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13 /10/2023

Mr Sam Keenan,
Committee Secretariat,
Public Accounts Committee,
Leinster House,
Dublin 2.

Re: Ref (*Information requested relevant to upcoming Committee report on its engagements with the HSE*)

Dear Sam,

I refer to your recent correspondence to Mr. Bernard Gloster, Chief Executive Officer, Health Service Executive, regarding the following matters in relation to the HSE's 2020 Financial Statements:

1. An update on the budget and the timeline for the implementation of the proposed Integrated Financial Management System for the HSE, and the rationale for any changes to the budget or timeline since the last update provided to the Committee in September 2021
2. An update on the implementation of recommendations contained in the National Audit of Prescribing in Child and Adolescent Mental Health Services (CAMHS) published in July 2023
3. The number of HSE audits of Section 38 and Section 39 organisations in the years 2021 and 2022
4. The number of people on the current waiting lists nationwide for CAMHS, broken down by Community Healthcare Organisation (CHO) Area
5. The current staffing deficits in each CHO area
6. An update on the HSE's progress in implementing the HSE-specific recommendations contained in the 'Value for Money and Policy Review of Nursing Home Care Costs'

Please find below for the attention of the Public Account Committee members a briefing note as requested.

If any further information is required, please do not hesitate to contact me.

Yours sincerely,

Ray Mitchell

Ray Mitchell
Assistant National Director
Parliamentary Affairs Division

Briefing Note for the Public Accounts Committee

1. An update on the budget and the timeline for the implementation of the proposed Integrated Financial Management System for the HSE, and the rationale for any changes to the budget or timeline since the last update provided to the Committee in September 2021

1. Timeline

The previous update on IFMS implementation provided to the Committee was dated September 2021, when the project had completed the design stage of the IFMS Project. Early in the Build and Test Stage, the HSE decided to terminate the system integrator (SI) contract under its rights to do so on a no fault basis.

A public procurement process was completed in June 2022 to select a new SI to build, test and deploy the IFMS system, based on the approved design, to all entities in scope for IFMS, including HSE, Tusla, Section 38 and larger Section 39 voluntary organisations. The below tables set out the 2021 revisions to the project plan and approach, highlighting the deviation from the original 2020 baseline, including re-plans.

	Design Stage	Build & Test	Implementation Groups				Phase 1 40%	Phase 2 80% [1]
			A	B	C	D		
Original Plan (7 February 2020)								
Start	03/02/20	03/07/20	03/01/21	03/07/21	03/01/22	03/07/22	09/12/19	**02/03/23**
Finish[2]	02/07/20	02/01/21	02/09/21	02/03/22	02/09/22	02/03/23	21/04/23	**02/03/24**
Re-plan Post COVID-19 First Wave (23 September 2020) *Reflects initial COVID delays with net change of 4 months to overall plan*								
Start	03/02/20	05/02/21	03/08/21	10/01/22	06/06/22	05/12/22	09/12/19	**03/07/23**
Finish	05/02/21	03/08/21	03/04/22	02/08/22	03/01/23	03/07/23	25/08/23	**10/07/24**
Re-plan Post Design Stage (5 July 2021) *Reflects project pause for COVID-19 Third Wave, additional delays and extension of build and test timeline with net change of 12 months to overall plan*								
Start	03/02/20	05/07/21	03/03/22	01/10/22	01/03/23	01/08/23	09/12/19	**01/03/24**
Finish	02/07/21	04/04/22	01/11/22	01/05/23	01/10/23	01/03/24	01/05/24	**01/03/25**

Table 1: IFMS Project Plan – deviation from original baseline as submitted 26 August 2021

[1] Indicative timelines for Phase 2 which included the balance of HSE areas and PCRS.

[2] Implementation finish dates represent go-live dates and do not include Hypercare period.

To mitigate any potential delays to the overall timeline to achieve cumulative 80% of all health expenditure on IFMS in 2025, the IFMS Statement of Requirements was updated as part of the new SI procurement process to rebalance the Phases and bring forward the implementation of PCRS in to Phase 1. See Table 2 below.

	Design Stage	Build & Test	Implementation Groups						Phase 1 80%	Phase 2 Vols.
			A	B	C	D	E	F		
Provisional Re-plan – Statement of Requirements (December 2021) *Revisions were aimed at holding to the greatest extent possible the original 2025 timeline for 80% expenditure. This is achieved by bringing **all HSE Statutory including PCRS** and three voluntary early adopters in to Phase 1. Implementation to all remaining voluntaries in scope would be in Phase 2.*										
Start	03/02/20	01/09/22	01/09/22	01/04/23	01/10/23	01/05/23	01/08/24	01/11/24	**09/12/19**	01/03/25
Finish	02/07/21	31/03/23	30/04/23	31/11/23	31/05/24	30/11/24	28/02/25	31/05/25	**31/05/25**	31/07/28

Table 2: IFMS Project Plan – Updated SOR December 2021

The Statement of Requirements invited prospective tenderers to review and refine the provisional re-plan based on their recommended approach. The new SI assessed the above implementation approach, under a number of key complexity criteria including organisational scope, business process and solution, data and change. The SI recommended a three-month period for design review and validation and a first go-live date of July 2023. This was to de-risk the initial implementation, which contained the majority of the solution complexity. Each Implementation Group was assessed, and considered the organisational footprint and legacy users. The SI advised that combining implementation groups was significantly mitigated towards the end of Phase 1 as shared services, change management and implementation will have been proven multiple time and stabilised prior to the final implementation group. The new SI's Integrated Programme Plan for Phase 1 as outlined in Table 3 below was approved by Programme Governance in September 2022. This plan provides for three early adopters from the Voluntary Health Service to be included in Phase 1. Under this approved plan, IFMS will be implemented to all remaining Voluntary Health Organisation in scope in descending order of budget allocation, from May 2025 onwards.

	Design Stage	Design Validation	Build & Test	Implementation Groups					Phase 1 80%	Phase 2 Vols.[3]
				1	2	3	4	5		
Integrated Programme Plan – New SI (14 September 2022) *Following the new SI's review of the provisional re-plan per the SOR, an integrated programme plan that incorporates a design review and validation stage and five implementation groups was approved by programme governance.*										
Start	03/02/20	18/07/22	13/10/22	01/12/22	01/06/23	31/11/23	01/05/24	01/10/24	**09/12/19**	01/05/25
Finish	02/07/21	12/10/22	31/03/23	03/07/23	01/01/24	01/07/24	02/12/24	05/05/25	**05/05/25**	31/07/28

Table 3: IFMS Integrated Programme Plan – New SI

[3] From 2025, IFMS will be implemented to all remaining Voluntary Health Organisations in scope in descending order of budget allocation.

The Design Validation Stage and the Build & Test Stage were all completed to Plan. IFMS went live on Monday 3 July as planned and is now operational across Implementation Group 1 – HSE East (incl. National and Corporate services, National Distribution Centre, Primary Care Reimbursement Service) and Tusla.

In line with the project schedule, the planned ramp up of operations with c.4,000 end users in Implementation Group 1 has taken place, involving optimisation of system and process efficiencies across the entire system during a twelve week Hypercare period post go-live. Dedicated IFMS Helpdesks have been in place to support HSE and Tusla staff, patients, and suppliers through the changeover to IFMS.

As with any major transformation programme of the scale and complexity of IFMS, it is taking the HSE time to adapt to the changes. There has been a sustained focus by the IFMS project team (HSE and SI) to support operations and end users. In addition, SI resources were focussed on technical optimisation post go-live to maximise efficiencies based on service and end user feedback. This has had the consequential impact of delaying the Implementation Group 2 plan. Key lessons learned have been captured from this first implementation and will inform the approach to Implementation Groups 2 – 5. Finance Reform Programme Governance, approved in principle a revision to the September 2022 IFMS Plan for the remainder of Phase 1 (IG2 to IG5), to allow for detailed re-planning while holding to the greatest extent possible to the original 2025 timeline for 80% health sector expenditure transacted on IFMS. **Table 4 below**, provides the proposed revisions to the plan. The go-live date of 1 November 2025 for the last of the five Implementation Groups represents a projected 6 month net extension in the project timeline when compared against the 2022 plan. The projected timeline set out below will achieve 80% of all health expenditure on IFMS in Q4 2025, rather than in Q2 2025 per the previous plan.

When compared against the original February 2020 (pre-COVID-19 pandemic, and pre-cyberattack) target date of 02/03/24 (Q1 2024), the projected net delay overall is 20 months, comprising:

July 2021: 12-month met extension due to COVID-19 pandemic and cyberattack.
September 2022: 2-month net extension on re-plan following appointment of new SI.
September 2023: indicative 6-month extension post IG1 implementation.

	Design Stage	Design Validation	Build & Test	Implementation Groups					Phase 1 80%	Phase 2 Vols.
				1	2	3	4	5		
Integrated Programme Plan – Post IG1 Re-plan (November 2023) *The plan is currently going through a process of detailed re-planning that will incorporate the lessons learned from Implementation Group 1.*										
Start	03/02/20	18/07/22	13/10/22	01/12/22	07/08/23	01/05/24	14/10/24	14/03/25	**09/12/19**	01/05/25
Finish	02/07/21	12/10/22	31/03/23	03/07/23	01/05/24	01/01/2	01/06/25	01/11/25	**01/11/25**	31/07/28

Table 4: IFMS Integrated Programme Plan – Post IG1

2. ICT Capital Budget Analysis

The contractual commitment arising from the 2022 SI tender can be accommodated within the current allocation of €82m. In summary: it will, over the next few years, be necessary for a case to be made to adjust upwards the ICT Capital budget, however

- The capital cost within the contract is €59.4m, with €40.8m of that being contractually committed once the contract is approved and signed, but the remaining €18.6m, is subject to drawdown provisions in later years.
- The approved ICT capital budget for the project is €82m, with €16.8m incurred up to the date of the contract approval in June 2022.
- While the €59.4m + €16.8m comes to €76.2m, and is within the €82m budget, there are already committed, and to be committed costs that mean the total costs of the project will exceed the €82m budget over the next number of years. Also relevant here is that the SI contract includes CPI indexation provisions from month 25 onwards.
- Accordingly, in advance of the drawdown referred to above which is relevant to the later years of the project, it will be necessary at a future point to seek an adjustment to the current €82m budget.
- Some points of note that will be relevant when the case to adjust the budget is being made will include:
  - The budget approval was received in 2016 based on work done in 2014 & 2015.
  - All figures from this period were pre-tender estimates.
  - The business case submitted, in line with The Public Spending Code requirements, was for €82m excluding VAT.
- There will be further engagement with the Department of Health on the detail to be included in a business case to adjust the budget. This engagement will include the timeline for resource allocation over the project's lifecycle to end of 2028.

3. Finance Reform Programme Budget

Against the overall capital budget of **€82million**, the Finance Reform Programme has incurred the following costs to end Q3 2023:

Finance Reform Programme Cumulative ICT Capital Expenditure to end Q3 2023	
SAP Phase 1 Stabilisation – Implementation HSE Mid-West	€1,354,289
SAP Implementation Consolidated Financial Intelligence	€787,692
SAP Phase 2 Stabilisation – Implementation HSE North West, Crumlin and CHI	€2,818,314
IFMS Lot 1 SAP – ERP Software Solution	€3,904,203
IFMS Infrastructure and Hosting	€4,430,169
IFMS Software and Licencing	€1,514,956
External System Integrator and Specialist Project Support	€29,231,340
Cumulative Expenditure at end Q3 2023	**€44,040,963**

Table 5: FRP Capital Expenditure to end Q3 2023

2. An update on the implementation of recommendations contained in the National Audit of Prescribing in Child and Adolescent Mental Health Services (CAMHS) published in July 2023

	Prescribing Practice Audit Recommendations	Update 02/10/23
1.	A national software system for patient administration and clinical records in CAMHS in Ireland must be commissioned immediately. The requirement for a national IT system for CAMHS is urgent and long overdue. The lack of any national IT infrastructure in CAMHS was a barrier to efficient data gathering for this audit and likely impacted clinical services due to the extent of time required to complete the data collection and input. This will require dedicated ring-fenced funding.	Supported by HSE e-Health and with input from CHO colleagues, HSE Community Operations has conducted a review of the current ICT landscape in CAMHS. Five existing ICT systems have been assessed against identified requirements for an interim solution, bearing in mind that a comprehensive suite of functionalities will be provided by the ICCMS. In addition to a single system solution, there will be targeted short-term digital enhancements (e.g. e-referral, shared diaries and dictation systems). A recommendation has been given to the oversight group to proceed with a single system solution as a critical priority and the procurement status of this option is being investigated, to ensure it can be rolled out to the CHOs with no system currently. An update on this is expected imminently.
2.	National Guidelines and protocols for prescribing, monitoring and consent must be developed and rolled out across all CHO CAMH services. These will support clinical practice and inform future annual national audits of prescribing in CAMHS. - These guidelines and protocols should be consensus based, evidence based, referencing international standards, guidelines, and literature. This should be supported by the development of standardized clinical documentation. Data from this baseline audit on off-label usage and target symptoms could inform some of this process. - A standardized procedure for obtaining and documentation of informed consent should be designed, implemented, and rolled out nationally. - This should be supported by user-friendly medication information resources such as patient and carer information booklets and side-effect monitoring tools to assist parents, guardians, and young patients.	This Action is already incorporated as part of the Sharing the Vision (StV) Implementation Plan 2022 – 2024 and StV recommendation 44. Informed by engagement with the Clinical Lead for the HSEs National Medication Safety Programme and the ICGP, a small working group is now preparing a position paper on the delivery of this critical, but complex recommendation. As a next step, a meeting is being arranged (this month October) with the HSEs National Clinical Lead for Integrated Care, NCAGL's for mental health and primary care, Clinical Lead for Chronic Disease and public health colleagues. Once complete, this position paper will set out a proposed programme to reduce risk of harm by inappropriate polypharmacy, including objectives, deliverables, risk mitigation and suggested approach to its implementation. Updates in relation to this action are provided at the monthly National Oversight Group co-chaired by the Chief Operations Officer and the Chief Clinical Officer.

3.	An annual national audit of prescribing in CAMHS should be commissioned under the governance of the HSE NCCA, using standards set out by National Guidelines and protocols. The feasibility of an annual audit in the manual format as conducted in this baseline audit is questionable due to the high dependency on clinical staff time. It must be supported by electronic systems for data input and collection of material for audit. Ideally data collection should be prospective and longitudinal. o The tool from this audit should be modified and expanded with use of customizable lists and collect detailed data on physical health parameters (e.g., blood tests and ECGs). The information and data from this study could be utilized to inform a data set and expanded audit tool. o Future audit should include detailed examination of compliance with all physical assessment parameters including specific blood tests and ECG etc. as required for each medication class. o The need for this is supported by the fact that only two of six basic criteria standards were met.	A request has been submitted on the 29th September 2023 to the Healthcare Audit Unit, Internal Audit Division, Health Service Executive to include CAMHS prescribing practice as an area for prioritisation on the HSE Audit schedule for 2024.
4.	Separate audits of prescribing and developmental disorders should be undertaken nationally across disability services in context in the context of the available developmental therapies.	Since the appointment of the Assistant National Director and National Clinical Lead for Child and Youth Mental, a mapping process is underway to ensure the full set of all recommendations arising from the Maskey Report, Mental Health Commission Report, audits of prescribing practice and adherence to the CAMHS operational guidance, etc. as well as work undertaken currently as part of the Sharing the Vision programme. This roadmap will define the key milestones that need to be accomplished, the expected timelines for each and a more granular level timeline for activities that need to be undertaken to accomplish the milestone. Engagement with primary care and disability services is a key priority in the coming weeks, where this recommendation will be discussed.
5.	Future audits should be commissioned to audit the availability and access to non-medication related interventions (e.g., psychosocial treatments) within and between CAMHS teams. This will assist in understanding the relationship between the availability of therapies and the need for prescribing.	Since the appointment of the Assistant National Director and National Clinical Lead for Child and Youth Mental, a mapping process is underway to ensure the full set of all recommendations arising from the Maskey Report, Mental Health Commission Report, audits of prescribing practice and adherence to the CAMHS operational guidance, etc. as well as work undertaken

		currently as part of the Sharing the Vision programme. This roadmap will define the key milestones that need to be accomplished, the expected timelines for each and a more granular level timeline for activities that need to be undertaken to accomplish the milestone. A future audit on the availability and access to non-medication related interventions (e.g., psychosocial treatments) will be commissioned as part of this process
6.	A secondary analysis should be commissioned of the dataset collected from this Audit to further explore links between medication dose, age, indications and comorbidities. This secondary analysis will add knowledge to national prescribing guidelines in CAMHS, assist in laying the framework for future national and local audits, and inform service development	A request has been submitted on the 29th September 2023 to the Healthcare Audit Unit, Internal Audit Division, Health Service Executive to include CAMHS prescribing practice as an area for prioritisation on the HSE Audit schedule for 2024. If successful discussions will take place on secondary analysis proposal.
7.	Prescription of psychotropics for children and adolescents in CAMHS should always be overseen by consultant psychiatrists.	This has been communicated to CHO Management and ECDs by formal memo, prior to the publication of the Maskey Report in January 2022. Of note the audit found less than 50 percent of children attending CAMHS were prescribed medication with 95% of those having their medication prescribed by a consultant or in consultation with a consultant.

3. The number of HSE audits of Section 38 and Section 39 organisations in the years 2021 and 2022

The scope of the HSE Internal Audit covers all systems and activities throughout the HSE and bodies totally or partially funded by the HSE (which includes S38s and S39s).

The number of audit reports related to S38 and S39 are as follows:

Year	Reports
2021	23
2022	80

The increase from 2021 to 2022 was due to redeployment of staff to internal audit duties (post Covid restrictions), and additional audit capacity from an outsourced contract.

Internal Audit reports are released under Freedom of Information quarterly.

4. The number of people on the current waiting lists nationwide for CAMHS, broken down by Community Healthcare Organisation (CHO) Area

At the end of August (latest data), nationally there was a decrease of 164 children on the waiting list for community mental health services, from 4,055 in July to 3,891 in August 2023.

There are 656 children waiting longer than 12 months in August 2023.

CHO1 have (5), CHO2 (39), CHO3 (63) CHO4 (348), CHO5 (37), CHO6 (22), CHO7 (27), CHO8 (115) and CHO9 (0) children waiting longer than 12 months to be seen by CAMHS.

The CAMHS waiting list will require an additional 1,075 people to be seen to reach the pre pandemic wait list levels of 2,816 (March 2020)

Below is the breakdown by CHO by length of wait time.

	Total waiting to be seen	**<= 12 weeks No.**	**> 12 <= 26 weeks No**	**>26 <=39 weeks No**	**>39 <=52 Weeks No**	**>52 Weeks No**
National Total	**3,891**	**1,401**	**941**	**549**	**344**	**656**
CHO 1	294	122	86	46	35	5
CHO 2	233	79	51	34	30	39
CHO 3	297	87	82	46	19	63
CHO 4	937	215	164	122	88	348
CHO 5	254	76	65	44	32	37
CHO 6	604	259	157	118	48	22
CHO 7	417	203	119	49	19	27
CHO 8	695	285	150	73	72	115
CHO 9	160	75	67	17	1	0

5. The current staffing deficits in each CHO area

Work is ongoing to coordinate and analyse information to respond to this query. We hope to have the information within the next two weeks.

6. An update on the HSE's progress in implementing the HSE-specific recommendations contained in the 'Value for Money and Policy Review of Nursing Home Care Costs'

This note is to provide a briefing on the following HSE specific recommendations – Value for Money & Policy Review of Nursing Home Care Cost.

Recommendation 3: *The interRAI Single Assessment Tool should be rolled out nationally, along with a set of national operational policy and guidelines, to determine the care needs of the applications to the NHSS. Within a defined period of time (determined by the Department), care needs assessments used to determine funding under the Nursing Homes Support Scheme should be undertaken using the interRAI Single Assessment Tool.*

Update:
Funding has been made available from the Department of Health (DoH) for its national roll out in community settings, with an initial focus on the home support sector. The HSE has in place a number of work streams to inform the design and implementation of an operating model for Home Support services and interRAI as part of the wider home support reform programme and governance structures.

Investment secured for home support will commence the rollout of interRAI through delivering 128 interRAI assessors, which are currently being recruited and will collect and analyse data from these assessments which will be critical in determining how to integrate care needs assessment into the NHSS.

Recommendation 6: *An extensive review and audit process be established as a matter of urgency to examine the operation, costs, staffing, rostering, use of agency staff and cost assignment in public nursing units prioritising the most expensive nursing homes. The process should be supported by external expertise as required. Cost improvement measures should be a key outcome along with recommendations for future use and/or alternative service models where costs improvement measures cannot be achieved.*

Update: Significant work has already taken place to support an extensive review on the cost of care of publically managed CNUs. This work took the form of an audit and validation process of all public and section 38 beds in the summer of 2022. Following on from this validation exercise, face to face engagements with CHO areas were udnertaken to identify cost drivers and to support any remedial actions to address variances.

The HSE has now established a Cost of Care Working Group as part of the overall Expenditure Management Programme. The primary objective is to ensure effective implementation of the financial framework, developing a plan to address the public cost of care that builds on the results of the Executive's 2022 review of public bed capacity and is aimed at reducing the variance between the actual and published costs of public residential care funded through the NHSS. Actions underway include to examine the operation, costs, staffing, rostering, use of agency staff and cost assignment in public nursing units with a key focus on CNUs with higher cost of care levels. This plan will be developed in consultation with the Department and include provision for an independently supported review and audit in accordance with the recommendations of the Value for Money review.

The delivery of residential services has been met with significant challenges, these challenges have had a negative impact on the variance between the paid cost of care and the actual cost of care per bed. A number of these identified challenges relate to legislative responsibilities, staffing levels, inflationary factors and IPC requirements to support isolation facilities.

Rectifying the Cost of Care issue is also reliant on a number of dependencies:

- Safe Staffing Framework project (DH CNO nursing strategy to set safe staffing levels).
- National Older Persons Residential Steering Group to develop a framework/ model for residential services inclusive of demand modelling.

- Completion of the National Capital Investment Programme to increase bed stock and maximise capacity.
- Availability of reliable, real time data related to residential care services i.e. Community Bed Management System.

Summative points of Note:

1. Total costs of public Units have remained relatively stable overall with increases linked to agreed pay awards etc.

2. The key issues is the increase in the actual cost per bed per week rather than the total costs.

3. That the total cost of beds, driven by the identified factors is spread over a diminished and in some cases a continual declining number of beds thus resulting in a higher average actual cost per bed per week.

4. The funding model of public beds is such (*i.e*. via NHSS and only "breakeven" if achieve 95% occupancy) that movements in average costs per bed result in significant local financial issues, particularly if local average costs are outside of the limits allowed for within NHSS rates.

5. Having an understanding of bed movements is vital, ie what category of beds are closed (long stay versus short stay) and why, what type of beds are necessary to meet particular cares needs of a specific area. This information is necessary for the support of any new model of residential care (that may result in the reconfiguration of beds stock from Long Term Care to Short Term care) so that the rostering arrangements are as efficient as possible. This will minimise in so far as practical the cost of safely staffing whatever number of beds are open in any given unit at any point in time.

Recommendation 7: *The published cost of care for public nursing homes should be explicit whereby the cost of care referred to is the maximum cost of care that can be charged to the NHSS. For the purposes of transparency, a list showing the actual eligible costs incurred by each nursing home, highlighting any variances against the maximum cost of care should be published shortly after the end of each financial year. Rationale: While it is appropriate that the HSE, at a national level, sets the maximum cost of care, as it deems reasonable for each public nursing home, the majority of public nursing homes are incurring costs greater than this. The published cost of care, which shows the maximum costs chargeable to the NHSS, could be misconstrued as a reflection of the actual costs public nursing homes are incurring per resident per bed per week. For the purposes of transparency, a separate list which clearly shows the cost variances should be published shortly after the end of each financial year.*

Update:

This recommendation relates to publication of the cost of care for public nursing homes. The weekly paid/published cost of care at public nursing homes is published on the HSE website and is updated yearly. On the 13th April 2023, the HSE published its annual updated cost of providing care in its public residential care centres for older people.

The cost of care at public Nursing Homes/Community Nursing Units is calculated annually by the HSE and implemented as part of the funding process for Public Units under the NHSS Act 2009. In 2023, the paid cost of care, per bed, per week is €1,844. This is an increase from €1,698 in 2022. The cost of care was set at the 2022-paid rate, plus the pay increases for public servants awarded in 2022, as per Building Momentum. These costs apply to the operating costs of providing care in these centres. They do not relate to the amount a person will pay towards their care under the Nursing Homes Support Scheme (Fair Deal). The amount a person pays towards the cost of their nursing home care under the Nursing Homes Support Scheme (Fair Deal) is calculated based on the value of their assets and income when they apply for nursing home care. This calculation follows the requirements of the Nursing Homes Support Scheme Act 2009. The average actual cost of care for July 2023 is €2,484.

It is acknowledged that there are variations in the cost of care across public centres as well as across private nursing homes, with public nursing homes generally having a higher cost of care. A number of factors contribute to these costs including;

- Reductions in the number of long-stay public beds in public Nursing Homes/Community Nursing Units to comply with HIQA residential care standards, while fixed costs such as lighting, heating and maintenance costs have increased.
- Public nursing homes generally have higher ratios of nursing and other staff in place than private nursing homes.
- Rates of pay and leave entitlements in public sector are higher than in private sector.

The total extra cost of providing NHSS service at public nursing homes is published as part of the HSE AFS, within Note 12 as Nursing Home Fixed and Other Unit Costs – see 2022 AFS note below for information.

Note 12 Long Term Residential Care (incorporating Nursing Homes Support Scheme / Fair Deal)

The Nursing Homes Support Scheme (Fair Deal) commenced in 2009 and phases out the former Nursing Homes Subvention Scheme and the 'contract beds' system for older persons. Under the scheme, people who need long term residential care services have their income and assets assessed, and then contribute up to 80% of assessable income and up to 7.5% per annum of the value of the assets they own, subject to a maximum period of three years in respect of their principal private residence, towards the cost of their care. The HSE pays the balance, if any, of the costs of their care in both registered public and private nursing homes covered under the scheme.

Costs of Long Term Residential Care (Nursing Homes Support Scheme / Fair Deal)

	2022 €'000	2021 €'000
Private Nursing Homes	**686,227**	655,704
Section 39 Agencies	**21,412**	21,475
Private Nursing Homes Contract Beds and Subvention Payments	**5,669**	7,625
COVID-19 Temporary Assistance Payment Scheme (TAPS)**	**22,762**	48,083
Temporary Inflation Payment Scheme (TIPS)***	**4,132**	0
Pandemic Special Recognition Payment (PSRP)****	**30,095**	0
Total Payments to Private Nursing Homes including Section 39 Agencies	**770,297**	732,887
Gross NHSS Cost of Public Nursing Homes*	**330,808**	331,417
Payments to Section 38 Agencies	**23,983**	24,555
Nursing Home Fixed and Other Unit Costs	**138,743**	109,947
Total Long Term Residential Care	**1,263,831**	**1,198,806**

Recommendation 8: *The Department of Health and the HSE should examine if a cohort of existing long-term care residents supported under the NHSS could have remained at home for longer had the right package of supports been available.*

Update*:*
To support older people to live in their own home with dignity and independence for as long as possible significant work is underway for the development of a statutory home support scheme for the financing and regulation of home-support services. It is intended that the new scheme will provide equitable and transparent access to high-quality services based on a person's assessed care-needs, and that it will operate consistently across the country. This will enable many older people to continue to live as independently as possible in their own community.

Significant investment in additional hours of home care to be delivered continues in advance of the commencement of a reformed model of service delivery for home support and recruitment campaign for 128 interRAI assessors.

Substantial investment continues to be made in HSE capacity to offer additional hours of home support including packages that are targeted at long-term care avoidance. This provides a test case of the scenario envisaged by this recommendation, whereby additional funding has been made available to support those who would otherwise have entered long-term residential care.

Data from July YTD indicates 12,282,749 Home Support Hours were delivered with 314,315 more hours have been delivered YTD 2023 when compared to the SPLY. At the end of July 51,279 people were in receipt of Home Support and 13,487 new clients have been provided with a service since January 2023, assisting in the avoidance of admission to long-stay residential care. See table below for further detail on HS Activity July YTD;

Home Support Activity - NATIONAL SUMMARY								
Description	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Total
Target PM	2,003,435	1,834,122	2,003,435	1,946,997	2,093,286	1,946,997	2,003,435	13,831,707
Total Hours	1,735,018	1,672,228	1,773,743	1,729,775	1,812,242	1,820,829	1,738,913	12,282,749
Total Direct Hours	641,915	627,593	660,432	641,289	683,550	669,460	690,881	**4,615,119**
Total Indirect Hours	1,093,103	1,044,635	1,113,311	1,088,486	1,128,692	1,151,369	1,048,032	**7,667,630**
Direct %	37%	38%	37%	37%	38%	37%	40%	**38%**
Indirect %	63%	62%	63%	63%	62%	63%	60%	**62%**
Total Waiting List	6,370	6,246	6,441	6,168	6,201	6,020	5,992	5,992
Asesssed & Waiting on Funding	7	10	7	1	3	-	-	**-**
Assessed & Waiting on Carers	6,362	6,234	6,432	6,166	6,198	6,020	5,992	**5,992**
Assessed & Waiting on Equipment/Adaptations	1	2	2	1	-	-	-	**-**
New Clients - Referral Source	2,160	1,905	1,880	1,675	2,309	1,823	1,735	13,487
Referred from Acute	798	692	764	663	907	692	577	**5,093**
Referred from Community	1,362	1,213	1,116	1,012	1,402	1,131	1,158	**8,394**
Churn Rate - New Clients	4%	3%	3%	3%	4%	3%	3%	3%
Churn Rate - Leavers	4%	3%	3%	3%	8%	5%	3%	3%
New Clients	2,160	1,905	1,880	1,675	2,309	1,823	1,735	**13,487**
Ceased Clients	2,050	1,456	1,681	1,745	4,449	2,902	1,437	**15,720**
Clients - First Day	56,162	56,272	56,721	56,920	56,850	54,703	50,981	**50,981**
Clients - Last Day	56,272	56,721	56,920	56,850	54,710	53,624	51,279	**51,279**

With regard to a broader analysis examination of whether or not residents could have remained at home if the right package of supports had been made available, there are complex questions of choice, family support and access to community supports that mean that the availability of a home support package may not be the only, or even the primary, driver of the decision to enter care.

Recommendation 9: *The recommendations of this review should be implemented having regard to the recommendations of the final report published by the COVID-19 Nursing Homes Expert Panel on 19 August 2020.*

Update:
The COVID-19 Nursing Home Expert Panel Report includes 86 recommendations in total, over 15 thematic areas, with associated timelines for implementation over the short, medium and long term. The Minister for Health established an oversight structure to ensure the implementation of the important recommendations contained in this Report. Work to progress the implementation of the Expert Panel report continues, as it provides an important framework for the ongoing response to COVID-19 and longer-term reform and integration of older person residential and community services.

Work is presently underway by the Department, the Minister for Older People and the HSE to review progress and to ensure that the recommendations of the Nursing Home Expert Panel are considered in conjunction with the recommendations of this report. To date many of the recommendations of the Expert Panel report have been implemented, particularly its short- and medium-term recommendations.

The Expert Panel also identified the need for greater integration of RCFs in the wider health care system in line with the overall reform programme. As a result, the Expert Panel recommended to '*Establish new integrated Community Support Teams with clearly defined joint leadership and responsibility across each CHO and Hospital Group area on a permanent basis [...] in the interim, the existing COVID-19 Response Teams should remain in place*'.

Community Support Teams are being implemented on a phased bases as follows:

- Phase 1 - IPC related functions as carried out by existing Covid-19 Response Teams
- Phase 2 - Service integration for Residential Care Facilities for the Older Person

New posts associated with Phase 1 of CST's; (Director of Nursing, Clinical Nurse Manager II and Grade IV Admin) are progressing through recruitment stages across CHO areas. Appointees have commenced or are at latter stages of recruitment. The additional posts associated with CST's will be realized in Phase 2 as part of the longer-term reform and integration of older person residential and community services.

Health Service Executive
October 2023