, thus, a major national and international campaign to attract talent will be implemented.

This initiative is for the maintenance of Staff Health and Wellbeing, given the on-going pandemic and increasing pressure on non COVID services. It includes the statutory provision of a safe working environment for all staff and mitigation of risk to all physical, chemical, biological and psychosocial hazards. The challenge of COVID-19 will require a sustained response beyond Winter. Increasing activity can be related to the following factors:

- Increased absenteeism and anticipated doubling of occupational health management referrals due to staff exhaustion, and post COVID-19 fatigue;
- Doubling of flu clinics for staff;
- Sustained and increased levels of contact tracing (based on patterns during COVID-19 surge, this is likely to be c. 2000 staff cases per month, for assessment, testing and contact tracing);
- On-going operation of COVID-19 staff helpline; and
- Anticipated increased HSE staffing will increase demand for pre-employment and occupational health services and safety training.

This initiative includes the integration of six key staff supports namely Occupational Health, Staff Health and Safety, Staff Mental Health, Rehabilitation of injured and sick staff, Organisational Health and Staff Personal Health.

eHealth, Data and Information



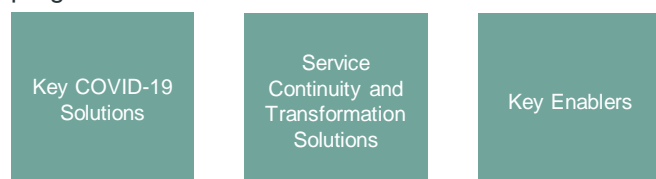
The single, over-arching Recovery Planning and Transformation process being undertaken by the HSE will ensure we have the best chance not only of recovering from the COVID-19 crisis but also capitalising on the best of the clinical, cultural, information and technological changes that are happening as part of the HSE's response to the pandemic.

The Office of the Chief Information Officer will support services in the implementation of key technology enabled solutions as articulated by the services that are required for maintaining the COVID-19 response, underpinning key winter pressure initiatives and facilitating a return to business in an integrated care environment.

Successful delivery of the solutions is dependent on the following:

- Business Sponsorship: each solution must have a clear business sponsor who is responsible for identifying, articulating and driving the business benefit inherent within the respective business case;
- Clinical Leadership: where appropriate, solutions must have clear clinical leadership for the duration of the initiative from inception through to deployment and benefits realisation;
- Transformation Project: these solutions must be viewed as transformation projects where ICT is an enabler of change but the transformation is being led by the business; and
- Outcome Based: projects must have clear and defined outcomes which enable metrics to be identified to drive and evaluate project success.

Three categories of technology solutions encompass 28, large individual projects within the overall programme:



The following are a selection of the projects that will directly support the recovery and winter pressure requirements;

Enterprise Appointment Scheduler

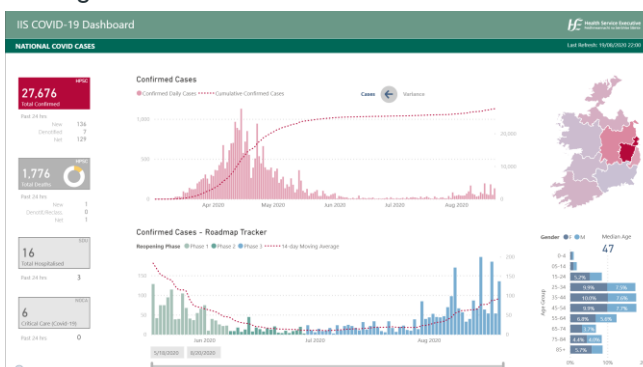
A facility available across the health service that enables referrals for services such as consultations (including tele-health video and remote consultations), screening, vaccinations and diagnostic tests to be received, schedules in primary, community and acute care to be created in line with available resources and appointment slots to be assigned and communicated to patients and clinicians. The scheduling functionality takes account of constraints and seeks to optimise resource usage and track outcomes for e.g. Do Not Attend (DNAs).

National Waiting List Management

Application that consolidates waiting list information for acute and community services. Information for inpatient, day case and outpatient service users is collated and organised at a national level with information flowing to and from the national waiting list management system and other key operational systems. Waiting list information can be interrogated and actively managed to ensure optimum patient flow.

Analytics and reporting

During the pandemic, the delivery of a connected, combined and shared data infrastructure that provided insights and situational awareness to manage the crisis was a success. A centralised data repository (Health Analytics and Insights) was delivered, which provided an aggregated source of truth providing accurate and robust digital data and information to support evidence-based planning and operations. The Integrated Information Service (IIS) delivered the IIS COVID-19 Monitoring Dashboard and a total of 3 dashboards under Test and Trace at the end of June 2020; an additional 1 (serial testing) in July and August has been added and 5 additional dashboards across strategic initiatives to the end of 2020 are in train.



eHealth, Data and Information



Analytics and reporting (cont'd)

This initiative is to ensure the provision of additional skilled resources to support the growing demand for reliable, timely and accurate health insights across our strategic reform initiatives such as Scheduled Care, Enhanced Primary and Acute Care, as well as Services Continuity and Test and Trace for COVID-19. It includes resources to support data analytics and insights initiatives underpinning these strategic initiatives.

Health Performance Visualisation Platform

As we plan and manage the safe delivery of our service in the context of COVID-19, we urgently need the necessary data flows and analytics capacity to see what is happening, in terms of activity, waiting lists, bed flow blockages etc., across our hospital network to safely manage our services during this pandemic in real time. In particular, there are five domains where this platform will provide clear real time visibility, outlined below:

- Outpatients: daily waiting lists at hospital and at patient level with reliable data on the productivity of clinics by speciality in each hospital
- Procedures (surgery): daily waiting lists at hospital, patient and procedure level, to provide greater understanding of the productivity of theatres and procedure rooms
- Emergency Departments: build on the current limited ability to see demand, capacity and the admissions process by Hospital to identify any bed flow challenges or blockages
- Beds: national critical care and general bed capacity and demand, monitor inpatient lengths of stay, the timeliness of discharge, and the likelihood of readmission
- Diagnostics: Daily waiting list for access to diagnostics and scopes to ensure people have early diagnosis and can be directed to appropriate services if needed

The aim of this initiative is to implement a Health Performance Visualisation Platform (HPVP) commencing September 2020 with completion of phase 1 by December 2021 with 28 hospitals live.

ePharmacy & ePrescribing

ePharmacy provides the ability to deploy digital solutions across different care settings to make the delivery of pharmacy safer and more efficient. The initiative will provide capabilities including:

- National pharmacy system for acute and community residential settings;
- Development of a standardised National Medicinal Product Catalogue
- Electronic prescriptions in primary care;
- Adoption of EU wide pharmacy standards; and
- Continued supported Roll out of the National Cancer Information System (NCIS).

Immunisation

A National Immunisation Information System (NIIS) will support the workflow processes and management of immunisation campaigns for both children and adults nationally. The NIIS will interface with other service provider systems including GP, Pharmacy and PCERS etc.

Home Support Management System

Case management system for home help that enables day to day assignment and delivery of home help through careplan development and management, appointments and scheduling, quality audits, reporting and staff scheduling.

Residential Care Management System

Case management system for residential care that enables day to day care of residents through case management, careplan development and management, assessments, appointments and scheduling, quality audits and reporting.

Community Hub Management System

The Community Hub Management System will support patient care management in the Community Setting. A solution is required to facilitate referrals, waiting list management, appointment scheduling and administration, assessment, care planning and case management.

