COVID 19 MEASURE	Planned Gross Cost	Estimated Revenue Costs 5/05/2020	Estimated Capital Costs 5/5/2020	Estimated costs to 5/06/2020	Specific Sanction Received
COVID Action Plan	**€m**	**€m**	**€m**	**€m**	
Other Accommodation & Isolation Facilities	66	2	1	3	
Acute Hospital	146	13	37	50	
Private Hospitals *	426	234	-	234	24-Mar
Temporary Payment Assistance Scheme	73	27	-	27	03-Apr
Community Assessment Hubs	27	3	5	8	01-Apr
Absenteeism	62	1	-	1	
Redeployment to Public Health	-	2	-	2	
Contact Tracing	2	2	-	2	
COVID Related Consultancy	-	2	-	2	
Student Nurses	41	13	-	13	06-Apr
Medical Interns	25	3	-	3	02-Apr
Balance of €1,827m Planned Gross Costs	296	-	-	-	
Indirect COVID Impacts - Hospital income	-	36	-	36	
Indirect COVID Impacts - PCRS	-	21	-	21	
TOTAL	**1,827**	**801**	**131**	**932**	

* private hospital expenditure is based on the actual cost for April-20 and an estimate for May & five days of June. expenditure pending completion of a review of actual expenditure incurred by the private hospitals for the period in line with the agreement in place. It also includes private consultant costs in April and May.

26. The Health Service Executive is producing a weekly report on expenditure on COVID-19 and this is considered by the Health Budget Oversight Group. This report provides an estimate of the gross expenditure position and is not intended to fully represent the totality of COVID-19 related expenditure for the period encompassed. It is a subset of known and estimated COVID-19 spend as reported on a weekly basis. The HSE notes that there are likely to be costs directly incurred or loss of income at local level for which there is no national visibility on a week to week basis. The normal monthly financial reporting by the HSE has sought to capture these local costs.

Details in respect of specific measures

Private Hospitals

27. In line with Government Decision S180/20/10/0648, a sum of €426m was sanctioned as being the minimum required to secure 100% of the capacity of the private hospital sector for 6 months. The HSE is committed to meeting the eligible costs of the participating private hospitals on a cost only basis for the period of the arrangement.

28. The arrangement was put in place from 30th March 2020 for an initial period of three months, with the requirement that notification be provided by the Health Service Executive no later than 30th May if the arrangement were to continue beyond the initial period or not.

29. Following submission of a Memorandum on Friday 29th May, Government decided (Ref S180/20//0648B) not to extend the arrangement with the private hospitals, and notice was served by the HSE to this effect. Negotiations have commenced to secure a new arrangement with the private hospitals to be effective from 1 July.

[redacted]

Personal Protective Equipment - PPE

31. Due to the urgent nature of the need for PPE, specific sanction of €208m was provided to the HSE on the 17th March to procure supplies from China. An additional €44m was also allocated for supplies from other vendors. This funding is included in the overall funding approved by Government (refer S180/20/10/0648).

32. To June 5th, €370m worth of PPE has been delivered, based on the latest tracking information. €176m of this relates to the contract with China Resources referenced above and €194m is in relation to contracts with other suppliers.

33. Work is underway in the context of further additional requirements for PPE for the remainder of the year. Future cost estimates are currently based on the HSE's own clinical guidance of requirements and a demand model prepared by PwC, which is being assessed in the context of compliance with the Public Spending Code.

34. The HSE reports that potential purchase costs associated with PPE needs are some five times higher compared to pre-COVID prices for the same volume. Recognising these developments and the importance of security of supply, consideration is being given to the promotion and development of indigenous industrial capacity to contribute to meeting Ireland's supply needs into the future. The Department of Health plans to engage further with the Department of Business, Enterprise and Innovation, and relevant agencies on this matter.

Testing and Contract Tracing

35. The National Public Health Emergency Team has recommended that the health service needs to increase testing capacity to 100,000 tests per week for the remainder of 2020. This is a critical public health intervention in the context of the Government's Roadmap for Reopening Society and Business.

36. The HSE has developed a plan for building its capacity to 100,000 tests a week for the remainder of 2020, and the necessary capacity has been secured with both national and international laboratories. Planning and logistics are being completed which will reduce the turnaround time from swab to result significantly.

37. The cost identified by the HSE is in the region of €375m in 2020 to provide capacity for 100,000 tests per week in addition to the €41m referenced above. This represents a very substantial and additional cost over and above existing approved funding. This cost will reduce if the level of testing actually undertaken is below 100,000 per week, and contracts have been negotiated to try to minimise the nugatory risk that the State could be paying for activity not utilised; however, to secure the relevant capacity, this risk cannot be fully negated.

38. The Government considered the testing and tracing proposal at its meeting of 19th June, and additional funding of €167m was approved to provide for capacity of 100,000 tests to end August. As minimum thresholds have been avoided in most cases, this sum will allow for testing to continue beyond end August where actual testing levels do not reach this capacity. Any additional funding required beyond this sum will be subject to further consideration by Government and a Supplementary Estimate.

GP COVID-19 Contract Costs

39. Sanction of €110m was provided to the HSE on the 16th March for GP services and is included in the funding approved by Government (refer S180/20/10/0648).

40. To June 5th the Health Service Executive has reimbursed €53m to General Practitioners, representing:
    - €3m for 42k respiratory clinic consultations, 51% of estimate consultations (78k)
    - €45m for circa 1.7 million telephone consultations, representing 63% of estimate telephone consultations (2.7m)
    - €1m for 21k GP extended day consultations,
    - €4m for 102k out of hours consultations.

41. The scheme is a three month scheme and expired on 14th June 2020. The Minister for Health and the Minister for Public Expenditure and Reform agreed that the scheme be extended for a further eight weeks to 10 August as follows;
    1) The payment of €30 for COVID consultations for all patients will be continued. Any further extension beyond 10 August will be subject to review in advance of 10 August.
    2) The payment of €75 for dedicated COVID respiratory clinics for all patients will be continued. Any further extension beyond 10 August will be subject to review in advance of 10 August.
    3) The payment of €25 for remote consultations with GMS patients will be continued to 10 August but not beyond that date.
    4) Payment for extended hours consultations at the higher rate of €41.63 will be discontinued from 14 June.

42. The cost of the above approach will be demand-led and thus difficult to forecast with certainty. For the purposes of modelling, the demand for services as experienced in the week from 23 to 29 May inclusive, the latest period for which we have figures, has been used. On this basis the estimated additional expenditure is €38.4m. It is anticipated that this extension can be accommodated within the original sanctioned amount of €110m.

Private Nursing Home Assistance Scheme

43. On 3rd April 2020, sanction was received for €73m for temporary assistance payments to support resilience and service continuity in private and voluntary nursing homes.

44. Two separate payments are available under the Temporary Assistance Payment Scheme (TAPS). The standard assistance payment is available to all providers to help meet additional costs incurred in building resilience (Form A). The second payment is only available to nursing homes with a confirmed outbreak, in recognition of the additional costs in dealing with an outbreak. (Form B)

45. [redacted] Expenditure on the scheme is being tracked closely to ascertain whether and when a sanction request for additional funding may be required as a result of the extension of the scheme.

46. The Scheme was originally intended to operate for three months and is currently under review by the Department of Health and the Department of Public Expenditure & Reform with a view to determine the need for an extension of the scheme or the parameters of an extension within the context of direct supports now provided by the HSE e.g. PPE, clinical supports for outbreaks.

Isolation facilities in 3rd Party Providers – Citywest

47. On 25th March sanction was provided for expenditure associated with the establishment of an accommodation hub and emergency hospital at the Citywest hotel for a period of 7 months. This included 756 hotel rooms, with capacity of over 1,000 people, as well as the potential to establish an emergency field hospital within the convention centre, which would have the capacity of 700-900 beds.

48. To May 31st the Health Service Executive reported that a total of 528 people had been isolated in the facility, with 47 in residence at the end of May. It has not been necessary to bring the field hospital into operation.

49. The low occupancy rates are a direct result of the positive impact the public health measures have had on reducing infection and avoiding existing health services being overwhelmed. Although current occupancy rates remain low, it is important to recognise the potential for further waves of the epidemic in which case there is a substantial contingency valuation in retaining additional reserve capacity. At the same time, consideration is being given to identifying alternate uses for the facility should occupancy remain low, as the contract cannot be terminated before October.

50. The license with City West includes a 120 day break clause and the earliest date the HSE can exercise this clause is 23 June 2020. Engagement through the HBOG is well advanced in relation to potential alternative uses for the facility over the remainder of the current license agreement, in the event of low surge requirements, and regarding potential future use beyond the current license term. A decision by the HSE to extend the agreement beyond its current term would be subject to separate sanction.

Capital

51. COVID-19 related Capital Expenditure to the 5th June amounts to a total estimated spend of €86m. The majority of the acute capital spend is for intermediate care beds and acute beds. The community spend relates community nursing beds, the roll out of the Community Testing Centres followed by the roll out of the Community Assessment Hubs for the management of conditions in the community and the avoidance of hospital referral, with 29 Hubs opened as at 31st May.

52. Due to the urgent nature of the need for ventilators, specific sanction of €74m was provided to the Department on the 21st March for the HSE to procure supplies; this is included in the funding approved by Government (refer S180/20/10/0648 & S180/20/10/0648A).

53. Additional cost has also been incurred for Medical Gas upgrades which allowed for oxygen supplies to be provided in acute hospitals outside the ICU environment, thereby providing more High Dependency access. ICT investment, the majority of which was to facilitate HSE staff working from home where possible and for system development to facilitate new referral and work processes, accounts for the remainder of the capital expenditure.

Risks to overall costs

54. To date, €1,997 million has been sanctioned in gross terms based upon an assessment of the gross cost of known measures at that time. The approval is on the basis that the net impact on the Health Vote would need to take account of any impact of displaced activity, redeployment of staff and reprioritisation of service developments. Limited data is available at this point to properly assess the overall impact of COVID-19 on expenditure on the Health Vote.

55. On the positive side, there are some areas of expenditure within the approved figure which are anticipated to underspend in 2020. In addition, displaced activity, the potential for consideration of the postponement of 2020 new developments and staff redeployment will have a positive impact on the overall net impact.

56. However, as set out above, substantial measures including PPE and private hospital capacity will be subject to separate consideration by Government. The gross 2020 cost associated with these measures is substantial.

57. Other significant risks have been identified from the outset of the COVID-19 response which have not been addressed within the additional gross sanction, including
    - challenges to the achievement of savings set out in the NSP (e.g. 1% efficiency reduction in disability provider budgets, reduction in pharmacy fees, general vacancy control, agency / overtime conversion, overhead and procurement efficiencies) – over €250m target in NSP

    - the potential increase in GMS coverage as a result of unemployment and substantial pressures arising in Section 39 and other private providers not encompassed within the Nursing Home Assistance Scheme.

    - The impact on acute hospital and community income (driven primarily by the loss of private income) is likely to be substantial – PHI income alone in the acute sector is budgeted at over 500m and the impact of reduction / cessation of services is unknown at this stage.

58. At this stage, it is too early to anticipate the effect that the pandemic may have on unemployment levels and the direct correlation with medical card entitlement, although this is being kept under close review. In that regard, Government decisions in relation to the continuation or otherwise of the COVID-19 Pandemic Unemployment Payment will be central to the potential for growth in medical card numbers in the coming months. The Department of Health estimates the half year cost at €5m per 10,000 additional cards.

59. Taking account of the above and acknowledging that Government decisions will be required for additional expenditure measures, there is a risk that the net impact on the Health Vote could be significantly in excess of the amount sanctioned to date. This impact will be kept under close review and further monthly updates will be provided to Government.

Summary

60. To end May the Health Vote was €1,061m ahead of profile, comprising a €1,062m overspend on current expenditure offset by a surplus on capital of €1m and a small surplus on Appropriations in Aid. HSE Vote expenditure is ahead of profile due to direct expenditure on the COVID-19 National Action Plan measures and indirect costs associated with loss of income, inability to achieve savings and supplies stockpiling.

61. While Government approval has to date been given for €1,997m gross expenditure in relation to the planned response to COVID-19, this was subject to the finalisation of a net position at a later date. The net adjustment to the Health Vote for 2020 in relation to the COVID-19 National Action Plan is yet to be determined. Discussions with the Department of Public Expenditure and Reform are indicating that the REV adjustment for Health will be limited to the above sum already approved by Government, which would exclude substantial costs set out in Section 11 above. However, the Minister for Public Expenditure and Reform, in his memorandum to the Government last week (Ref: DPE/053/005/2020) notes that there is uncertainty in relation to the ongoing impact of COVID-19 on certain sectors and that further measures may be necessary after the Revised Estimates for 2020 have been agreed by the Dáil. Any decisions for future health measures will be subject to consideration by Government and any further costs arising would be dealt with by way of Supplementary Estimate.

ACCOUNTING UNIT

1. The Accounting Unit are responsible for supporting the Secretary General in successfully discharging his role as Accounting Officer for the Department. The unit's primary responsibility is processing, accounting for and reporting on all payments made by the Department. This culminates in the production of the Annual Appropriation Account and managing the audit of these financial statements, performed by the Office of the Comptroller and Auditor General (C&AG). This usually takes place in the months of February and June. The unit also assists the Office of the C&AG with chapters of its annual report and the annual audit of the HSE financial statements.

2. The unit is responsible for payments to:
    - HSE
    - Other agencies
    - Tribunals & Inquiries under the aegis of the Department
    - Other legal costs
    - Funds such as Sláintecare and Healthy Ireland
    - DoH staff pay costs
    - Non-Pay administration costs
    - Miscellaneous expenditure including payments to thalidomide survivors and funding regional and local drugs task forces

3. In 2020 these payments will amount to approximately €20bn. Approval for payment of grant-in-aid funding to the HSE and all funded bodies under the aegis of the Department comes from the Vote Management Unit. All other instructions to pay are approved by the respective line units within the Department.

4. All grant payments and payroll preparation is performed by staff working remotely in line with current recommendations. The unit expect to be in a position to process all remaining non-pay instructions to pay remotely in the coming months.

5. The unit produce monthly financial performance reports for the Department of Public Expenditure and Reform (both forecasts and returns) and the Parliamentary Budget Office on the Department's financial performance. The unit provides internal monthly reports for budget holders across the Department. Periodic reports are prepared for other stakeholders including the Department of Finance, Central Statistics Office and the Hepatitis C and HIV Compensation Tribunal.

6. The unit discharge all liabilities on behalf of the Tribunal and assist the Tribunal Secretariat in completing the Tribunal's annual report. The unit are also responsible for completing the annual financial statements for the Hepatitis C and HIV Compensation Tribunal Special Account and Reparation Fund as set out in sections 10 and 11 of the 1997 Hepatitis C Tribunal Act. These entities are under the aegis of the Exchequer function in the Department of Finance.

7. The Accounting Unit holds the co-ordination role for the Department's own funds in the annual estimates process and the profiling of this expenditure. The unit liaises with individual line units, as well as across all the Corporate Services division, to identify the Department's requirements for the following year. When the budget has been completed, the Department work with the units for the Revised Estimates to identify the most effective utilisation of allocated resources.

Summary of Covid-19 Issues

Health Sector Workforce expansion

1. Maximise and supporting the work force in response to the Covid-19 pandemic is a key priority. From a staffing perspective this included a number of strategies inclusive of drawing from existing recruitment pools, increasing the hours of part time staff, leveraging agency usage, rehiring of retired clinicians, redeployment of staff and encouraging those on career break to return early, and the postponement of annual leave.

2. The unit supports the NPHET Workforce Subgroup. The subgroup's focus is on HR and strategic workforce issues relating to Covid-19 and a key priority of the group is ensuring that the Health Sector Workforce is supported to meet the increase in demand associated with the response to Covid-19.

3. The HSE have recruited nationally via their Health Business Services recruit team, as well as locally via Hospital Groups/Community Healthcare Organisations. Health care workers have also been employed on temporary contracts on via the HSEs Be on Call for Ireland initiative, although for the most part, the other workforce maximisation measures were more heavily utilised.

4. These measures, along with the temporary contracting of student nurses as Health Care Assistants, and students as radiography assistants and medical laboratory assistant, together with the early intake of medical interns will have implications in relation to the pay budget and staffing levels set out in the HSE's Pay and Numbers Strategy for 2020 as agreed with the Department of Health and the Department of Public Expenditure and Reform. As many of the Covid related posts are temporary, it is too early to measure the ongoing impact, but these matters are currently under consideration.

5. In total, to date €490m in additional pay funding, and up to c.5,000 whole time equivalent (WTE) staff have been approved in principle to support the response to the Covid pandemic. The following table outlined the recruitment position at 1 June 2020 as advised by the HSE, however, it does not include recruitment that may have happened locally and is reported in arrears:

Posts Filled - COVID 19	
HBS Recruit	1627
HCA Conversion	2,199
Be on Call	166
Medical Interns	951
TOTAL	**3969**

Programme for Government Commitments

6. The efforts set out above in relation to the maximisation of the public health sector workforce may support the Programme for Government measures relating to the recruitment of additional frontline staff.

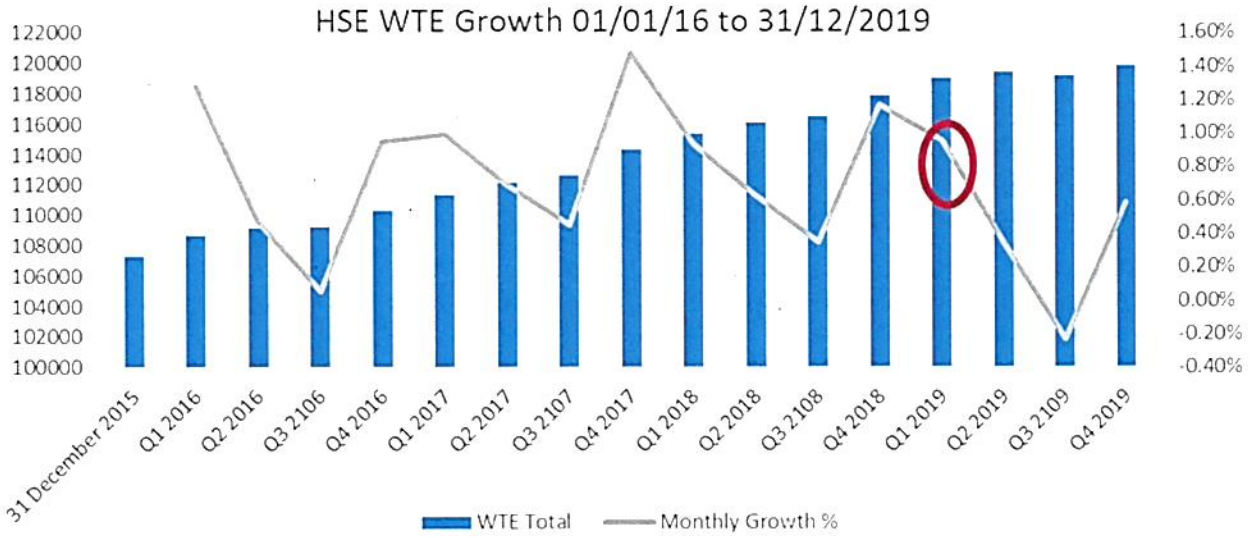
Unit Summary

- Oversight and implementation of government policy in the health sector in respect of numbers employed, pay, pensions and the terms and conditions of employment.
- Responsibility for the pay budget, overall staffing levels and related organisational issues.
- Sanction holder for senior management posts (Grade VIII and above in Management & Administration staffing category).
- Provision of pay and superannuation policy clarification and guidance to the HSE and Non-Commercial State Agencies (NCSAs).

HSE Pay Budget and Staffing levels (pre Covid)

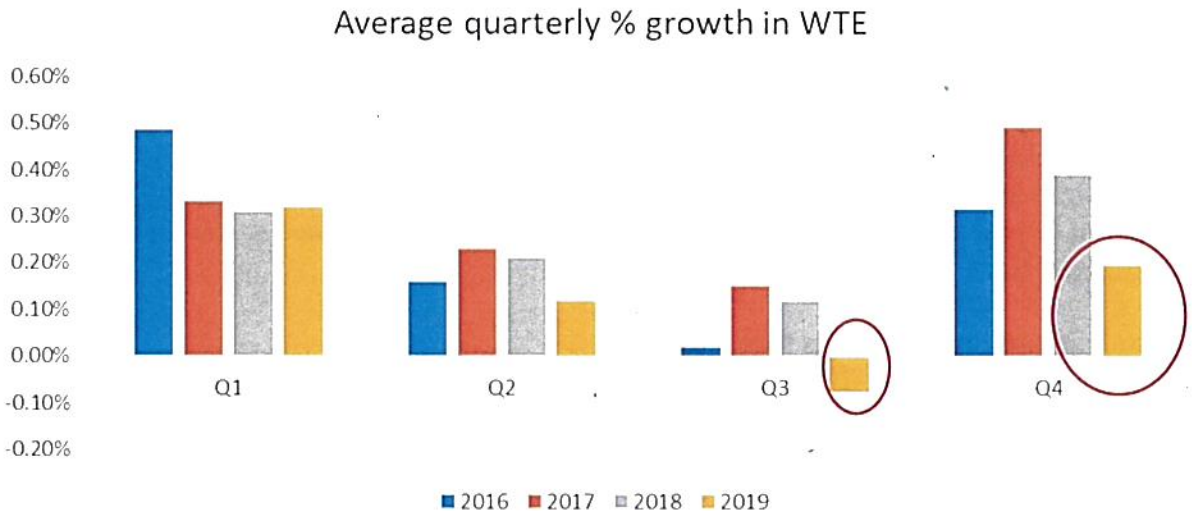
7. In line with the Health Act 2004, as amended, the Health Service Executive (HSE) National Service Plan must contain estimates of the number of employees of the Executive during the period.
8. Pay is often the biggest single driver for each of the services and for the implementation of policy decisions. (Pay budget is c.46% of the overall HSE budget). It is also a driver of higher pension costs.
9. The number of Whole Time Equivalent (WTE) staff has evolved as a key barometer of success in managing the health sector from a pay budget and employment control perspective.

The following table shows the total numbers and growth trend on a quarterly basis since 2016:



Recruitment control measures

10. The HSE introduced recruitment interim control measures in early 2019 (circled red above) due to staff levels being significantly beyond budget and restated the controls in September 2019.
11. Notwithstanding the controls, funding continued to be available for the ongoing recruitment of approved funded development posts and critical posts. Thus, while the rate of growth (grey line above) decreased, overall staffing levels did continue to increase where funding was available. (There was no 'embargo' or 'moratorium').
12. Similarly, the increase in recruitment which traditionally occurs in Q4 each year (hiring of student nurses etc) occurred in 2019, just at a more controlled and affordable level than in previous years as evidenced in the following table:



13. Similar staffing controls were planned for 2020, distinguishing between services which are operating within profiled monthly pay budgets and those who are operating on an unaffordable basis.

14. Notwithstanding the controlled recruitment environment, funding was available during 2020, and recruitment is allowable in relation to:
    - Services with a sustainable 2020 financial breakeven position
    - Funded service development posts
    - Slaintecare Integration Fund
    - Brexit Funded posts
    - Critical posts
    - Posts relating to conversions from agency and overtime.

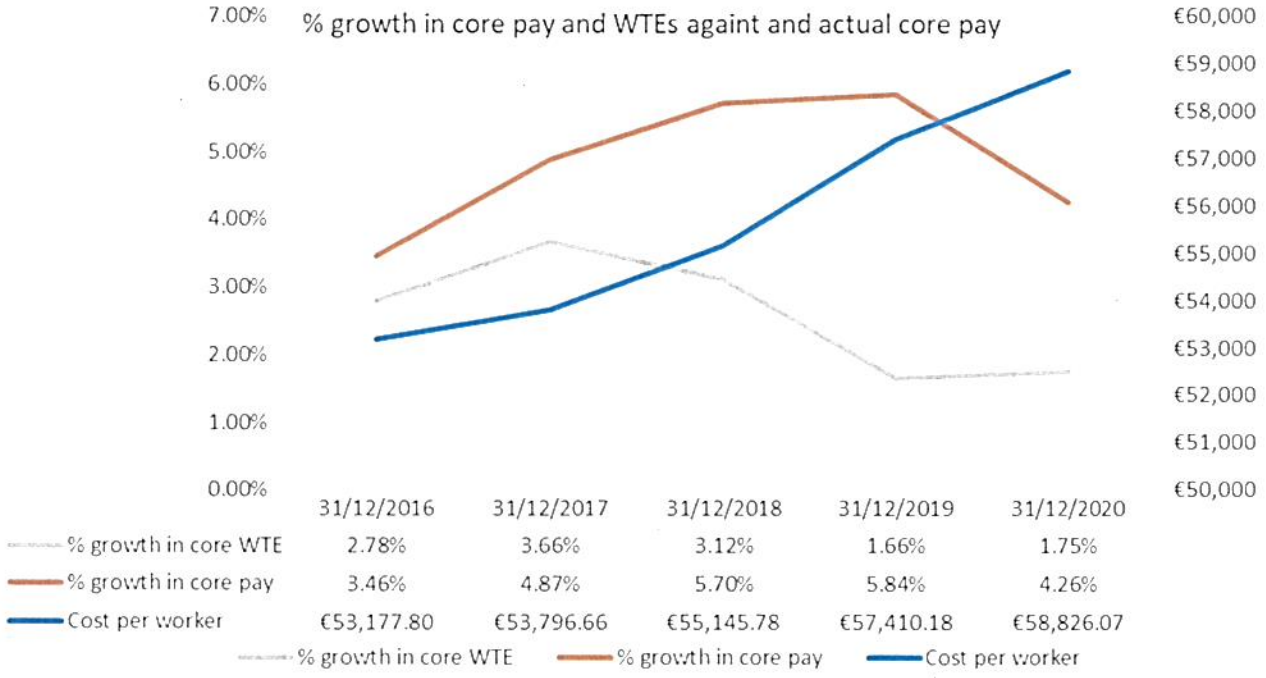
15. However, due to the increase in staffing requirements in response to COVID-19 emergency, recruitment controls were relaxed, and numerous recruitment initiatives have taken place since March 2020 to maximise the current workforce. Work is ongoing to determine what level of 'business as usual' recruitment took place, and the need for ongoing Covid related hires.

Pay Budget (pre Covid):

16. The pay bill for the HSE continues to grow and is a function of both price (pay increases; IR deals) and volume (increased staffing numbers). The following table details the pay budget for the HSE (including Section 38 services) for the last 4 years and projection for 2020, comprising core pay, overtime and agency pay. Overall pay is, on average, 45% of the entire HSE budget, with overtime and agency consistently at 4% and 6% of the pay budget respectively. Agency and overtime rate are both functions of the pay rate, and thus increase correspondingly.

Year Ending	31/12/2016	31/12/2017	31/12/2018	31/12/2019	31/12/2020
Core Pay	€5,863.29	€6,148.78	€6,499.32	€6,878.72	€7,171.70
Overtime	€235.18	€255.93	€279.44	€293.04	€280.92
Locum / Agency	€344.84	€367.16	€403.97	€423.28	€421.38
Total Pay Budget	€6,443.31	€6,771.87	€7,182.73	€7,595.03	€7,874.00
HSE Exchequer Funding	€14,100.00	€14,800.00	€16,000.00	€17,500.00	€18,300.00
Pay as % funding	46%	46%	45%	43%	43%

17. While the total pay bill has risen in each year, the following table identifies how the increase in the average cost per worker results in a negative correlation between the pay budget and the number of whole-time equivalents (WTEs) employed. This is essentially the impact of increasing pay from public sector pay deals and collective Industrial Relations (IR) related outcomes.



	31/12/2016	31/12/2017	31/12/2018	31/12/2019	31/12/2020
% growth in core WTE	2.78%	3.66%	3.12%	1.66%	1.75%
% growth in core pay	3.46%	4.87%	5.70%	5.84%	4.26%
Cost per worker	€53,177.80	€53,796.66	€55,145.78	€57,410.18	€58,826.07

Delivering on Key Policy Initiatives

Pay and Numbers Strategy (PNS) 2020

18. This was due to be reviewed and agreed to by the department in February 2020. Decisions may have to be made regarding service development funding, employment controls and the HSE's planned strategy to balance service delivery with containment within the pay budget.
19. The impact of Covid 19 related recruitment on the PNS will not be fully realised until the end of the year and PNS 2021 will seek to further expand and support the health workforce.

HSE central management function restructure

20. The HSE advised pre Covid of a review it is undertaking of its central senior management structure. [redacted] The impact of the Covid emergency period has now to be considered in the context of any planning in this regard.

Overall Function of the Unit

1. To support the development and implementation of Government policies on employment in the health sector in respect of pay and terms and conditions of employment for all grades in the public health service. The objective is to develop and implement pay policy in a manner that supports the implementation of health policy, is consistent with the financial parameters set for the health service and maintains industrial relations harmony.

Industrial Relations matters in the context of COVID-19

Supporting efforts to maximise the workforce

2. Several workforce initiatives were facilitated and supported through various Industrial Relations engagements between the trade unions / worker representatives and health service management, involving other stakeholders as required. These initiatives helped supply much valued additional resources to the health service as the public health emergency evolved. Among these were a redeployment agreement to support nursing homes and other initiatives to utilise healthcare students and graduates as part of the overall effort to provide further resources to the health service during the emergency.

Industrial Relations Management during COVID-19

3. The HSE and worker representatives met regularly (usually twice weekly) on matters arising during the evolving public health emergency. The Department also provided a representative to this forum, to assist where required on matters arising and to link in with the wider Department of Health. The forum also assisted management with supporting communication and clarifications on important developments, such as regular updates on staffing levels, PPE provision, occupational health matters and HR circulars. While the HSE have confirmed that a collaborative environment has been maintained between management and the trade unions in dealing with matters arising during this emergency, there are matters where resolution has not been possible, and these will be handled in due course through the normal industrial relations adjudication process.

Significant Events/Milestones

Pay Talks on the successor to the Public Service Stability Agreement (PSSA) 2018 to 2020.

4. **The *Programme for Government* commits to seek to negotiate a new public pay deal with the public service unions: 'Our approach to those negotiations will be guided by the State's financial position and outlook, challenges in relation to recruitment and retention, and conditions within the broader labour market, and will be anchored in the respect for the important role played by public servants. As part of any pay deal, we will ensure that there is an emphasis on embedding positive work practice changes that have emerged due to the COVID-19 Emergency as well as general productivity gains and effectiveness based on measurable outcomes'.**

5. Whilst the current PSSA is in existence until the end of December this year, preparations for successor talks are continuing. Over the past four years, pay agreements (PSSA and others) have increased the pay bill for c.€1 billion in 2020 over 2017 base. Therefore, it is critical for the financial stability of the health service to ensure that any agreements that form part of the next PSSA are fully costed, fully funded and support the Slaintecare reform programme.

IR Unit - Nursing

General Context – Nursing Recruitment and Retention

6. The overall numbers of Nurses and Midwives working in the public health service are higher than ten years ago and substantially up (12%) on 2013 (the year when numbers of nurses and midwives were at their lowest in the period). However, there are particular grades where there has been a noticeable reduction in staff numbers during the same period, in particular, the psychiatric nursing cohort.

7. **The *Programme for Government* commits to continue to implement the Nursing Agreement, which includes additional measures to assist with the recruitment and retention of nurses into the public health service. In particular, it commits to 'establish an expert group on nursing and midwifery to advance the nursing and midwifery professions'.**

Nursing Agreement

8. The Nursing Agreement 2019 combines the findings of the Public Service Pay Commission (PSPC) and the Labour Court recommendations (LCR 21900/1) to resolve the Nursing Dispute. These measures should have a positive impact on the overall recruitment and retention of nurses and midwives. The Agreement includes measures that are envisaged to 'begin a process of transformation of the profession', including a new Enhanced Nurse Practice (ENP) role as well as improvements in pay and allowances for certain grades and locations. An agreement was also reached with the Psychiatric Nursing cohort, underpinned by elements contained in the agreement for General Nursing, with similar measures agreed to resolve the dispute and a way forward for unresolved matters. The HSE have continued to roll out the new ENP role despite the challenges posed to local HR departments during the COVID-19 pandemic. The Expert Review Body, which forms part of the Agreement, is scheduled to commence its work shortly.

IR Unit - Allied Health Professionals

9. **The *Programme for Government* makes a commitment to engage with radiographers, paramedics and healthcare assistants on how their roles can be developed.**

Radiography review

10. A national review of radiography services as provided for by a 2012 Labour Court Recommendation (LCR) has recently been completed. It is anticipated that this review will be raised by SIPTU during the pay talks. A key recommendation that SIPTU wish to progress is in relation to an advanced practice role for radiographers.

Section 39 Organisations – Pay restoration (Ref C162968-18)

11. Section 39 agencies are agencies under Section 39 of the Health Act 2004 where the HSE provides a grant to allow the agency to provide services similar or ancillary to the HSE. Phased Pay restoration for 50 agencies involved in a pilot commenced with an effective date of 30 April 2019. Costs for this pilot was €7.5m. Under the WRC agreement, a further process is required for the remainder of S39 funded agencies (approx. 250). Despite the engagement that took place at the WRC, it was not possible to reach an agreement between the parties. It is hoped that when the demands of the pandemic allow, engagement at the WRC can be reconvened.

Job Evaluation Scheme for Support Staff Grades (LCR 22066)

12. As part of the talks which took place under the Lansdowne Road Agreement, a chairman's note was agreed by all parties on the reintroduction of a Job Evaluation Scheme in the Health Sector.

Following extensive engagement and industrial disputes, the process is being conducted over 4 Phases. Funding has been allocated for Phase 1 and 2 which is in the process of implementation. The outcome of phase 3 has recommended that uplifts are awarded to home care support employees. The outcome of phase 4 is awaited. The significant cost implications associated with the implementation of phase 3 and 4 (covering approx. 14,000 WTE and estimated by the HSE at c.€15 million) will be considered in the context of the annual estimates process.

Chefs (LCR 22065)

13. Industrial action relating to Chefs in 2019 was referred to the Labour Court who recommended that a joint process should take place to build upon work already done by SIPTU. A steering group was established to conduct a review of the role of the chef grades. DoH and the HSE are engaging with DPER in relation to the findings of the report. The estimated cost of €2.9m will be considered in the context of the annual estimates process.

IR Unit - Medical (other than GPs)

14. **The *Programme for Government* makes a commitment to finalise the new Sláintecare consultant contract and legislate for public-only work in public hospitals. It also commits to increase the number of public only consultants in our hospitals.**

Consultants – Proposed Sláintecare 'Public only' Contract

15. In December 2019 the Government agreed to introduce a new contract for consultant doctors as part of the move towards the long-term goal of universal, single-tier healthcare - as envisaged in the Sláintecare Report (2017) and the Report of the Independent Review Group (2019). Key parts of Government decision:-

- From a date in Q1 2020: to be agreed by the Minister for Health and the Minister for Public Expenditure and Reform:
- all consultant appointment on the Sláintecare Contract public-only consultant contract
- existing consultants will be offered the opportunity to switch to the new proposed contract
- the new contract will be offered at increased pay levels - max of €252,150 with the completion of FEMPI restoration no later than July 2022
- The salary scale for Slaintecare Contract is fully aligned to the existing pre-2012 Type A.
- **Legislation is required to introduce the Contract for serving consultants.**
- Subject to available resources and annual Estimates discussions, the number of consultants will be incrementally increased by a net 1,000 whole-time-equivalents over the next 10 years.
- The 2020 Estimate does **not** include funding for implementation.

[redacted]

Consultant status and pay for Public Health Specialists

17. As envisaged in Sláintecare, the Scally Report (Cervical Check) and the MacCraith Group in relation to the future role of public health, it is considered imperative that public health specialists be accorded consultant status in the coming year, in line with the status they have in other countries. This is being progressed as part of the body of work in train (being led by the CMO's Office and HSE's leadership team) to finalise future structures for Public Health in Ireland that will enable Sláintecare.

Governance of Scheduled and Unscheduled Care within the Department of Health

1. The Department has placed a particular priority on performance improvement in scheduled and unscheduled care in order to improve access for patients. At the end of 2017, a new Unit was established in the Department with a remit to work with colleagues in the HSE and National Treatment Purchase Fund (NTPF) to provide strategic direction and drive a whole-of-Department approach to performance oversight and innovation in this area. The monitoring and reporting on waiting list and ED performances are key activities of the Unit. The Unit is headed by a Director and 2 Principal Officers each respectively overseeing Scheduled and Unscheduled Care Performance.

2. The function of the Scheduled Care side of the Unit is to develop and maintain effective oversight, monitoring and reporting of HSE performance on waiting lists. The Unit works closely with counterparts in the HSE and NTPF to develop an annual Scheduled Care Access Plan, which sets out activity targets for both the HSE and the NTPF, along with measures to improve care for patients waiting for Scheduled Care. The 2018 and 2019 Access Plans resulted in positive improvements in Inpatient and Daycase (IPDC) waiting lists with a reduction of 18% from 2017 to 2019, and some broader trends in improvement for GI Scopes and Outpatient (OPD) lists. The 2020 Access Plan had not been finalised by March 2020 when the Covid-19 pandemic forced the cancellation of routine elective scheduled care.

3. The Unscheduled Care side of the Unit oversees performance of Emergency Departments and the HSE's winter preparedness plans and associated funding. The Unit holds fortnightly governance meetings with the Special Delivery Unit (SDU) in the HSE to review performance of emergency departments. The Unit also contacts the SDU on a daily basis in relation to sites of particular concern. Daily, weekly and monthly performance reports are prepared and submitted to the Minister's Office. The Unit engages with the HSE on winter planning to set out the approach to ensure that service providers are prepared for the additional external pressures associated with the winter period.

4. The Unit also works with the Slaintecare Implementation Office on the issue of access and capacity for acute hospital care. It was involved in the NPHET Acute Hospitals Preparedness and Vulnerable People Sub-Groups and was the central Department Unit overseeing the arrangement with private hospitals in response to Covid-19

The main issues dealt with by the Unit are outlined below.

Scheduled Care

2020 Suspension of Elective Scheduled Care

5. In response to the pandemic the HSE had to take measures, as recommended by NPHET on 27th March, to defer all non-urgent elective scheduled care activity. This was to ensure patient safety and that all appropriate resources were made available for Covid-19 related activity and time-critical essential work. Following the development of guidelines for safe care by NPHET's Expert Advisory Group (EAG), on 5th May NPHET recommended that the delivery of acute care, including non-urgent scheduled care, should be determined by appropriate clinical and operational decision making.

Resumption of HSE Activity

6. The HSE is preparing a strategic framework for the delivery of services in a Covid-19 environment. The purpose of the strategic framework for service continuity is to guide the reintroduction of services that were suspended or reduced as a result of Covid-19, including scheduled care. In doing so, the document outlines:
   - The impact of Covid-19 on services across community and acute settings;
   - International context for reintroducing services in a Covid-19 environment;
   - Challenges to service continuity in a Covid-19 environment;
   - The need for continued adaptation to ways of working in service delivery;
   - Guiding principles for reintroducing services in a Covid-19 environment;
   - An overview of the phased approach to reintroducing services based on an analysis of demand, priorities, risks and benefits across services;
   - Common requirements to reintroduce services in a Covid-19 environment;
   - Next steps to reintroduction the delivery of services.

Impact of Covid-19 on Scheduled Care Activity and Waiting Lists

7. The EAG currently recommends that in-patient occupancy levels are maintained at ≤ 80% to facilitate the delivery of care safely. In addition, the measures approved by NPHET will have an impact on matters such as workflow, patient pathways, patient engagement and communication, infrastructure, physical distancing, capacity and resources which will impact on scheduled care activity levels and capacity. HSE Acute Operations continue to build methodologies to gather information relating to the impact Covid-19 has had on scheduled care. These efforts are being carried out in a collaborative manner through the Scheduled Care Data Group comprising colleagues from HSE, NTPF and the wider Department.

[redacted]

Unscheduled Care

Winter Plan

10. The 2020/21 Winter Plan, to be developed by the HSE, will seek to build on the 2019/20 winter plan which was supported by an additional €26m in 2019 and a further €13.8 million in 2020. This was used to relieve demand for ED services, support discharge and other initiatives to help hospitals deal with the challenges associated with winter. The 2020/21 Winter Plan will have to plan for the safe delivery of emergency care services in a Covid-19 environment. It will seek to reduce attendances at ED by offering alternatives in community care settings and to reduce the number of people receiving care on trolleys by having capacity available to admit patient in a timely manner. These objectives will be challenging to achieve. In relation to the 2020/21 winter plan the Department has written to the HSE to request a comprehensive winter plan which takes account of the additional pressures of providing a safe service in a Covid-19 environment.

Emergency Departments

11. The public hospital system has seen a growing demand for unscheduled care in recent years, with many sites reporting a significant increase in demand that can be seen in the increased number of patients attending and being admitted. This ahas also increased the number waiting on trolleys as measured by TrollyGar. The Covid-19 pandemic has placed increased demands on the safe delivery of emergency care. The HSE has reported that the key factors contributing to delays for older patients in EDs are the requirement for isolation and the need for multiple inputs to the assessment and care of older patients. Older patients are deemed to be at a higher risk of CPE infection and therefore are more likely to be subject to screening and the requirement for isolation facilities. The HSE is implementing a range of initiatives such the Integrated Care of the Older Persons Programme, the development of Frailty Intervention Teams within Emergency Departments. These initiatives are aimed at early intervention and better management of the specific needs of older persons. As set out in Sláintecare, moving care options for patients closer to their homes and into their local communities is a key part of the solution.

National ED Performance

12. In 2019, the number of patients attending our hospital EDs increased by 12.9% and the number of ED admissions increased by 4.4% compared to 2018. Total attendance in 2019 was 1.346m of which 352,000 were admitted. Between January and December 2019, the number of patients recorded as waiting on trolleys in acute hospitals nationally at 8am was 114,481, an increase of 14,078 (14.0%) compared to the same period in 2018 (100,403). ED performance from mid-March 2020 was severely impacted by Covid-19 with a 50% drop in attendance. Numbers attending have returned to near normal since mid-June. Nationally, between January and May 2020:
    - The number of patients recorded as waiting on trolleys in acute hospitals at 8am was 25,900, a decrease of 20,722 compared to the same period in 2019 (46,622);
    - Total ED attendances were 445,608, a decrease of 118,808 compared to the same period in 2019 (546,416);
    - Total ED admissions were 124,996, a decrease of 23,269 compared to the same period in 2019 (148,265);
    - The median time between patient registration in the ED and discharge or admission to a hospital bed in May 2020 was 3.35 hours, which was 0.98 hours (-22.7%) lower than the same month last year May 2019 (4.33 hours); and
    - The median time between patient registration in the ED and discharge or admission to a hospital bed for patients over the age of 75 in May 2020 was 4.70 hours, which was 2.28 hours (-32.7%) lower than the same month last year May 2019 (6.98 hours).

13. Significant changes in ED activity were observed during the course of the current Covid-19 outbreak. The weekly reports provided by the HSE (subject to validation) suggest that ED attendances have increased from a low point of 12,908 attendances in week 13 (25 March) to 23,402 ED attendances in Week 23 (3 – 9 June). This represents a 2.8% increase compared to the previous week (22,772) but is 9.4% lower than the same week in 2019 (25,821). Prior to Covid-19, the average weekly ED attendances for the first 9 weeks of the year were approximately 24,000 per week. A total of 4,183 admissions were reported in week 13, however, this figure has since increased to 6,234 in week 23. This represents a 5.7% increase compared to week 22 (5,896) and a 4.9% decrease on the same week last year (6,552). According to TrolleyGAR figures, the number of patients counted as waiting on trolleys at 8am in week 23 was 713. This represents a 127.8% increase compared to the previous week (313) and a decrease of 60% compared to the same week last year (1,782).

Delayed Transfers of Care (DTOCs)

14. Delayed Transfer of Care cases are former patients who have been declared medically fit to be discharged from an acute hospital, but who are unable to return home or access nursing home or rehab care for a variety of reasons. The average number of delayed transfers of care was consistently higher in 2019 compared to previous years. The number reduced substantially at the start of the Covid-19 outbreak as hospitals sought to free up capacity and transfer patients suitable for discharge to more appropriate settings. However, mainly due to challenges in the nursing home sector, the numbers are increasing again and are likely to present a significant challenge in the immediate future. There was a daily average of 382 delayed discharges in May 2020, which was 131 (+52.2%) more than in April 2020 (251), and 224 (-37.0%) fewer than May 2019 (606).

NTPF Support

15. The National Treatment Purchase Fund (NTPF) agreed, at the Minister's request, to support the marginal costs of funding 220 additional beds for three months to the end of March 2020 at a cost of €5.8 million. As of 10 February 2020, the HSE confirmed 187 of those beds, which include acute, rehabilitation and nursing home beds, opened as planned. The agreement with the NTPF was until the end of June 2020 due to the Covid-19 -19 outbreak. The HSE has asked that the arrangement be extended, this is currently under review.

Bed Capacity Overview

Bed Capacity Review

16. In 2018 a Health Service Capacity Review was carried out for the Department by PA Consultants. It highlighted the expected growth in demand across all parts of the health services. It further addressed the potentially unsafe levels of acute hospital bed occupancy and forecast capacity requirements by 2031. It based these forecast on 2 scenarios one with reforms in the delivery of health and social care and one without these reforms. Ireland has among the highest acute bed occupancy rates in the developed world (currently at 95%) and far above safe international norms of 85%. The fact that the public hospital system is running at close to full capacity means that there are blockages in the system which are shown by the high numbers on hospital trolleys, particularly in winter and the numbers on waiting lists. It is against this background that the Health Service Capacity Review recommended an increase in acute hospitals beds of over 2,600 by 2031 under a reform scenario, to support the projected increase in demand for services in the years ahead. The National Development Plan provides for the full 2,600 beds by the earlier date of 2027. The Health Service Capacity Review recommendation was made in the context of the need for a major investment in additional capacity in both

hospital and community – combined with a wide-scale reform of the manner and the location of where health services are provided. Since 2017, an additional 274 beds have been opened. In addition, 66 beds from the Winter Plan 2018/2019 are now open on an on-going basis.

Impact of Covid-19

17. The HSE has submitted a draft Strategic Framework for Service Continuity in a Covid-19 environment. It also submitted a discussion document on the proposed Post-June arrangement with private hospitals. Both documents indicate that there will be a significant impact on its capacity to deliver services in the post Covid-19 environment. The main factors highlighted in relation to the provision of acute hospital care are the need to enforce safe distancing which will lead to a reduction in beds; the objective of operating generally at 80% capacity to operate safe levels of activity and comply with infection control measures; the reduced throughput due to the reduction in theatre capacity due to infection control measures and reduced staff productivity due the need to don and doff PPE. The HSE is estimating a 20% decrease in targeted inpatient cases for 2020. It has also estimated there could be shortfall in capacity, due to safe distancing requirements and reducing utilisation to 80%, of 4,700 beds, based on a current baseline of 11,000 beds.

The National Treatment Purchase Fund (NTPF)

Role of the NTPF

18. The Unit has responsibility for the governance oversight of the National Treatment Purchase Fund (NTPF). The main function of the NTPF is commissioning treatment for long-waiting patients to improve inpatient, daycase and outpatient waiting times for scheduled care. The NTPF use hospital waiting list data to identify the longest waiting patients on hospital waiting lists and to identify high volume procedures. Commissioning is carried out through insourcing in the public hospital system as well as outsourcing to private hospitals. Clinical Authorisation Notices (CANs) are issued to hospitals to facilitate the movement of patients for NTPF funded treatment. Commissioning has increased in recent years in line with the NTPF's budgetary allocation, from €15m in 2017, to €50m in 2018, to €75m in 2019 and to €100m in 2020.

19. To support its main function the NTPF also publishes quality-assured waiting list information in relation to public hospital services. The NTPF's Audit and Quality Assurance Review Programme's role is to audit hospital waiting lists, ensuring that waiting list data returned by public hospitals is in compliance with national data reporting requirements and hospital practices are in compliance with national waiting list protocols and that the waiting list data returned by public hospitals is accurate.

20. The NTPF are also responsible for negotiating pricing agreements and the purchase of quality care from providers of long-term residential care on behalf of the State. The Nursing Home Support Scheme (NHSS), commonly referred to as 'Fair Deal' is a system of financial support for people who require long-term residential care. The price to be paid for the provision of care in both private nursing homes and section 39 voluntary nursing homes is negotiated by facility by the NTPF. Policy responsibility within the Department for this function lies with Services for Older People Unit.

21. The role of the NTPF has evolved over the past two years to include:
    - The establishment of the National Centralised Validation Unit (NCVU) in 2018 to ensure that waiting list data is accurate and reflects the actual demand for hospital services. (In 2019, the NTPF validated more than 260,000 patients, resulting in 53,000 patients being removed from waiting lists.);
    - Funding the Emergency Department Authorisation Notices (EDANs) scheme which enables hospital sites to access additional diagnostics, freeing up capacity for ED diagnostic needs. (To date the NTPF has issued more than 46,000 EDANS and funding to the value of €6 million has been sanctioned for the issuing of EDANs.);
    - Funding the marginal costs of funding 220 additional beds as part of this year's winter plan at a cost of €5.8 million.

22. The NTPF has provided support to the HSE and the Department in response to the Covid-19 pandemic. This support included administering payments under the Temporary Assistance Payment Scheme to nursing homes on behalf of the HSE and collating the data on patients in private hospitals through its Patient Admission Management System.

Use of Private Hospitals in Response to Covid-19

23. In anticipation of the projected surge in Covid-19 cases and the expected impact on the health care system a major part of the response was to urgently ramp up capacity for acute hospital care facilities. A critical element of the strategy was to put in place an arrangement with the private hospitals to use their facilities as part of the public system, to provide essential acute hospital services for the duration of the emergency.

24. Following negotiations with the private hospitals, an overarching agreement with the 18 private acute hospitals was agreed at the end of March. Under the agreement, the HSE secured 100% of the capacity of the private hospitals until the end of June. They were linked to the Hospital Groups within their region which provided operational and clinical governance the duration of the arrangement. All patients treated in private hospitals were treated as public patients and neither the private hospitals nor medical consultants, carrying out work in them, were entitled to private fees. The Government decided not to extend the arrangement. However it did mandate the HSE to seek to agree, with the private hospitals, a new arrangement to come into effect from 1 July which would provide the HSE with full access to private hospital capacity in the event of a surge of Covid-19 cases and separately with ongoing agreed access, in collaboration with the National Treatment Purchase Fund, to private hospital services to address the HSE's priority needs in providing both essential care and addressing elective care for public patients experiencing delays.

25. The Private Hospitals Association has indicated that their members wish to return to their normal business, which is mainly providing scheduled care for private patients. However, they have also indicated that they are available to begin negotiations regarding the HSE using some of their capacity but want the HSE to set out its requirements. They have also indicated that while the PHA would be willing to negotiate an arrangement in the event of a surge of Covid-19 cases, it would be more appropriate for the HSE to negotiate bilaterally with hospitals regarding the provision of capacity to address the other requirements. It should be noted in this context that one of the hospitals (the Beacon) has left the Association and will have to be negotiated with separately.

26. The HSE is currently refining its needs in relation to the three requirements set out in the Government Decision. In terms of the requirement for elective work and replacement capacity,

the initial assessment suggests that our requirement will exceed the full capacity of the private hospitals and therefore the HSE is also considering alternative solutions such as increases in the number of ICU beds, community care options, access to diagnostics and virtual consultations. A key requirement will be to identify the most appropriate methods of procurement for the different services needed and the HSE is working to determine these. The HSE is also considering the transition arrangement for public patients currently in the private hospitals.

27. The negotiations with the PHA with regard to arrangements in the event of a surge pf Covid-19 cases are ongoing.

PERFORMANCE MANAGEMENT UNIT

1. The Performance Management Unit's primary function is to lead and co-ordinate the Department oversight of the HSE performance, and performance management process, in terms of delivery of the Health Services committed to in the National Service Plan.
2. The Unit is responsible for the coordination of the Department's input into the HSE's Corporate Plan and annual National Service Plan; the Unit also coordinates performance oversight of the HSE through monitoring and assessing the HSE's performance against strategic and operational targets including via the monthly Performance Profile and Management Data Report; improving and strengthening oversight, and supporting more structured and strategic dialogue between the Department and the HSE; overseeing and supporting the HSE's implementation of its Performance and Accountability Framework; including by providing support to Line Units in their engagement with HSE counterparts and inputting into governance oversight of the HSE.

HSE Service Plan and Planning Process

3. The HSE National Service Plan (the Plan) sets out the type and volume of services to be provided by the HSE, plus its delivery of policy and reform. In 2020, The HSE was provided with a budget of Net €17 billion.
4. The HSE National Service Plan 2020 was s the first Plan developed and adopted under the new Governance arrangements, including the recently established Board, in the HSE.
5. The HSE were required to take account of a number of important requirements when developing the Plan, these included a Strategic Direction Statement with an annual statement of priorities and the approved level of expenditure for 2020.
6. The Unit leads on the NSP development and approval process in the Department.
7. The planning process begins around June, and culminates in a hectic 28 days around following Budget day
8. The Unit is currently working with Corporate Legislation Unit on a new Health Bill, aimed at, amongst other issues, improving planning processes relating to the National Service Plan and the Corporate Plan.

Roadmap for the Continuity of Services in a Covid Environment

9. The Unit has recently been tasked to coordinate the Department's input into the HSE's proposed Roadmap for the Continuity of Services in a Covid Environment. A Framework to support the development of this Roadmap was discussed by the HSE Board on 17th June. The Minister for Health intends to write to the HSE requesting that they develop and submit the following:
    - a single resumption plan (or roadmap) which sets out, expected timeframes that individual services will resume, across location and service type.
    - A revised National Service Plan setting out in clear terms the quantification of service level activity levels that can be achieved for the remainder of 2020, and the associated costs.

New HSE Board: Governance and oversight arrangements between the Board, the Executive and the DoH

10. The Health Executive (Governance) Act 2019 formally established a non-executive HSE Board and put in place the Chief Executive Officer post for the HSE. Given the new structures, the Department and the HSE agreed a revised model of engagement to reflect these new governance structures. The engagement model includes governance, performance, National Service Plan implementation, policy and reform. In line with the DPER *Code of Practice for the Governance of State Bodies* of Governance the Department, in conjunction with the HSE, are in the process of

developing an **Oversight Agreement**. The Oversight Agreement is a written statement between the Department of Health and the HSE which clearly defines the terms of the HSE's relationship with the Minister for Health and the Department of Health as the parent Department. The Department is currently developing a draft Agreement and once it has been finalised and approved by the Minister it will be forwarded to the HSE for their consideration, input and agreement. The Department is also examining how best to configure itself in order to provide effective and robust oversight of the HSE.

HSE Annual Report 2019

11. The HSE produces and publishes an Annual Report on the performance of its functions during the preceding year which normally also includes its Annual Financial Statements. The Annual Report and Financial Statements 2019 was submitted to the Department on 15th May 2020. The Annual Report does not require the approval of the Minister but must be laid before the Houses of the Oireachtas within 21 days of its receipt. The Annual Report and Financial Statements 2019 was laid before both Houses on 5th June 2020 following a submission for the information of the Minister.

HSE Corporate Plan

12. The HSE are currently working on a new Corporate Plan for the period 2020 – 2022. The Corporate Plan provides direction to the HSE over a three-year period and provides an overarching framework within which the yearly Service Plan are prepared.
13. The Minister issued a Strategic Direction Statement to the HSE on 19th August 2019 to support the development of the HSE Corporate Plan 2020 -2022.
14. While the new Plan is being developed, a one-year interim Plan for 2019 is currently in place. This has now expired but due to the Covid19 pandemic it has been agreed to allow the HSE additional time (to the end of July) to submit the plan to the Minister for approval.
15. The Unit coordinates the development of the Strategic Direction, the Department's input into the Plan and leads the Departments input into the approval process.

HSE Performance Profiles & DoH-HSE performance engagement model

16. There are a number of reporting streams whereby the HSE provides information to the Department in respect of its performance against the delivery of agreed strategic and operational targets in the National Service Plan. One of the main sources are the HSE's Performance Profile (PP) and Management Data Report (MDR) which provide information on HSE performance against National Service Plan targets. These reports are submitted to the Department on a monthly basis and are published quarterly by the HSE.
17. The latest performance reports received cover the month of April 2020.
18. The PP and MDR form the basis of the monthly performance oversight process both within the HSE (under its Performance and Accountability Framework – see below) and between the Department and the HSE.
19. The Unit coordinates this process by providing support to Line Units in their engagement with HSE counterparts and inputting into governance oversight of the HSE. PMU collates performance challenges across the internal system and escalates to senior management for engagement to address underperformance.
20. As referenced previously, a new model of performance engagement was agreed over the latter part of 2019 between the Department and the HSE and became fully operational in March 2020 (January 2020 reporting cycle). Key innovations include the designation of divisional Performance Officers at Principal Officer level, preparation of Divisional Report Cards (DRCs) by Divisions/Units (rather than centrally by PMU) and the introduction of a Cross-Divisional Performance Review meeting as part of the monthly process.

21. This Cross-Divisional meeting provides the opportunity for designated Performance Officers to input into the corporate process and avail of the insights of colleagues in other service areas and from the corporate support units.
22. Operational areas of concern are raised by Performance Officers and brought forward for consideration by DoH Management Board at its monthly Performance Management Board Meeting.
23. Issues can be further escalated, as appropriate, to the monthly performance engagement between the HSE Chief Operations Officer and the Department's Secretary General Governance and Performance.
24. There is also a monthly High Level DoH-HSE Review meeting attended by the Department's Secretary General, the HSE CEO and other senior management as required. Operational issues which have not been resolved by other means through DoH-HSE engagement at lower levels of the process can be escalated to this meeting.
25. The process is underpinned by regular engagements between DoH and HSE officials at operational level at which issues affecting performance are discussed and valuable information shared. While these interactions are not a formal part of the HSE's Performance and Accountability Framework, they are a key underpinning element of the engagement model.
26. Engagements under the agreed DoH-HSE performance oversight model were deferred on a temporary basis in March 2020, at the request of the CEO, to allow the HSE to focus its efforts on dealing with the COVID-19 emergency. PMU operated a scaled-down performance process in April, May, and June (February, March and April 2020 reporting cycles). Given the longer timeframe of the pandemic and the planning underway for the phased reintroduction of non COVID-19 work, the Department will be in contact with the HSE to re-instigate the full performance oversight model from the next performance cycle onwards.
27. It is expected that reinstating the full performance engagement oversight model will be challenging due to staffing and operational pressures being experienced in both organisations and the additional challenge of integrating the new reporting streams of Covid-related work and expenditure into an overall view of performance.

HSE Performance and Accountability Framework (PAF)

28. The PAF set out how the HSE undertake performance management and ensure accountability. It covers performance engagement meetings, escalation process, and sanctions.
29. Following the enactment of the HSE Governance Act 2019, further new governance arrangements will be necessary and there is an expectation that a revised PAF will be developed to reflect any new accountability arrangements.
30. In the meantime, the HSE continue to use the existing PAF as part of their monthly performance cycle, particularly the monthly escalation reports which highlight areas of underperformance/concern where intervention at a senior level is required.
31. Under the HSE PAF, a National Performance Oversight Group (NPOG) scrutinises the performance of the health service provider organisations (in particular Hospital Groups, CHOs, NAS, PCRS and other national services) and assesses performance against the National Service Plan. The NPOG meets on a monthly basis and is chaired by the Chief Operations Officer, with other members of the HSE senior management team as standing members.
32. The PAF contains provision for the formal escalation of individual Hospital Groups, CHOs or other services that are not achieving national performance expectations set out in the National Service Plan and National Scorecard. 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.

Health Systems Performance Assessment Framework – EU Commission Project

33. The Unit initiated and leads a major project to develop a new overarching performance assessment framework for the entire health system with funding secured from the EU Commission.
34. The intention is to deliver a reliable framework for assessing the performance of the health system with measurable and quantifiable outcomes-based indicators which can be linked to relevant health policies and strategies enabling the integration of policy and reform into an overall view of performance for the health system. Identification of the relevant domains and indicators to inform the development of a HSPA framework will provide a method for the collection, collation, and analysis of health outcomes data.
35. The University of Amsterdam has been chosen by the EU Commission as the provider for the project.
36. Governance structures have been agreed and set up, including a Project Working Group, an Advisory Group and a Steering Group.
37. The project working Group have met on a number of occasions. The first Advisory Group meeting was held on March 11th. The Steering Group was due to meet in the first quarter of 2020, but this engagement has been postponed due to the Covid-19 pandemic and is in the process of being rescheduled for the second half of 2020.
38. The University of Amsterdam is currently engaging in mixed-method consultation with a number of different stakeholders including citizens, health service providers, policy makers, managers and regulators.
39. The project has an expected 18- month timeframe and is due to conclude in February 2021.

AGENCY GOVERNANCE, CLINICAL INDEMNITY UNIT AND CERVICALCHECK TRIBUNAL

Overview of Unit

1. The Unit is composed of three sections, Agency Governance, Clinical Indemnity and the Cervical Check Tribunal. The Unit also currently holds the staff of the Cervical Check Tribunal. Upon establishment the Tribunal will operate independently, with administrative matters relating thereto overseen by the Cervical Check Tribunal section. The unit has a broad remit including overseeing Governance and appointments for 19 aegis bodies and 52 boards; monitoring expenditure and developments that arise in Clinical Indemnity claims against the HSE, advising and assisting on indemnity issues and the establishment of the Cervical Check Tribunal.

Agency Governance Section Responsibilities

- Oversee Compliance with the Code of Practice for the Governance of State Bodies (19 aegis bodies in the Department of Health)
- Oversight of the appointment process to 52 state boards under the aegis of the Minister and is responsible for overseeing that vacancies are filled in accordance with Department of Public Expenditure and Reform Guidelines

Matters that may require a decision from the Minister in the short term

2. The Minister will be required to consider the following board appointments which are due to be made:

3. Beaumont Hospital Board
   The Chair Designate Gillian Harford (currently a board member) is to be appointed by the Minister. This can only take place following her appearance at the Joint Committee on Health. A request was made to the previous Joint Committee regarding her appearance. This will have to be renewed on the formation of a new committee.

4. Board of the Health Service Executive
   The Health Service Executive Governance Act 2019 formally established the Board of the HSE which commenced on 28th June 2019. The Board comprises 12 members – a Chairperson, a Deputy Chairperson and ten members. There are currently 2 vacancies on the board including a vacancy for a "health professional" and a "patient advocate". A Public Appointments Service campaign will be required to identify suitable individuals for appointment by the Minister.

5. VHI
   The Chair Designate Paul O'Faherty (currently a board member) is to be appointed by the Minister. This can only take place following his appearance at the Joint Committee on Health. A request will be made to the new Joint Committee requesting his appearance when the committee is established.

6. The Minister will be required to approve and sign off on Ministerial board appointments arising in the coming weeks.

Clinical Indemnity Section Responsibilities

7. The section works with the State Claims Agency which has responsibility for the State's clinical and general indemnity schemes - to monitor key cases and expenditure as well as considering how policy can be updated in response to emerging trends and issues.

8. We manage the process for dealing with payment of MDU Refusal cases- these are historical cases where the Medical Defence Union has determined that they are not responsible for the claim, and the State has put an arrangement in place to ensure that no patient is left uncompensated.

9. We also deal with legacy issues concerning Symphysiotomy and the Drogheda Review, including the Michael Shine case and a case currently underway in the European Court of Human Rights.

10. During the Covid19 emergency the Unit has taken on significant work aiding units seeking advice on a range of Covid Indemnity related issues. The Unit has engaged across Government to develop understanding of indemnity and insurance issues arising as a result of Covid19 and has worked with key Health service areas to get Govt approval to extend State Indemnity to certain bodies/organisations as necessary and to arrange for delegation orders to be made.

Update on progress in delivering on key policy initiatives

Expert Group to Review the Law of Torts and the current systems for the Management of Clinical Negligence Claims – 'Meenan Report':

11. In June 2018 an Expert Group was established to examine tort law as it currently applies to personal injuries arising in the healthcare context and to consider further options for reform of relevant tort law;

12. Judge Meenan has (17 January 2020) submitted the Final Report of the Expert Group to the Minister for Health and the Minister for Justice and Equality.

[redacted]

14. The Minister is required to:
    Make a decision regarding the next steps to be taken, beginning with whether the Minister wishes to bring a Memo to Government shortly and whether the Minister, in conjunction with the Minister for Justice and Equality, wishes to publish the Report.

Review of the current arrangements in respect of Clinical Indemnity

15. The Government Decision of 17 December 2019 on "Update on the implementation of Slaintecare reform Programme", notes the intention of the Minister for Health to review current arrangements in respect of Clinical Indemnity. The wording from the Government Memo states that "The Minister will initiate a critical review of the current arrangements in respect of Clinical Indemnity with a view to exploring the feasibility of the gradual removal of state cover relating to private patients being treated in public hospitals". The review is to report during 2020. The Department is currently scoping the parameters of such a review in consultation with the State Claims Agency.

16. The Minister is required to:
Consider the outcome of the review before the end of 2020.

The CervicalCheck Non-Disclosure Ex-Gratia Scheme

17. On 11 March 2019, the Government agreed to the establishment of an ex-gratia scheme for those affected by the non-disclosure of the Cervical Check audit. The Independent Assessment Panel, chaired by Justice Aindrias Ó Caoimh, determined that €20,000 was the appropriate amount for the ex-gratia payment and all 166 applicants to date have received payment. The scheme remains open. It is expected that the Independent Assessment Panel will submit a Report on the Scheme to the Minister shortly.

18. The Minister is required to:
Receive and note the Report on the Scheme shortly.

Medical Defence Union (MDU) Refusals

19. In 2005, an arrangement was put in place between the Minister for Health and the IHCA and the IMO to ensure that in the event of an adverse clinical incident that (i) no patient was left uncompensated, (ii) no doctor who was a member of the Medical Defence Union was left without indemnity / insurance cover in the event that the MDU refused to indemnify. Under these arrangements, the consultant can request the assistance of the Minister in meeting the cost of damages/costs arising from the claim. In settlement the MDU paid the State €45m. The State Claims Agency (SCA) oversees the management of these claims and submits requests for payment on a regular basis. The approval of the Minister is required on a case by case basis. There were 50 payments made in 2019 amounting to a total of approximately €20m (this included one large payment of approx. €17m). The same number of payments is expected in 2020 amounting to approximately €6m, based on previous years. Work is underway to delegate responsibility to the State Claims Agency for managing these claims and it is anticipated that this should be complete by year end.

20. The Minister is required to:
Approve the MDU requests on a case by case basis and later in the year to approve the delegation for the management of these claims to the State Claims Agency.

<u>CervicalCheck Tribunal Section Responsibilities</u>

21. The CervicalCheck Tribunal Section has responsibility for setting up the CervicalCheck Tribunal under the CervicalCheck Tribunal Act 2019.

22. On foot of the issues arising in respect of CervicalCheck, on 2 August 2018 the Government asked Mr. Justice Charles Meenan to make recommendations about how claims arising out of CervicalCheck could be resolved outside of the court process. Mr Justice Meenan's report, which was published on 16 October 2018, proposed that a statutory tribunal be established for the purpose of hearing and determining claims arising from CervicalCheck. Based on the recommendations set out in Mr. Justice Meenan's report, in December 2018 the Government agreed to establish such a Tribunal and approved the appointment of Ms. Justice Mary Irvine as Chair of the Tribunal.

23. The legislation necessary to establish the Tribunal, the CervicalCheck Tribunal Act 2019, passed through the Oireachtas and was signed into law by the President on 23 July 2019. In addition to

the process for the hearing and determination of claims, the Act provides for Restoration of Trust Meetings.

24. It is intended that the Tribunal's function in respect of hearing and determining claims will be commenced initially and its function in respect of Restoration of Trust Meetings will be commenced relatively shortly thereafter.

Update on progress in setting up the Tribunal

25. Department staff and the Tribunal's nominated Registrar have been working with the Chairperson to progress the practical arrangements for setting up the Tribunal, including:
    - Identifying and fitting out suitable premises in the Infinity building in Smithfield
    - Putting in place rules to regulate the practice and procedure of the Tribunal
    - Adequately staffing the Tribunal
    - Revising arrangements to ensure the Tribunal can operate as safely as possible in light of COVID-19

26. In addition to the Chair, the Tribunal is required to consist of at least two suitably qualified ordinary members. Appointments to the Tribunal are made by the Minister for Health. On 9 January 2020, the Minister informed the Government of his intention to appoint Mr. Justice Michael Peart and Mr. Justice Brian McGovern as ordinary members of the Tribunal.

27. As the key administrative arrangements were in place, it was intended that the Tribunal would be established by the end of March 2020. However, due to the outbreak of COVID-19, in line with the public health measures being taken to control the outbreak of the virus it was decided to delay the establishment of the Tribunal. Of particular concern in establishing the Tribunal is that the claimants are in a group considered to be particularly at risk if they were to contract the virus.

28. On 12 June 2020, the Government nominated Judge Irvine as President of the High Court. Accordingly, she will no longer be in a position take up the role of Chairperson of the Tribunal.

The Minister is required to

29. Once a suitable person has been identified to replace Judge Irvine as chairperson of the Tribunal, to establish the Tribunal the following actions by the Minister will be required:
    - Commencement of the CervicalCheck Tribunal Act 2019
    - Appoint a date for establishment under Section 4 of the Act
    - Formal appointment each of the members under section 6 of the Act, including the chairperson.

30. The 'establishment day' of the Tribunal is a matter for the Minister, however final arrangements are being made in order that the Tribunal will be in a position to establish as soon as a new chairperson has been appointed and confirmed that he/she is satisfied with the arrangements.

31. The issue of access to Legal Aid for claimants before the Tribunal has not been resolved and a position will have to be reached in consultation with the Minister for Justice