HSE Urgent and Emergency Care Operational Plan 2024

Q2 2024 –Q1 2025

June 2024

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Executive Summary

Introduction

The population of Ireland is now at its highest count in 171 years with life expectancy above that of the EU average. The volume of attendances at our Emergency Departments has increased by 10% since 2019 which equates to circa 125,000 additional visits. The profile of health risk across the population, combined with ageing, means an increase in the number of people living with chronic disease and frailty who need healthcare. One third of adults aged ≥ 75 years are living with frailty in Ireland and up to 70% of older adults who present to ED are living with frailty. ED attendances in those aged ≥ 75 years has increased by 22% since 2019 and admissions have increased by 17% across the same period.

This demand growth combined with demographic changes and other health system capacity challenges, is resulting in sustained and record UEC pressures almost all year round.

UEC Plan 2024-2026

The HSE has developed a Multiannual National Urgent and Emergency Care (UEC) Plan 2024-2026. This plan, once approved by the HSE Board and the Minister for Health, will provide direction on the actions we will take over the next three years to improve our urgent and emergency care services on an incremental and sustained basis. The plan aims to achieve the following clear benefits for patients and those important to them as well as our staff:

- Patients can access urgent and emergency care in the right place at the right time, reducing harm and risk and improving health outcomes
- Patient's experience of using urgent and emergency care improves as wait times in our EDs reduce and discharges are timely
- Patients get early access to specialist care and those at risk are identified quickly
- The experience and wellbeing of staff working in our urgent and emergency care services is improved.

Urgent and Emergency Care Operational Plan 2024

The UEC Operational Plan 2024 builds on the work undertaken to set out and deliver the 2023 UEC Operational Plan and associated improvements in patient care. This plan sets out the priorities and actions required at a local and regional service level, in the HSE Centre and during periods of surge, to deliver on the objectives of the multiannual UEC plan and support UEC delivery and performance in year one (2024) and leading into year two (2025) and year three (2026).

Priority actions are set out under four operational pillars:

- Hospital avoidance
- Emergency Department operations
- In-hospital care delivery
- Discharge management

Actions vary in terms of their scale, timelines and location of delivery, as well as the stage of the patient pathway that they support, enable or improve. High impact operational actions from across each pillar that are to be prioritised by services for early and consistent delivery are presented overleaf. The detailed actions under each pillar follow thereafter. These high impact actions are primarily focused on achieving greater efficiencies, helping to better balance capacity and demand within the system and optimising patient flow.

The delivery of this plan will be supported by the overall investment in health services via the National Service Plans in 2024 and 2025. National Service Plan (NSP) 2024 investments are as set out at a high level in table 1 below.

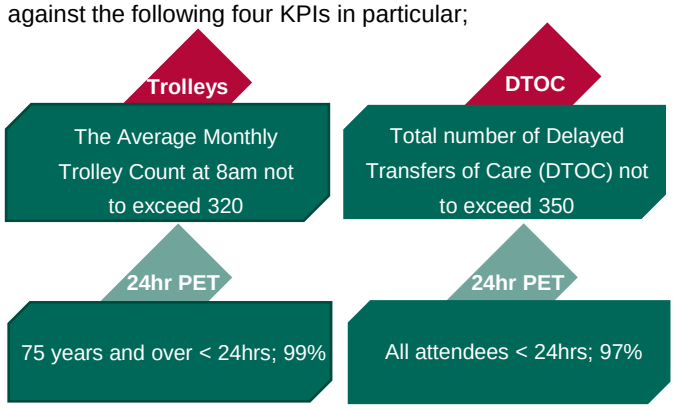
Table1. NSP 2024 Investment Profile

National Service Plan 2024	
Total Budget Allocation	€23.8bn
Total Additional Enduring WTE	2,951
Additional Community Beds; short stay	27
Additional Community Beds; long stay	147
Additional Acute In-Patient Beds	163
Additional Critical Care Beds	22

Note: Total budget and WTE allocation includes €2.8bn and 683 WTE for disability services and excludes Capital Budget (€1.2bn)

Key Performance Indicators

Following on from the delivery of the 2023 UEC Operational Plan, the number of patients on ED trolleys fell by 15.8% between July and December of 2023 compared to the same period in 2022. In 2024 there will be renewed focus on achieving UEC targets whilst managing increasing demand. The full set of UEC KPIs is set out in NSP 2024. The delivery of this UEC Operational Plan will be measured against the following four KPIs in particular;



In addition, a productivity measure will monitor the average length of stay for those admitted over 14 days (avLoS for those over 14 days not to exceed 28 days).

UEC Operational Actions

These actions are for prioritised and consistent delivery. The full suite of actions are set out under the 4 operational pillars on pages 6-9.

Hospital Avoidance **ED Operations** **In Hospital Care Delivery** **Discharge Management**

Vaccine Preventable Illness	Promote uptake of Influenza, Measles and COVID-19 vaccinations to improve compliance for all target groups including Healthcare Workers
Specialist Care in the Community	• Community Specialist Teams (CSTs) for Chronic Disease Management to deliver 19,000 patient contacts each month • CSTs for Older Persons will deliver 11,750 patient contacts each month
GP Out of Hours	Work with GP Out of Hours Services to maintain/increase GP OOH contacts and reduce the level of GP OOH referrals to EDs
NAS Care Pathways	Maximise usage of existing NAS alternative care pathways
Local Injury Units	Injury Units to provide a 7-day service, 8am to 8pm including Bank Holidays
Patient Streaming at ED	High levels of streaming in the emergency department e.g. to Medical Assessment Units, GEMs Units, Injury Units, ICPOP assessment and other appropriate services
Senior Decision Makers in ED	Roster amendments for Senior Decision Makers developed on a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand
Consultant Rounding in ED	Consultant daily rounding of admitted patients each morning in EDs and in surge beds to expedite decisions and treatment
Demand and Capacity Management	Each hospital/community service to have a centralised operational hub that provides visibility of all available bed capacity in hospitals, community and private facilities
Clinical and Operational Oversight	Senior clinical and operational decision makers rosters to be developed on a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand
Cohorting	All sites will have plans in place to support the transition to hospital wide cohorting of patients to specialty or dedicated wards, commencing with the cohorting of Older Adults (≥ 75 years) to specialist geriatric wards by year end
Extended Hours	Roster amendments and additional services should be developed on a 6/7 basis in the interim, ultimately working to a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand
Senior Clinical Review	All admitted patients on wards to have senior clinical review every morning to expedite decisions and treatment
Length of Stay	Hospitals will implement protocols for inpatients with Length of Stay over 14 days transitioning to over 7 days
Patient Flow	All clinically appropriate patients in Model 3 and Model 4s to transfer to alternative care settings including Model 2s, Rehabilitation Beds and Transitional Care Beds (TCBs)
Discharge Plan for Every Patient	All inpatients to have a comprehensive plan for discharge, developed in conjunction with community services. A predicted date of discharge is to be assigned at time of admission
Discharge Processes	Operational processes will be in place to support the discharge of patients prior to midday on a 7/7 basis, and to deliver a consistent level of discharges each day
Managing Delayed Transfers of Care	In anticipation of their final care plan being fulfilled, all available options are to be put to suitable patients who are experiencing a DTOC if they have already been approved for NHSS long term care. Patient choice to be prioritised, however in line with the discharge policy, patients will be safely transferred on the third offer provided to them

Detailed Actions By Operational Pillar

Pillar 1: Hospital Avoidance

Introduction

Avoidance operations encompasses the activities undertaken to support patients to avoid attending EDs (ED avoidance) and the need to be admitted to inpatient services (admission avoidance). The table below sets out the targeted actions required under specific focus areas to support hospital and admission avoidance.

Ref.	Focus area	Targeted action	Output
Local and Regional Actions			
1.1	Emergency Dept. in the Home (EDITH)	• Operationalise an EDITH Service in UHL • Extend EDITH service in SVUH moving to 24/7 365 service	ED Avoidance
1.2	GP Out of Hours (OOH)	Work with GP Out of Hours Services to maintain/increase GP OOH contacts and reduce the level of GP OOH referrals to EDs	ED Avoidance
1.3	Productivity and Efficiency	Put plans in place to expand the use of video enabled care for select services e.g. Older Adults, chronic disease and specialist services to avoid unnecessary hospital attendances	ED Avoidance
1.4	Productivity and Efficiency	Flex the ECC model to support over 2,800 admissions to nursing homes (NH) through inpatient geriatric assessment, Community Specialist Team (CST) led advance care planning and access to CHN services	ED Avoidance
1.5	Injury Units (IU)	• Standardising the opening hours of all Acute Hospital delivered Injury Units to provide a 7-day service, 8am to 8pm including Bank Holidays • Open additional IUs	ED Avoidance
1.6	Health Promotion and Prevention	• Promote uptake of influenza and COVID-19 vaccinations to improve compliance for all target groups including Healthcare Workers • Promote uptake of immunisation catch-up programmes in particular measles	ED and Admission Avoidance
1.7	Children and Young People	• Optimise the usage of Paediatric Rapid Access Clinics	ED Avoidance
1.8	Communications	Deliver national and local communications campaigns to provide information on alternative pathways, keeping well, vaccinations and respiratory illnesses	ED Avoidance
National Actions			
1.9	Productivity and Efficiency	• Community Specialist Teams (CSTs) for Chronic Disease Management will deliver 19,000 patient contacts each month • CSTs for Integrated Care Programme for Older Persons (ICPOP) will deliver 11,750 patient contacts each month	ED Avoidance
1.10	Productivity and Efficiency	• Maximise usage of existing NAS alternative care pathways (Pathfinder, Hear and Treat, Community Paramedics)	ED Avoidance
Surge Measures (aligned to agreed funding)			
1.11	GPs	Extended GP hours over OOH periods and weekends will be delivered	ED Avoidance
1.12	Patient Flow	CHOs to roster additional and extended hours for staff to support patients at risk of hospital admission (incl. ICPOP Nursing Home in-reach teams)	ED Avoidance
1.13	Communications	Campaigns to promote self-care at home, alternative pathways and vaccination programmes	ED Avoidance

Pillar 2: ED Operations

Introduction

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

Ref.	Focus area	Targeted action	KPIs
Local and Regional Actions			
2.1	Patient Streaming	High levels of streaming on arrival at the emergency department e.g. to Medical Assessment Units, GEMs Units, Injury Units, ICPOP assessment and other appropriate services	• 24hr PET*
2.2	Older Adults Pathway	Prioritise care and compassion for older adults identified as at risk in our EDs by rostering a designated person to keep them informed and assist them as needed during each shift	• 24hr ≥ 75 years PET
2.3	Older Adults Pathway	All EDs to have plans in place to screen all patients ≥ 75 years for Delirium and Frailty at triage (or within 15 minutes of registration) and provide early access to specialist emergency and gerontology care	• 24hr ≥ 75 years PET
2.4	Senior Decision Makers in ED	Senior Decision Makers on-site in ED, 7/7 including Bank/Public Holidays	• Trolley Count • 24hr PET
2.5	Consultant Rounding in ED	Consultant daily rounding of admitted patients each morning in EDs and surge beds to expedite decisions and treatment	• Trolley Count • 24hr PET
2.6	Children and Young People	Standardised Paediatric care pathways are in place in EDs to ensure an integrated approach to the particular care requirements of presenting children and young people including the transfer of care to specialist or secondary care services (e.g. HDUs, CHI, Disability Services including Intellectual Disabilities, CAMHs, emergency placements etc.)	• Trolley Count
2.7	Older Adults Pathway	Establish UEC (Older Adults) Clinical and Operational Regional Governance Groups to plan for and deliver the Older Adults Pathway as part of an Age Friendly Health System by end of 2024	• 24hr ≥ 75 years PET
National Actions			
2.8	Acute Floor ICT Solutions	Ready Beaumont Hospital for AFIS go-live in 2025	• 24hr PET
2.9	Safe Staffing	Progress the implementation of the initial Safe Staffing Phase 2 for EDs	• Trolley Count • 24hr PET
Surge Measures (aligned to agreed funding)			
2.10	NAS Private Capacity	Additional capacity will be in place through voluntary and private ambulance services to improve egress and general flow	• NAS Response Times

***24 hr PET incorporates PET KPIs all attendees and for those ≥ 75 years**

Pillar 3: In Hospital Care Delivery

Introduction

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

Ref.	Focus area	Targeted action	KPIs / Output
Local and Regional Actions			
3.1	Senior Clinical Review	All patients will have senior clinical review every morning to expedite decisions and treatment	• LoS
3.2	Clinical and Operational Oversight	Senior clinical and operational decision makers rosters to be developed on a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand	• Trolley Count • 24hr PET
3.3	Extended Hours	Roster amendments and additional services should be developed on a 6/7 basis in the interim, ultimately working to a 7/7 basis and implemented to meet the predictable increased weekend and public holiday demand	• Trolley Count • 24hr PET
3.4	Cohorting	All sites will have plans in place to transition to hospital wide cohorting of patients to specialty or dedicated wards, commencing with the cohorting of Older Adults (≥ 75 years) to specialist geriatric wards by year end	• LoS
3.5	Length of Stay (LoS)	Hospitals will implement protocols for inpatients with Length of Stay over 14 days transitioning to over 7 days	• LoS • DTOC
3.6	Demand and Capacity Management	Each hospital/community to have a centralised operational hub or equivalent that provides visibility of all available bed capacity in hospitals, community and private facilities to support demand and capacity management, utilising as standard the “every bed used every day” approach	• Trolley Count • 24hr PET
3.7	Patient Flow	All clinically appropriate patients in Model 3 and Model 4s to transfer to alternative care settings including Model 2s, Rehabilitation Beds and Transitional Care Beds (TCBs)	• LoS • DTOC
3.8	Acute Virtual Wards (AVW)	Open a 10 bedded Acute Virtual Ward in University Hospital Limerick (UHL) and in St Vincent's University Hospital (SVUH) in Q2, scaling to 25 virtual beds for each site by year end to deliver 50 virtual beds in total	• LoS
3.9	Children and Young People	Sites that deliver services to children and young people to maximise the implementation of short stay paediatric pathways to facilitate appropriate early treatment and patient discharge	• LoS
3.10	Demand and Capacity	All regions working in conjunction with Public Health Service Improvement teams, to utilise their baseline UEC demand projections by service and site to develop site specific UEC improvement trajectory plans	• Trolley Count • 24hr PET
3.11	Patient Flow	Sites to make optimal use of the additional Acute beds delivered under the Capital Plan in 2024	• Trolley Count • 24hr PET
3.12	Patient Flow	Optimise full use of available private capacity of 140 beds as per the established Private Hospital Framework (current framework is in place until December 2024)	• Trolley Count • 24hr PET • LoS

Pillar 3: In Hospital Care Delivery cont.

Ref.	Focus area	Targeted action	KPIs / Output
Surge Measures (aligned to agreed funding)			
3.13	Extended Diagnostics	Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid delays in flow	• Trolley Count • 24hr PET • LoS
3.14	Patient Flow	All sites and CHOs to roster additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs across acute and community services	• Trolley Count • 24hr PET • LoS

Pillar 4: Discharge Management

Introduction

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

Ref.	Focus area	Targeted action	KPIs / Output
Local and Regional Actions			
4.1	Discharge Processes	All patients to have a comprehensive plan for discharge, developed in conjunction with community services. A predicted date of discharge is to be assigned at the time of admission	• LoS • DTOC
4.2	Discharge Processes	In anticipation of their final care plan being fulfilled, all available options are to be put to suitable patients who are experiencing a DTOC if they have already been approved for NHSS long term care. Patient choice to be prioritised, however in line with the discharge policy, patients will be safely transferred on the third offer provided to them	• LoS • DTOC
4.3	Discharge Processes	Discharge and transfer of care processes will be in place to ensure that families, carers or community/ long term care services receive a full and timely handover of care	• LoS • DTOC
4.4	Discharge Processes	Operational processes will be in place to support the discharge of patients prior to midday and on a 7/7 basis to support a consistent level of discharge each day	• LoS • Trolley Count
4.5	Patient Flow	Sites to make optimal use of the additional community beds delivered under the Capital Plan in 2024	• LoS • DTOC
4.6	Patient Flow	Timely approval and delivery of home support hours to enable increased access to care and supports in the community and egress from acute hospitals, through the delivery of 22 million home support hours to approximately 54,100 people	• LoS • DTOC
4.7	Transitional Care Funding (TCF)	The continued use of TCF to facilitate the discharging of all eligible patients to private nursing home beds.	• LoS • DTOC
Surge Measures (aligned to agreed funding)			
4.8	CIT	Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients	• LoS • DTOC

Governance and Reporting

Governance and Reporting

Governance and Reporting

The HSE UEC Operational Plan 2024 aims to support the delivery and management of UEC until end Q1 2025 by establishing clear integrated operational actions and targets alongside approved surge measures to mitigate the risks associated with high UEC demand pressures.

An integrated system of governance and accountability will support the delivery of this plan by providing ongoing monitoring and oversight of UEC activities and performance. The integrated UEC governance and oversight arrangements with DoH and at national and regional HSE level are set out in figure 1 below.

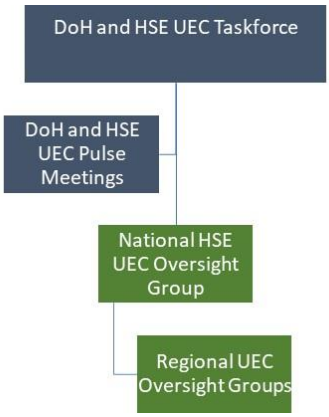


Figure 1. UEC Governance and Oversight Arrangements

Integrated DoH and HSE UEC Taskforce and Ministerial Meetings

The oversight and implementation of the UEC Plan will continue to be facilitated by a monthly cycle of Taskforce meetings and associated Ministerial meetings. These groups are comprised of senior representatives of the DoH and HSE. The Taskforce will drive and oversee the implementation of the UEC Plan each year and will ensure effective communication and information sharing across all aspects of the UEC plan implementation, throughout the DoH and HSE with all key stakeholders. The Taskforce reports directly to the Minister for Health on UEC performance and the status of UEC Operational Plan activities. These structures are supported by fortnightly DoH and HSE Pulse meetings. The schedule of Pulse meetings will be subject to change during periods of surge as set out on P.17 under *Surge Measures Governance and Reporting.*

National HSE Governance

The National HSE UEC Oversight Group is responsible for overseeing the implementation of the UEC plan within the HSE, serving as a point of escalation in managing risks and issues, providing direction and support to regional/local governance groups, authorising the switching on/off of surge measures and communicating any such decisions to the DoH in a timely manner. Due to the restructuring of the HSE centre, the membership of the UEC Oversight Group will be subject to revision in line with the new governance structures.

Local Governance

At service level Regional Executive Officers will be responsible for operational performance including the delivery of the UEC plans and will be key members of the UEC Oversight Group. Local integrated governance structures and arrangements have been established to facilitate the delivery of planned UEC service improvements. Each Health Region will ensure monitoring and reporting arrangements are in place to assess implementation of local plans, efficacy of same and performance against UEC KPI targets taking account of agreed local performance trajectories.

In addition to the UEC actions and priorities that require local delivery, there are actions that will be progressed at a national level to ensure consistency of approach in the implementation of new programmes such as the roll out of Acute Virtual Wards or because they fall under the remit of National teams including, Technology and Transformation or Communications. These projects and programmes will be reported and monitored as part of the overall UEC programme.

Reporting and monitoring

Regular oversight at national and regional levels will be provided to support the implementation of the operational plan, support operational grip and performance in relation to UEC KPIs.

Monitoring and reporting of progress against the Operational Plan will be coordinated and managed centrally. This will ensure that reporting is aligned, integrated and reflects the status of projects and measures delivered as specified in this UEC Operational Plan 2024.

Each Health Region will provide timely updates for reporting to the Oversight Group, the HSE Board and the UEC Taskforce.

Governance and Reporting

UEC KPI performance monitoring

Ongoing regular reporting and monitoring is provided on UEC activity and performance to inform data driven actions at a national and regional level. Clear UEC targets have been set for this plan. These targets will function alongside the full suite of KPIs in the HSE NSP.

Each action in the plan is linked with UEC performance and targets. Progress in relation to UEC activity, performance and targets will be reported as per agreed schedules as follows;

- daily UEC situational analysis reports distributed to the UEC Oversight Group and the DoH which include acute ED demand, general acute and critical care bed demand and availability including capacity and capability; and
- weekly PMO and monthly UEC reports at a national and site level basis that report on the delivery of UEC Plan actions and compare activity and performance in relation to previous weeks and years.

UEC reports are reviewed at pulse meetings with representatives of the HSE UEC Oversight Group.

Focus UEC KPIs

24hr Patient Experience Time

- 24hr PET ≥ 75 years
  The system will aim to maintain and exceed the target of 99% of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration.
  There is a particular focus on 24hr PET for this age cohort to mitigate the patient safety risks associated with extended wait times times.
- 24hr PET all attendees
  The system will aim to ensure that 97% of all attendees are in ED for < 24hrs.
  Focusing on PET and enhancing compliance with PET targets will have a positive impact on trolley numbers numbers.

8am Trolley Count

- The HSE continues to work toward ensuring that the maximum average monthly 8am trolley average does not exceed 320 patients. Maintaining this target will require the delivery of measures and initiatives to reduced congestion and improve patient flow due to the increased demographic pressures being faced year on year.

Delayed Transfers of Care (DTOC)

- Measures will continue to be progressed to ensure the no. of beds subject to delayed transfers of care are ≤350. This will improve patient outcomes and enhance patient flow. A reduction in DTOCs can ultimately increase bed availability for acutely unwell patients, reduce ambulance delays and decrease admitted PETs.

Productivity Measure

Length of Stay (LoS)

- Reducing length of stay for those patients with a LoS >14 days, will improve operational outcomes in addressing demand-capacity mismatches for both UEC and elective admissions. Decreasing LoS is important for patient outcomes in reducing Health Care Associated Infections (HCAIs) and maintaining functional independence.

Data Intelligence

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

Health Protection Surveillance Centre (HPSC) reporting

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

Integrated Service Model (ISM) reporting

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

Surge Measures

Surge Measures

Introduction

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

In order to respond to and mitigate the patient safety risks associated with such high UEC activity and resultant congestion, surge measures have been planned. These measures have been informed by the previous UEC Operational Plan 2023 and the 2023 After Action Review and may be updated following the completion of the UEC Operational Plan 2023 AAR due Q2 2024.

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

Surge period outlook; Nov' 2024 – Feb' 2025

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

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

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

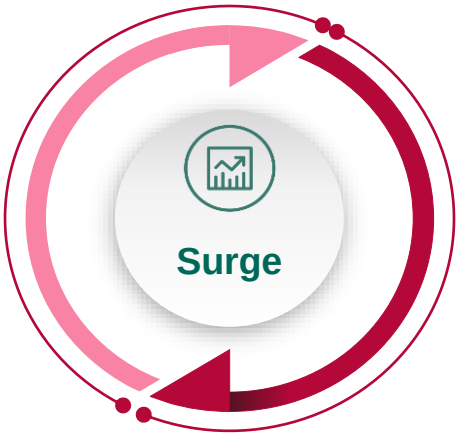
Surge measure categories

The HSE recognises the need to adapt and respond appropriately to periods of surge during Winter 2024/ 2025 as part of the UEC Operational Plan. A flexible approach will be required when implementing surge measures, which recognises the need for some measures to be progressed and in place in advance of the Winter period. Other surge measures will require initiation and scaling based on evidence-based indicators of increasing respiratory viruses, UEC congestion and potential patient safety risks. Other indicators will support the cessation of surge measures. Accordingly, two categories of surge initiatives have been developed:

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

Category 1

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



Category 2

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

Surge Measures

Category 2 Surge measure indicators and triggers

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

Sample Metrics and Triggers

Indicators	
Initiation of surge measures	**Cessation of surge measures**

1. Weekly surveillance data indicates respiratory related hospitalisations (for COVID-19, influenza or RSV) in excess of previous seasonal means or thresholds (based on historical data over several seasons) for that week.
2. Sentinel GP influenza-like illness (ILI) consultation rate is above baseline threshold and increased significantly (e.g. rate has doubled - overall or in age specific groups) compared to previous week(s).
3. A reduction in doubling time of concern of hospitalisations due to confirmed Covid-19/influenza.
4. An increased trend in the number of respiratory virus outbreaks in health and social care settings over 2-3 weeks (a trend that can't be explained by way of change in surveillance processes/testing/policy).
5. Observed actuals are in excess of and/or in advance of modelled ISM pessimistic scenarios for any of the following:
  1. Occupancy
  2. Trolleys
  3. Admitted patients on emergency beds.
6. Significant sustained upward trend in UEC demand in relation to attendances and admissions over 3 successive weeks.
	• Sustained downward trend over two weeks of Acute Respiratory Infection (ARI) hospitalisation should trigger review with de-escalation of interventions should it be sustained for a further week.
	• Sentinel GP ILI consultation rate has decreased for three weeks in succession.
	• Significant sustained downward trend in UEC demand in relation to attendances and admissions over three successive weeks.

Trigger/Cessation

Decision based on composite risk assessment taking into consideration a combination of indicators as set out to include epidemiology, hospitalisation rates and UEC demand-capacity analysis.

Surge Measures

Surge Measures and costs

Through the course of 2024, we will continue to implement and embed the actions set out within this plan that are aimed at improving operational grip and UEC processes. Surge measures are set out below and will be subject to review following winter period 2023/2024 and may be amended accordingly.

Funding for surge measures, this calendar year, has been provided for in the Health Budget 2024 (€13.26m).

Instructions on surge activation will issue to the system in advance of the winter period (Nov' 2024 –Feb' 2025).

Category 2 Surge Measure	Descriptor	Funding
Hospital Avoidance		
GPs	Extended GP hours over out of hour (OOH) periods and weekends will be delivered.	€8,000,000
Patient Flow	CHOs to roster additional and extended hours for staff to support patients at risk of hospital admission.	See costs in "Overtime Hours" below
Communications	Campaigns to promote self-care at home, alternative pathways and vaccination programmes.	n/a
ED Operations		
NAS Private Capacity	Additional capacity will be in place through voluntary and private ambulance services.	€4,000,000
In Hospital Operations		
Patient Flow	All sites and CHOs to roster additional and extended hours for senior decision makers, staff integral to patient flow and HSCPs across acute and community services.	See costs in "Overtime Hours" below
Diagnostics	Arrangements will be put in place for extended hours for public, private and mobile diagnostics to avoid weekend and post weekend delays in flow.	€660,000
Discharge Operations		
CIT	Additional maximum hours to be put in place to support ED avoidance, admission avoidance and discharge for patients.	See costs in "Overtime Hours" below
Overtime Hours		
Overtime Hours	Patient Flow (Hospital Avoidance and In Hospital Operations) and CIT (Discharge Operations). To be provided for within existing contractual arrangements and not through use of exceptional measures.	€600,000
Total Cost		**€13,260,000**

Surge Measures

UEC Emergency Measures

If there are exceptionally high levels of escalation which cannot be mitigated alone by implementation of the immediate operational actions and surge capacity measures, an emergency can be declared by 1) Mandated implementation of emergency measures by the National HSE UEC Oversight Group or 2) Mandated implementation of emergency measures locally by the REO.

UEC Emergency Measures will include:

1. The CEO will determine the requirement for and will initiate a National Crisis Management Team (NCMT) approach to ensure patient quality and safety is maintained and that specific actions are mandated to manage UEC demand.
2. Senior leaders, senior decision makers and staff with key roles pertaining to UEC across Health Regions to defer or cancel annual leave to ensure leadership is on site to manage UEC demand.
3. Internal communications to be released across Health Regions to alert all staff of emergency measures.
4. Cancel elective surgery activity for a defined period of time, excluding time critical/ time sensitive surgery, and reprioritise staff members and inpatient capacity to emergency demand.
5. Enhanced focus on epidemiological data to determine the scale of demand and corresponding actions required.
6. Urgent communication with GPs and local nursing homes to be enhanced to increase awareness of emergency measures and the associated response required.

Surge Measures Governance and Reporting

National Governance

The HSE UEC Oversight Group is the forum where the surge measures will be launched and where the impact of these measures will be monitored continuously. The Chair of the HSE UEC Oversight Group is responsible for the execution of surge measures. The HSE UEC Oversight Group will meet twice weekly once emergency measures have been triggered. Twice weekly meetings will also be held with Regional Executive Officers, and their operational and clinical service leads chaired by the HSE UEC Oversight Group chair.The purpose of these meetings is to ensure that all implementation and tactical operational issues are escalated and resolved.

Local Governance

Integrated meetings will continue to take place twice weekly at a minimum to monitor UEC activity and the impact of surge measures. There will also be short operational pulse meetings with Regional Executive Officers, and relevant operational and clinical service leads on a daily basis to address tactical operational issues that need to be escalated and to inform national situational awareness.

Appendix

Appendix
Abbreviations

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

End