PAC-R-913

Correspondence 3C.1
Meeting 81 – 25/04/2013

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Oifig an Phríomhfheidhmeannaigh
Feidhmeannacht na Seirbhíse Sláinte
Urlár 1
Ospidéal an Dr. Steevens
Baile Átha Cliath 8

CEO's Office
Health Service Executive
1st Floor
Dr. Steevens' Hospital
Dublin 8

Tel: (01) 635 2000
Fax: (01) 635 2211
Email: ceopa@hse.ie

8 January, 2013

Dr Ambrose McLoughlin
Secretary General
Department of Health
Hawkins House
Dublin 2

Dear Ambrose

I enclose herewith the Vote 39 - HSE Vote Expenditure Return at 31 December, 2012.

Yours sincerely

Tony O'Brien
Deputy Chief Executive/
Director General Designate

Vote 39 Vote Expenditure Return at 31st December 2012

(As at 8th January 2013)

1. Vote Position at 31st December 2012 – Post Supplementary Estimate

Vote Return – December 2012	YTD Profile post 2012 Supplementary Estimate €'000	December YTD Outturn €'000	Over (Under) €'000
Gross Current Expenditure	13,680,455	13,659,349	(21,106)
Gross Capital Expenditure	354,000	341,150	(12,850)
Total Gross Vote Expenditure	**14,034,455**	**14,000,499**	**(33,956)**
Appropriations-in-Aid			
- Receipts collected by HSE	1,113,917	1,097,261	(16,656)
- Receipts EU Health Costs	220,000	220,000	-
- Other Receipts	171,605	167,605	(4,000)
- Capital Receipts	8,000	4,479	(3,521)
- Total	**1,513,522**	**1,489,345**	**(24,177)**
Net Expenditure	**12,520,933**	**12,511,154**	**(9,779)**

2. Supplementary Estimate 2012

A supplementary Estimate of €360m was passed by the Dail on the 13th December 2012 which related to deficits in services (Medical Cards, Community Drugs Schemes and the Acute Hospital Sector).

3. Comparison to Issues Return

The December Vote Return is broadly consistent with the issues return submitted on the 18th December 2012.

4. Capital Position at 31st December 2012 - Post Supplementary Estimate

Subhead	YTD Profile post 2012 Supplementary Estimate €'000	December YTD Outturn €'000	Over (Under) €'000
B.15 Children & Family Services	974	800	(174)
C.1 – Capital - Construction	320,487	308,117	(12,370)
C.2 – Capital - Lottery	2,539	2,539	-
C.3 – Capital - Information Systems	22,000	21,694	(306)
C.4 – Mental Health Facilities	8,000	8,000	-
Gross Capital Expenditure	**354,000**	**341,150**	**(12,850)**
D.10 Receipts from the Disposal of Mental Health and other Health Facilities	8,000	4,479	(3,521)
Net Capital Expenditure	**346,000**	**336,671**	**(9,329)**

5. General Commentary

The December vote expenditure return is prepared on the basis of:

- cash issued to HSE areas;
- estimates of appropriations-in-aid collected directly by the HSE;
- actual receipts from the private insurance agreement;
- other actual receipts from the Revenue Commissioners and from the UK Department of Health in relation to the recovery of EU health costs.

The outturn for subhead B.15 - Children & Family Services and B.13 – Service Developments is returned at the Estimate allocation as the actual outturn is not available given that the HSE does not have a vote accounting system that can report on a subhead basis by care area.

The outturn for subhead B.12 – Long Term Residential Care is based on the standard cost of public long stay beds and actual bed occupancy. Clarification received from D/PER in relation to the appropriate charge will require the charge to be recalculated in time for incorporation in the 2012 Appropriation Account. .

Therefore while the gross expenditure is correct the individual subhead totals in the attached return are subject to amendment following completion and audit of the 2012 Appropriation account.

Net expenditure is under profile by €10m at year-end.

The above position is based on the actual cash issued to year end and is subject to change as bank balances and suspense account balances are reconciled for the preparation of the Appropriation Account. The final outturn for 2012 will not be available until the 2012 Appropriation Account is prepared in March 2013.

6. Issues by Gross Vote Subhead – Post Supplementary Estimate Revenue Position.

- The statutory sector is €16m under profile.

- The voluntary sector is €9m under profile.

- The medical card services and community schemes are €4m over profile.

- Payments to the State Claims Agency are on profile.

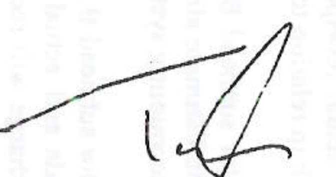
- Receipts of €4m from the Social Insurance Fund for the Dental and Ophthalmic Services Schemes did not materialise.

- A request for Virement will be sought from the D/PER when the draft 2012 Appropriation Account is prepared and the final subhead outturn is known.

Tony O'Brien
Accounting Officer

Date: 8th January 2013

Non Pay Returns for:	DEC													
	2012													
	RETURNS													REV
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year	Total Year
V39 - HEALTH SERVICE EXECUTIVE (NON PAY)	531,729	464,312	481,676	473,649	476,180	493,174	357,218	501,353	458,657	469,361	508,549	319,031	5,534,889	5,218,572
V39 - GROSS	583,099	523,982	524,995	538,688	529,780	545,774	540,817	555,952	521,258	519,960	563,149	526,869	6,474,323	6,226,952
V39 - ADMINISTRATION	3,541	3,509	3,525	3,525	3,525	3,526	3,525	3,526	3,526	3,526	3,526	3,525	42,305	42,305
A.1 - SALARIES, WAGES AND ALLOWANCES	3,520	3,488	3,504	3,504	3,504	3,504	3,504	3,504	3,504	3,504	3,504	3,502	42,046	42,046
A.2 - VALUE FOR MONEY POLICY REVIEWS	21	21	21	21	21	22	21	22	22	22	22	23	259	259
V39 - PROGRAMME EXPENDITURE	579,558	520,473	521,470	535,163	526,255	542,248	537,292	552,426	517,732	516,434	559,623	523,344	6,432,018	6,184,647
V39 - HSE REGIONS AND OTHER HEALTH AGENCIES	262,388	206,126	214,273	208,552	213,019	207,559	207,142	215,774	204,827	196,490	211,616	178,179	2,525,945	2,481,223
B.1 - HSE - DUBLIN MID LEINSTER REGION	35,331	35,257	32,254	31,948	34,185	36,541	36,577	37,941	30,786	33,664	36,474	30,614	411,572	403,907
B.2 - HSE - DUBLIN NORTH EAST REGION	30,423	27,928	26,441	29,651	31,685	30,355	27,865	36,584	31,287	30,253	34,918	20,738	358,128	349,357
B.3 - HSE - SOUTH REGION	48,876	47,170	49,464	43,508	49,255	45,959	49,234	46,014	47,371	42,013	47,959	45,653	562,476	551,134
B.4 - HSE - WEST REGION	52,592	45,218	50,942	58,393	49,394	48,342	49,997	50,054	52,092	50,601	52,358	57,049	617,032	601,228
B.5 - GRANT TO HEALTH BODIES	95,166	50,553	55,172	45,052	48,500	46,362	43,469	45,181	43,291	39,959	39,907	24,125	576,737	575,597
V39 - OTHER SERVICES	308,837	306,014	298,864	318,278	304,903	326,356	321,817	328,319	304,572	311,611	339,674	336,828	3,806,073	3,603,424
B.6 - MEDICAL CARD SERVICES SCHEME	228,803	220,832	213,155	228,717	222,849	239,258	232,727	233,790	236,141	231,135	239,200	219,829	2,746,436	2,509,004
B.7 - GRANT TO HEALTH AGENCIES (NAT LOTTERY)	626	626	626	626	626	626	626	626	626	626	626	627	7,513	7,513
B.8 - GRANT FOR SERVICES FOR HEP C	471	471	471	471	471	471	471	471	471	471	471	470	5,651	5,651
B.10 - PAYMENTS TO SPECIAL A/C - HEALTH REPAYMENTS SCHEME	0	500	0	500	0	0	0	250	0	0	0	450	1,700	1,700
B.11 - PAYMENTS TO SPECIAL A/C - HEPATITIS C SCHEME	0	0	0	0	0	0	0	0	0	0	0	700	700	1,500
B.12 - LONG TERM RESIDENTIAL CARE	54,311	47,580	53,580	52,164	54,223	52,785	54,160	55,187	40,624	52,931	70,147	55,632	643,324	643,324
B.13 - SERVICE DEVELOPMENTS	1,991	5,176	0	797	1,991	1,991	0	0	0	0	0	17,403	29,349	43,000
B.14 - PAYMENTS TO STATE CLAIMS AGENCY	0	4,224	4,483	10,200	0	6,441	10,180	12,172	3,653	2,905	2,763	18,647	75,668	96,000
B.15 - CHILDREN AND FAMILY SERVICES	22,635	26,605	26,549	24,803	24,743	24,784	23,653	25,823	23,057	23,543	26,467	23,070	295,732	295,732
V39 - CAPITAL SERVICES	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,337	100,000	100,000
C.3 - INFO SYSTEMS FOR HEALTH AGENCIES	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,337	100,000	100,000
V39 - APPROPRIATIONS IN AID	51,370	59,670	43,319	65,039	53,600	52,600	183,599	54,599	62,601	50,599	54,600	207,838	939,434	1,008,380
D - APPROPRIATIONS IN AID	51,370	59,670	43,319	65,039	53,600	52,600	183,599	54,599	62,601	50,599	54,600	207,838	939,434	1,008,380

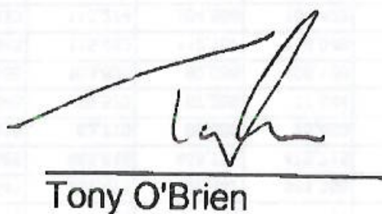


Tony O'Brien
Accounting Officer
8 January, 2013

Pay Returns for:	DEC													
	2012													
	RETURNS													REV
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year	Total Year
V39 - HEALTH SERVICE EXECUTIVE (PAY)	636,962	502,624	509,094	499,722	511,613	496,642	493,368	515,765	490,741	469,869	514,328	429,721	6,070,449	5,986,647
V39 - GROSS	666,829	525,491	546,571	528,200	540,637	526,709	523,354	545,546	511,176	498,192	543,061	458,660	6,414,426	6,323,803
V39 - HEALTH SERVICE EXECUTIVE (ADMIN)	1,713	1,697	1,705	1,705	1,705	1,705	1,704	1,705	1,705	1,705	1,705	1,707	20,461	20,461
A.1 - SALARIES, WAGES AND ALLOWANCES	1,702	1,686	1,694	1,694	1,694	1,694	1,694	1,694	1,694	1,694	1,694	1,697	20,331	20,331
A.2 - VALUE FOR MONEY POLICY REVIEWS	11	11	11	11	11	11	10	11	11	11	11	10	130	130
V39 - PROGRAMME EXPENDITURE	665,116	523,794	544,866	526,495	538,932	525,004	521,650	543,841	509,471	496,487	541,356	456,953	6,393,965	6,303,342
V39 - HSE REGIONS AND OTHER HEALTH AGENCIES	613,477	470,957	491,232	474,716	485,545	472,310	470,129	489,885	465,846	445,736	478,715	397,015	5,755,563	5,659,421
B.1 - HSE - DUBLIN MID LEINSTER REGION	73,117	72,962	66,746	66,114	70,743	75,618	75,695	78,516	63,710	69,666	75,480	63,356	851,723	835,861
B.2 - HSE - DUBLIN NORTH EAST REGION	67,648	62,102	58,792	65,930	70,455	67,495	61,961	81,348	69,570	67,269	77,644	46,110	796,324	776,820
B.3 - HSE - SOUTH REGION	107,129	103,390	108,419	95,364	107,960	100,733	107,913	100,855	103,830	92,086	105,120	100,064	1,232,863	1,208,004
B.4 - HSE - WEST REGION	116,568	100,225	112,911	129,425	109,480	107,149	110,817	110,943	115,462	112,157	116,049	126,450	1,367,636	1,332,609
B.5 - GRANT TO HEALTH BODIES	249,015	132,278	144,364	117,883	126,907	121,315	113,743	118,223	113,274	104,558	104,422	61,035	1,507,017	1,506,127
V39 - OTHER SERVICES	51,639	52,837	53,634	51,779	53,387	52,694	51,521	53,956	43,625	50,751	62,641	59,938	638,402	643,921
B.6 - MEDICAL CARD SERVICES SCHEME	800	772	745	799	779	836	813	817	825	808	776	830	9,600	8,770
B.8 - GRANT FOR SERVICES FOR HEP C	734	734	734	734	734	734	734	734	734	734	734	733	8,807	8,807
B.12 - LONG TERM RESIDENTIAL CARE	29,664	25,987	29,265	28,491	29,616	28,831	29,582	30,142	22,188	28,911	38,313	30,386	351,376	351,376
B.13 - SERVICE DEVELOPMENTS	926	2,407	0	371	926	926	0	0	0	0	0	8,095	13,651	20,000
B.15 - CHILDREN AND FAMILY SERVICES	19,515	22,937	22,890	21,384	21,332	21,367	20,392	22,263	19,878	20,298	22,818	19,894	254,968	254,968
V39 - APPROPRIATIONS IN AID	29,867	22,867	37,477	28,478	29,024	30,067	29,986	29,781	20,435	28,323	28,733	28,939	343,977	337,156
D - APPROPRIATIONS IN AID	29,867	22,867	37,477	28,478	29,024	30,067	29,986	29,781	20,435	28,323	28,733	28,939	343,977	337,156
PAY COST ANALYSIS													0	
OVERTIME, ALLOWANCES & PRSI	72,832	59,308	62,692	61,868	61,260	60,457	59,041	61,035	57,868	58,091	62,468	58,285	735,205	0
Overtime	23,981	19,528	20,642	20,371	20,171	19,906	19,440	20,097	19,054	19,127	20,568	19,191	242,076	
Allowances	7,129	5,805	6,137	6,056	5,996	5,918	5,779	5,974	5,664	5,686	6,115	5,705	71,964	
Employer PRSI	41,722	33,975	35,913	35,441	35,093	34,633	33,822	34,964	33,150	33,278	35,785	33,389	421,165	
PENSION LEVY	29,867	22,867	37,477	28,478	29,024	30,067	29,986	29,781	20,435	28,323	28,733	28,939	343,977	337,156
Receipts in respect of Civil Service staff													0	0
Receipts in respect of Public Service staff	29,867	22,867	37,477	28,478	29,024	30,067	29,986	29,781	20,435	28,323	28,733	28,939	343,977	337,156

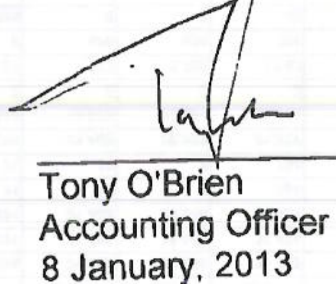
Tony O'Brien
Accounting Officer
8 January, 2013

Pension Returns for:	DEC												
	2012												
	RETURNS												REV
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year	Total Year
V39 - HEALTH SERVICE EXECUTIVE (PENSION)	**55,135**	**53,785**	**71,228**	**76,945**	**56,439**	**38,466**	**36,180**	**38,872**	**35,893**	**35,728**	**39,774**	**30,700**	**569,145**	**581,714**
V39 - GROSS	71,174	68,524	89,919	95,367	74,886	56,925	52,084	54,072	51,083	50,171	54,784	51,611	770,600	781,700
V39 - HEALTH SERVICE EXECUTIVE (ADMIN)	17,250	21,372	41,370	46,337	25,353	8,528	3,230	3,131	2,728	3,527	3,950	22,224	199,000	207,000
A.3 - PENSION LUMP SUM PAYMENTS	17,250	21,372	41,370	46,337	25,353	8,528	3,230	3,131	2,728	3,527	3,950	22,224	199,000	207,000
V39 - HSE REGIONS AND OTHER HEALTH AGENCIES	53,877	47,106	48,505	48,983	49,487	48,348	48,806	50,893	48,308	46,596	50,812	29,304	571,023	574,181
B.1 - HSE - DUBLIN MID LEINSTER REGION	9,329	9,309	8,516	8,435	9,026	9,648	9,658	10,018	8,129	8,889	9,630	-663	99,924	106,647
B.2 - HSE - DUBLIN NORTH EAST REGION	8,636	7,928	7,505	8,416	8,994	8,616	7,910	10,385	8,881	8,587	9,912	-2,854	92,916	99,167
B.3 - HSE - SOUTH REGION	13,639	13,163	13,803	12,141	13,744	12,824	13,738	12,840	13,219	11,724	13,383	-121	144,097	153,792
B.4 - HSE - WEST REGION	14,833	12,754	14,368	16,469	13,931	13,635	14,102	14,118	14,693	14,272	14,767	944	158,886	169,575
B.5 - GRANT TO HEALTH BODIES	7,440	3,952	4,313	3,522	3,792	3,625	3,398	3,532	3,384	3,124	3,120	31,998	75,200	45,000
V39 - OTHER SERVICES	47	46	44	47	46	49	48	48	49	48	22	83	577	519
B.6 - MEDICAL CARD SERVICES SCHEME	47	46	44	47	46	49	48	48	49	48	22	83	577	519
V39 - APPROPRIATIONS IN AID	16,039	14,739	18,691	18,422	18,447	18,459	15,904	15,200	15,190	14,443	15,010	20,911	201,455	199,986
D - APPROPRIATIONS IN AID	16,039	14,739	18,691	18,422	18,447	18,459	15,904	15,200	15,190	14,443	15,010	20,911	201,455	199,986
PENSION LUMP SUMS	17,250	21,372	41,370	46,337	25,353	8,528	3,230	3,131	2,728	3,527	3,950	22,224	199,000	0
Pension Lump Sum	17,250	21,372	41,370	46,337	25,353	8,528	3,230	3,131	2,728	3,527	3,950	22,224	199,000	



Tony O'Brien
Accounting Officer
8 January, 2013

	RETURNS													REV
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year	Total Year
V39 - HEALTH SERVICE EXECUTIVE (NET)	1,223,826	1,020,721	1,061,998	1,050,316	1,044,232	1,028,282	886,766	1,055,990	985,291	974,958	1,062,651	779,452	12,174,483	11,786,933
V39 - HEALTH SERVICE EXECUTIVE (GROSS)	1,321,102	1,117,997	1,161,485	1,162,255	1,145,303	1,129,408	1,116,255	1,155,570	1,083,517	1,068,323	1,160,994	1,037,140	13,659,349	13,332,455
V39 - HEALTH SERVICE EXECUTIVE (ADMIN)	22,504	26,578	46,600	51,567	30,583	13,759	8,459	8,362	7,959	8,758	9,181	27,456	261,766	269,766
A.1 - SALARIES, WAGES AND ALLOWANCES	5,222	5,174	5,198	5,198	5,198	5,198	5,198	5,198	5,198	5,198	5,198	5,199	62,377	62,377
A.2 - VALUE FOR MONEY POLICY REVIEWS	32	32	32	32	32	33	31	33	33	33	33	33	389	389
A.3 - PENSION LUMP SUM PAYMENTS	17,250	21,372	41,370	46,337	25,353	8,528	3,230	3,131	2,728	3,527	3,950	22,224	199,000	207,000
V39 - PROGRAMME EXPENDITURE	1,298,598	1,091,419	1,114,885	1,110,688	1,114,720	1,115,649	1,107,796	1,147,208	1,075,558	1,059,565	1,151,813	1,009,684	13,397,583	13,062,689
V39 - HSE REGIONS AND OTHER HEALTH AGENCIES	929,742	724,189	754,010	732,251	748,051	728,217	726,077	756,552	718,979	688,822	741,143	604,498	8,852,531	8,714,825
B.1 - HSE - DUBLIN MID LEINSTER REGION	117,777	117,528	107,516	106,497	113,954	121,807	121,930	126,475	102,625	112,219	121,584	93,307	1,363,219	1,346,415
B.2 - HSE - DUBLIN NORTH EAST REGION	106,707	97,958	92,738	103,997	111,134	106,466	97,736	128,317	109,738	106,109	122,474	63,994	1,247,368	1,226,344
B.3 - HSE - SOUTH REGION	169,644	163,723	171,686	151,013	170,959	159,516	170,885	159,709	164,420	145,823	166,462	145,596	1,939,436	1,912,930
B.4 - HSE - WEST REGION	183,993	158,197	178,221	204,287	172,805	169,126	174,916	175,115	182,247	177,030	183,174	184,443	2,143,554	2,103,412
B.5 - GRANT TO HEALTH BODIES	351,621	186,783	203,849	166,457	179,199	171,302	160,610	166,936	159,949	147,641	147,449	117,158	2,158,954	2,126,724
V39 - OTHER SERVICES	360,523	358,897	352,542	370,104	358,336	379,099	373,386	382,323	348,246	362,410	402,337	396,849	4,445,052	4,247,864
B.6 - MEDICAL CARD SERVICES SCHEME	229,650	221,650	213,944	229,563	223,674	240,143	233,588	234,655	237,015	231,991	239,998	220,742	2,756,613	2,518,293
B.7 - GRANT TO HEALTH AGENCIES (NAT LOTTERY)	626	626	626	626	626	626	626	626	626	626	626	627	7,513	7,513
B.8 - GRANT FOR SERVICES FOR HEP C	1,205	1,205	1,205	1,205	1,205	1,205	1,205	1,205	1,205	1,205	1,205	1,203	14,458	14,458
B.9 - DORMANT ACCOUNTS														
B.10 - PAYMENTS TO SPECIAL A/C - HEALTH REPAYMENTS SCHEME	0	500	0	500	0	0	0	250	0	0	0	450	1,700	1,700
B.11 - PAYMENTS TO SPECIAL A/C - HEPATITIS C SCHEME	0	0	0	0	0	0	0	0	0	0	0	700	700	1,500
B.12 - LONG TERM RESIDENTIAL CARE	83,975	73,567	82,845	80,655	83,839	81,616	83,742	85,329	62,812	81,842	108,460	86,018	994,700	994,700
B.13 - SERVICE DEVELOPMENTS	2,917	7,583	0	1,168	2,917	2,917	0	0	0	0	0	25,498	43,000	63,000
B.14 - PAYMENTS TO STATE CLAIMS AGENCY	0	4,224	4,483	10,200	0	6,441	10,180	12,172	3,653	2,905	2,763	18,647	75,668	96,000
B.15 - CHILDREN AND FAMILY SERVICES	42,150	49,542	49,439	46,187	46,075	46,151	44,045	48,086	42,935	43,841	49,285	42,964	550,700	550,700
V39 - CAPITAL SERVICES	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,337	100,000	100,000
C.1 - BUILDING AND EQUIPMENT														
C.2 - BUILDING AND EQUIPMENT (NAT LOTTERY)														
C.3 - INFO SYSTEMS FOR HEALTH AGENCIES	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,337	100,000	100,000
C.4 - BUILDING & EQUIPPING MENTAL HEALTH & OTHER HEALTH FACILITIES														
V39 - HEALTH SERVICE EXECUTIVE (AIA)	97,276	97,276	99,487	111,939	101,071	101,126	229,489	99,580	98,226	93,365	98,343	257,688	1,484,866	1,545,622
D - APPROPRIATIONS IN AID	97,276	97,276	99,487	111,939	101,071	101,126	229,489	99,580	98,226	93,365	98,343	257,688	1,484,866	1,545,522



Tony O'Brien
Accounting Officer
8 January, 2013

	Capital Returns for:	DEC													
		2012													
		RETURNS													REV
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Full Year	Total Year
Voted	V39 - HEALTH SERVICE EXECUTIVE (CAPITAL)	43,788	22,254	30,215	23,868	15,178	25,391	19,740	29,365	21,488	26,966	31,382	47,036	336,671	374,000
	V39 - GROSS	44,154	24,650	30,247	23,868	15,178	25,391	19,740	31,001	21,488	26,966	31,431	47,036	341,150	382,000
	V39 - PROGRAMME EXPENDITURE	44,154	24,650	30,247	23,868	15,178	25,391	19,740	31,001	21,488	26,966	31,431	47,036	341,150	382,000
	V39 - OTHER SERVICES	0	0	252	43	45	108	112	21	19	7	104	89	800	974
	B.15 - CHILDREN AND FAMILY SERVICES	0	0	252	43	45	108	112	21	19	7	104	89	800	974
	V39 - CAPITAL SERVICES	44,154	24,650	29,995	23,825	15,133	25,283	19,628	30,980	21,469	26,959	31,327	46,947	340,350	381,026
	C.1 - BUILDING AND EQUIPMENT	44,154	22,814	27,771	22,113	14,162	22,211	19,150	29,848	19,078	22,264	28,171	36,381	308,117	330,487
	C.2 - BUILDING AND EQUIPMENT (NAT LOTTERY)	0	0	0	0	0	0	0	0	0	0	0	2,539	2,539	2,539
	C.3 - INFO SYSTEMS FOR HEALTH AGENCIES	0	1,836	269	568	222	543	478	1,127	1,913	3,759	2,952	8,027	21,694	40,000
	C.4 - BUILDING & EQUIPPING MENTAL HEALTH & OTHER HEALTH FACILITIES	0	0	1,955	1,144	749	2,529	0	5	478	936	204	0	8,000	8,000
	V39 - APPROPRIATIONS IN AID	366	2,396	32	0	0	0	0	1,636	0	0	49	0	4,479	8,000
	D - APPROPRIATIONS IN AID	366	2,396	32	0	0	0	0	1,636	0	0	49	0	4,479	8,000

Tony O'Brien
Accounting Officer
8 January, 2013

CEO Report to the Board *(28th March 2013)*
Health Service Executive
January 2013 Performance Report
National Service Plan 2013

Key Service Messages

Hospital Access and Waiting Times

- **Volume of Elective Activity:** In January 15,092 elective inpatient admissions and 71,089 day case procedures were provided in our acute hospitals (total 86,181, up from 82,999 in 2012). This includes services for both adults and children.

- **Elective Procedures (adults):** At the end of the January 1,135 adults were waiting over 8 months for an inpatients procedure and 1,938 adults were waiting over 8 months for a Day Case procedure (total 3,073). It is intended that no adults will be waiting greater than 8 months for an elective procedure by year end.

- **Elective Procedures (children):** At the end of the January 181 children were waiting over 20 weeks for in inpatient elective procedure and 145 children were waiting over 20 weeks for an elective day case procedure (total 326). It is intended that no children will be waiting greater than 20 weeks for an elective procedure.

- **GI Endoscopy:** At the end of the January 594 patients were waiting greater than three months for a GI Endoscopy. It is intended that no one will be waiting greater than three months weeks for a GI endoscopy.

- **Outpatient Appointments:** At the end of the January 109,034 patients were waiting greater than 52 weeks for a first consultant led outpatient appointment. 71.8% of people were waiting less than 52 weeks. It is intended that no patient will be waiting longer than 52 weeks by year end.

HSE Primary Care Reimbursement Scheme

- HSE PCRS has incurred expenditure of €200.65m versus a budget of €200.4m resulting in a deficit of €0.25m year to date.
- The cost management initiatives profiled to deliver savings from January 2013 have successfully realised cost reductions of €11.65m resulting in YTD surplus of +€0.4m against target.

National Schemes	Approved Allocation €000	YTD			
		Actual €000	Budget €000	Variance €000	%
Medical Card Schemes	1,775,552	157,076	153,788	3,288	2.1%
Community Schemes	546,513	43,576	46,612	(3,036)	-6.5%
PCRS Total	**2,322,065**	**200,652**	**200,400**	**252**	**0.1%**

Medical Cards: As at the 4 February 2013, 95% of properly completed medical card applications have been processed within the 15 day turnaround, this is set against a National Service Plan target of 90%.

Medical Cards and GP Visit Cards	DML	DNE	South	West	YTD Total	No. cards same period last year	% variance YTD v. same period last year
Number of people covered by Medical Cards*	465,340	392,090	498,820	499,547	1,855,797	1,694,063	9.50%
Number of people covered by GP visit cards*	29,035	25,779	40,261	35,226	130,301	125,657	3.70%
Total	**494,375**	**417,869**	**539,081**	**534,773**	**1,986,098**	**1,819,720**	**9.10%**

*Includes discretionary cards

Community Services

Child Health Developmental Screening

- 8 LHOs have met or exceeded the target for the percentage of children reaching 10 months in the reporting period who have had their child development health screening on time before reaching 10 months of age. The LHO with the greatest challenge in performance where 60% or fewer children were seen on time for developmental checks were Dunlaoghaire (48.8%) and Galway (24.8%) which is currently under review.

Nursing Home Support Scheme (Fair Deal)

- In January 2013, 22,768 long term public and private residential places are supported under scheme also in January, 1,109 applications were received and 662 new clients were supported under the NHSS in public and private nursing homes. This was a net increase of 71 in the month. The scheme is taking on new clients within the limits of the resources available, in accordance with the legislation. In January 100% of complete NHSS applications were processed within four weeks.

Number of patients who have been approved for Long Term Residential Care funded beds								
	Number of patients in Long Term Residential Care funded beds							
HSE Region	NHSS Public Beds	No. of patients in NHSS Private	No. of patients on Subvention	No. of patients in Contract Beds	No. of 'savers' in Section 39 Units	Total in Payment during Month	Approved but not yet in payment	Overall Total
End Q4 – 2012	5,080	14,590	856	1,398	141	22,065	806	22,871
DML	1,385	3,860	184	738	-	6,167	260	6,427
DNE	941	2,803	178	327	19	4,268	192	4,460
South	1,487	3,983	191	158	121	5,940	138	6,078
West	1,275	4,007	275	121	-	5,678	125	5,803
Total – Jan 2013	5,088	14,653	828	1,344	140	22,053	715	22,768

Home Help Hours

- National Home Help Hours activity for January, while lower than the January 2013 and year to date targets, reflects an increased level of activity in the first month of 2013 above the December 2012 levels (+6,967 hours) which will continue into 2013 in order to bring activity in line with monthly & cumulative Service Plan targets. Activity will be closely monitored across the regions to ensure that agreed targets are adhered to.

Child Protection and Welfare Services

In accordance with the Programme for Government commitment legislation is being prepared to create a new Agency to take over the HSE's child welfare and protection responsibilities and the further decision to subsume the Family Support Agency into the new Agency.

- 12 LHOs have met the 100% target for the percentage of children in care who have an allocated social worker at the end of the reporting period. Within the Regions the LHOs with the greatest challenge in performance, where 80% or less of the children in care have an allocated social worker, are: HSE DML - Dun Laoghaire (73.0%), Laois Offaly (75.4%); HSE South - Wexford (67.0%); HSE West - Clare (68.8%), Tipperary North (76.7%): No LHO in HSE DNE demonstrated a percentage under 80%.

- 9 LHOs have met the 100% target for the percentage of children in care who currently have a written care plan, as defined by Child Care Regulations 1995, at the end of the reporting period. The HSE Region with the greatest challenge in performance, where 80% or less of the children in care have a written care plan, is HSE DML where 7 of out of 9 LHOs are below 80% coverage: Dunlaoghaire (67.2%), Dublin South East (59.4%), Dublin South City (42.4%), Dublin South West (73.3%), Dublin West (54.0%), Kildare West Wicklow (55.0%), and Laois Offaly (74.6%). In HSE West one LHO is below 80%, Mayo (44.5%) No LHO in HSE DNE or HSE South demonstrated a percentage under 80%.

Finance

The performance report for January shows a €12m (1.2%) deficit on an I&E basis. This is made up of a €10.9m deficit in hospitals and a €5.6m deficit in community services, with some offsetting surpluses in the fair deal and pensions. Demographic funding due to be allocated to the system will mitigate an element of these deficits.

A review of initial cost containment plans is in progress to assess their deliverability and completeness in the context of the breakeven requirement. At this stage it should be noted that the necessary indicative profiling of budget reductions to match phased commencement of cost management initiatives is a potential concern and will be addressed as part of this review.

The vote report at the end of February shows a net vote overspend of €13m when a €9m surplus on capital is offset against a €22m deficit on revenue. Patient receipts are €14m behind profile based upon the payments received from insurers. This matter is being followed up with the Private Health Insurance companies.

It should be noted that a further €150m in pay related savings has yet to be allocated pending the outcome of the negotiations to extend the Public Service Agreement.

Human Resources

The Health Sector is 630 WTEs below the current approved employment ceiling – outturn of 101,407 WTEs versus employment ceiling of 102,037 WTEs as notified by the Department of Health.

- January employment census shows a decrease of 99 WTEs from December 2012.

- The Statutory Sector and the Primary & Community Voluntaries decreased by -47 WTEs and -92 WTEs respectively while the Voluntary Hospitals increased by +58 WTEs.

- The Integrated Services Directorate in overall terms recorded a decrease of -92 WTEs, the Primary and Community Services recorded a decrease of -121 WTEs while the Acute Hospital Services recorded an increase of +35 WTEs.

NSP 2013 Performance Scorecard

Acute Care									
				Performance YTD			Performance this M/Q		
Performance Indicator	Report Frequency (NSP 2013)	Outturn 2012	Target 2013	Target YTD	Activity YTD	% var Activity YTD v Target YTD	Target this M/Q	Reported this M/Q	% var reported activity v target this M/Q
Emergency Care									
% of all attendees at ED who are discharged or admitted within 6 hours of registration	M	67.5%	95%	95%	63.5%	-33.2%	95%	63.5%	-33.2%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	M	81.5%	100%	100%	78.8%	-21.2%	100%	78.8%	-21.2%
Elective Waiting Time									
No. of adults waiting more than 8 months for an elective procedure	M		0	0	3,073		0*	3,073	
No. of children waiting more than 20 weeks for an elective procedure	M	89	0	0	326		0	326	
Colonoscopy / Gastrointestinal Service									
No. of people waiting more than 4 weeks for an urgent colonoscopy	M	0	0	0	0		0	0	
No of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	M	36	0	0	594		0	594	
Outpatients									
No. of people waiting longer than 52 weeks for OPD appointment	M		0	0	109,034		0**	109,034	
Day of Procedure Admission									
% of elective inpatients who had principal procedure conducted on day of admission	M	56%	75%	75%	56%	-25.0%	75%	56%	-25.0%
% of elective surgical inpatients who had principal procedure conducted on day of admission	M	New for 2013	85%	85%	71%	-16.5%	85%	71%	-16.5%
Re-Admission Rates									
% of surgical re-admissions to the same hospital within 30 days of discharge	M	New for 2013	<3%	<3%	2%	33.3%	<3%	2%	33.3%
% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	M	11.1%	9.6%	9.6%	11.2%	-16.5%	9.6%	11.2%	-16.5%
Surgery									
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	M	84.0%	95%	95%	83.8%	-11.8%	95%	83.8%	-11.8%
ALOS									
Medical patient average length of stay	M	7.2	5.8	5.8	7.0	-20.7%	5.8	7.0	-20.7%
Surgical patient average length of stay	M	New for 2013	4.5% reduction	Target being Set	4.8		Target being Set	4.8	
Non Acute Care									
Child Health									
% of children reaching 10 months in the reporting period who have had their child development health screening on time before reaching 10 months of age	M	85.7%	95%	95%	84.0%	-11.6%	95.0%	84.0%	-11.6%
Child Protection and Welfare Services									
% of children in care who have an allocated social worker at the end of the reporting period	M	91.9%	100%	100%	91.5%	-8.5%	100.0%	91.5%	-8.5%
% of children in care who currently have a written care plan, as defined by *Child Care Regulations 1995*, at the end of the reporting period	M	87.6%	100%	100%	87.3%	-12.7%	100.0%	87.3%	-12.7%

NSP 2013 Performance Scorecard

Non Acute Care											
					Performance YTD			Performance this M/Q			
	Performance Indicator	Report Frequency (NSP 2013)	Outturn 2012	Target 2013	Target YTD	Activity YTD	% var Activity YTD v Target YTD	Target this M/Q	Actual this M/Q	% var reported activity v target this M/Q
Quality, Access and Activity	**Primary Care**									
	No. of primary care physiotherapy patients seen for a first time assessment	M		139,102	11,592	12,848	10.8%	11,592	12,848	10.8%
	Older People Services									
	No. of people being funded under the Nursing Home Support Scheme (NHSS) in long term residential care at end of reporting period	M	22,871	22,761	22,619	22,768	0.7%	22,619	22,768	0.7%
	No. of persons in receipt of a Home Care Package	M	11,023	10,870	10,870	10,939	0.6%	10,870	10,939	0.6%
	No. of Home Help Hours provided for all care groups (excluding provision of hours from HCPs)	M	9,887,727	10.3m	803,813	717,195	-10.8%	803,813	717,195	-10.8%
	Palliative Care									
	% of specialist inpatient beds provided within 7 days	M	91%	92%	92%	94.0%	2.0%	92%	94%	2.0%
	% of home, non-acute hospital, long term residential care delivered by community teams within 7 days	M	83%	82%	82%	86.0%	5.0%	82%	86%	5.0%

FINANCE					
Income and Expenditure Key Performance Measurement	Approved Allocation €000	Actual YTD €000	Budget YTD €000	Variance YTD €000	% Var Act v Tar
Variance against Budget: Pay	6,951,060	588,031	581,994	6,037	1.0%
Variance against Budget: Non Pay	7,291,745	617,737	614,561	3,176	0.5%
Variance against Budget: Income	(1,917,712)	(156,765)	(159,593)	2,828	-1.8%
Variance against Budget: Income and Expenditure Total	**12,325,093**	**1,049,003**	**1,036,962**	**12,041**	**1.2%**
Vote Key Performance Measurement	REV 2013 '€000	Actual YTD €000	Profile YTD €000	(Under) / Over YTD €000	% Var Act v Tar
Vote expenditure vs Profile	12,320,921	1,246,519	1,236,330	10,189	0.8%
Income Key Performance Measurement	REV 2013 '€000	Actual YTD €000	Profile YTD €000	(Under) / Over YTD €000	% Var Act v Tar
Patient Private Insurance – Claims processed	530,603	33,498	39,217	-5,719	-15%

HUMAN RESOURCES						
	End of Year Ceiling 2013	WTE Dec 2012	Ceiling Jan 2013	WTE Jan 2013	WTE variance January 2013	% var January 2013
Variance from current target levels	98,955	101,506	102,037	101,407	-630	-0.62%
		Outturn 2011	Target	Actual YTD RTM*	Actual reported month	% variance RTM* from target
Absenteeism rates		5.02%	3.5%	4.73%	4.78%	35.1%

*Rolling three months

Items for mention

Memorandum of Understanding with the Director of Public Prosecutions (DPP)

A memorandum is to be signed between the HSE and the DPP to assist both organisations balance the duty of the HSE to protect the confidentiality of information it holds with the duty of the DPP to access material relevant to criminal proceedings.

The Memorandum is a guidance document intended to reflect a shared understanding and to promote consistency of practice between the HSE and the DPP, in relation to the secure disclosure of material under certain conditions for specific purposes.

The Memorandum does not mandate unrestricted access to information held by the HSE, but provides for the methodology and parameters for the secure disclosure of information. It promotes consistency of practice in all requests for information made to the HSE in criminal matters.

HSE Regional Service Plans 2013

On 28th February, the National Operational Plan, Regional Service Plans and Hospital Group plans were published to ensure that the HSE has a robust planning framework to support the implementation of the national service plan. Regional Plans set out the type and volume of services that each Health Service Executive (HSE) Region will provide directly and through a range of funded agencies during 2013. These services will be delivered within the agreed funding provided and within the overall employment control limit.

A key focus this year will be on reshaping and remodelling health services in line with the *'Future Health Framework'* including the development of hospital groups with new governance structures and stronger more integrated primary and social care sectors.

Speech by the Minister for Health, Dr. James Reilly T.D. to the Select Committee on Health and Children on the 2012 Supplementary Health Estimates

Chairman, members of the Select Committee

I wish to thank the Select Committee for giving me the opportunity to bring this Supplementary Estimate for Vote 39 before it.

The total additional funding being sought for the Health Service Executive is **€360 million.** However, I am allocating a once-off Extra Exchequer Receipt of **€45 million** from the Medical Defence Union, and savings of **€70 million** which have been identified within my Department's Vote which will contribute towards the HSE requirement; thus, the net cost to the Exchequer is **€245 million.** This represents just **1.8%** of the health sector budget for 2012.

This Estimate must be seen in the context of the challenges which faced the Health Service Executive this year. As Deputies will be aware the Health Sector faced very significant financial challenges in 2012 and 2013 will be no different. The 2012 National Service Plan was based on the achievement of cost reductions of €750m to meet the cost of delivering the maximum level of services possible, and commitments in the Programme for Government. A range of savings measures were identified in the Estimates to enable the HSE to meet these objectives in the implementation of the Plan.

The shortfall in the HSE Vote reflects the underlying expenditure difficulties in the acute hospital sector, child welfare and protection services and demand-led schemes. This Supplementary Estimate, together with the savings in my Department's Vote, the extra exchequer receipt from the MDU and other measures being taken by the HSE should ensure that the HSE achieves a balanced Vote at the end of this year.

An additional €162m is being sought to meet deficits in services, specifically in the acute hospital sector and child welfare and protection services. Spending in the Primary Care Reimbursement Service, effectively a demand led scheme, is projected to be in the region of €230m in deficit by the end of the year.

I will outline in a few minutes the details of this Estimate and the other measures being taken to address this year's deficit. But first of all I wish to outline to the Committee the reforms which are being initiated to strengthen the financial management systems of the HSE.

Reform of Financial Management in HSE.

My Department undertook strategic measures during 2012 to address the ongoing financial issues in the HSE. A review of the financial management systems in the Health Service Executive was commissioned. Its overall intention was to review the present state of the financial management system in place in the health sector in Ireland in the context of the serious overruns projected, the continuation of a challenging financial environment for the foreseeable future and the radical reforms envisioned in the Programme for Government.

The review came up with a number of recommendations to strengthen the financial management process within the HSE, with particular reference to managing the transition phase that the health sector is currently undergoing.

Subsequently, PA Consulting were engaged to draw up urgent measures to be put in place to strengthen the HSE's financial management capacity and processes having regard to the findings and recommendations of the Ogden Review. My Department is now working closely with PA and the HSE on a Financial Improvement Programme for the HSE.

2012 Supplementary Estimate

I will now set out the items making up this year's Supplementary Estimate.

The sector faced very significant financial challenges in 2012. The budget targets set for the HSE this year were extremely demanding and regrettably not all were achieved. The impact of the retirements under the "grace period" posed significant challenges given that some 4,700 people left the sector before the end of February.

Whilst cost containment plans were rolled out across the health sector, the continued escalation of expenditure in PCRS has resulted in a projected deficit for the HSE this year.

Income collection agreement

My Department has worked intensively with the main health insurers to agree a system of cash-flow and accelerated payment which will provide a cash flow benefit this year. At any one point in time some income will be outstanding to the HSE in relation to the treatment of private patients in public hospitals, but reducing the time taken to recover the income outstanding will provide a cashflow benefit to the HSE. This will be achieved in 2012 via the Income Collection Agreement which has just been finalised with the three main health insurers.

The Income Collection Agreement will reduce the total level of income outstanding to the HSE by insurers as it involves insurers making accelerated payments based on 70% of the estimated value of claims that have not yet been reported to insurers. The balancing 30% will be paid upon the validation of a fully collated claim from the HSE. The payment relates to treatment that has already been carried out in public hospitals but for which a claim has not yet been raised and therefore, it is not an advance payment.

As a result of this agreement the HSE will have a once-off cashflow benefit in 2012 in the region of €100 - €110m which will reduce the level of income outstanding to the HSE, and will therefore reduce the projected deficit by a corresponding amount. The money is a once-off payment in respect of private patients who have already been treated in publicly funded hospitals, but where the detailed claims have not yet been received by insurers.

Acute hospital services

2012 has seen an increase in expenditure in Acute Hospital services, above what was originally forecast in the National Service Plan. There are indications that cost containment measures put in place by the HSE are reducing expenditure, however, activity has increased, and therefore additional funding is required.

The 2012 National Service Plan set access targets for in-patient and daycase treatment whereby no adult should have to wait more than 9 months for an inpatient/daycase procedure date, and no child should have to wait more than 20 weeks for an inpatient/daycase procedure date. No patient should have to wait more than 13 weeks (3 months) for a routine GI endoscopy procedure.

I am happy to report that the number waiting for over 9 months for treatment has dropped 91% since the beginning of this year, while 70% of hospitals have fully achieved the target of having nobody waiting for more than nine months for treatment

I am also pleased to inform the Committee that there have been significant improvements in access to scheduled care (elective surgery - in-patient or daycase) since the Special Delivery Unit (SDU) was formed.

For instance, at the beginning of October there were a total of 8,250 patients to be treated before 20 December 2012 for the 9 month maximum wait time for elective surgery to be met. Of these, as of the end of November, 5846 patients (71%) had been treated. In Paediatrics 68% of those patients waiting, had been treated. Furthermore, 79% of those patients waiting for an endoscopy procedure at the beginning of October, had been treated by the end of November.

This progress is real and hospital management, staff, the SDU, Clinical Programmes and the HSE are all to be commended. However, it must be acknowledged that the impact of the retirements under the "grace period" has seen an increase in overtime and agency costs. Thus, additional funding of **€162m** is required to

address the deficit in acute hospital services. This use of agency and overtime will be much reduced if there is a successful conclusion to the negotiations being led by DPER to the new CP agreement.

PCRS

In relation to the Primary Care Reimbursement Service, the main drivers are the increase in full medical card holders while claims for High Tech drugs/medicines continuing to increase The excess of medical cards over what was projected in the HSE Service Plan arose from two principal reasons. A backlog in applications from 2011 was cleared at the start of this year, and a higher than anticipated number of applications for new cards. The HSE's 2012 National Service Plan provided for 1,838,126 medical cards which reflected a planned for growth of 105,000, or 6%, in eligible persons in the year.

The number of persons eligible for a medical card at end-October 2012 is 1,836,689. This is an increase of 142,626 from the 1st January 2012, or an increase of 8%. This represents an excess of 37,626 over planned growth for 2012. It is not possible to precisely forecast the end-year number of medical cards as this will depend on the number of people that apply for a medical card, the number of cards that are successfully renewed, and the number of cards that expire during the remaining months of the year. In order to address the deficit in PCRS, an additional sum of **€234m** is required. This is clearly demand as is the increase in ED attendances and hospital admissions. These are due to an increase our population, e.g., between 2006 and 2011 the population grew by 8.2%. The number of people over 65 grew by 14% and the numbers over 85 grew by 22%.

However, you will be aware that I recently announced that intensive negotiations with the Irish Pharmaceutical Healthcare Associations had reached a successful conclusion with a major new deal on the cost of drugs in the State, with a value in excess of €400m over the next three years. The new deal, combined with the IPHA agreement reached earlier in the year, means €16m in drug savings this year with much greater savings to be achieved over the next three years. The cost of new drugs in 2012 is estimated to be approximately €15 million. Examples include the cancer drug, Ipilimumab, and the Hepatitis C drugs, Boceprevir and Teleprevir. It is estimated that the deal will generate savings of up to €116m gross in 2013.

Savings

As I set out at the beginning of my address to you, my Department has identified savings of €70m. These savings arise within my Department's directly funded agencies, savings on legal costs, and savings within the National Treatment Purchase Fund. There is also a saving of €7.5m on my Departments Capital Vote. In addition, a once off extra exchequer receipt of €45m from the Medical Defence Union, will also offset the amount of supplementary funding required from the Exchequer. This €45 million cash lump sum is in settlement of on-going legal proceedings that sought to recover money paid by the State on behalf of refused Medical Defence Union members. These consultant members of the MDU found themselves in circumstances where they were refused indemnity cover by their Medical Defence Organisation. This dispute has been ongoing since 2004 and it is both timely and in the State's interests that a resolution has been reached.

Summary

In summary, given the extent of challenges faced by the Executive in 2012, the extra funding being requested through this Supplementary Estimate is relatively small. The Executive has been through a challenging year and faces an even tougher year ahead. My intention in bringing this Supplementary Estimate, together with the other measures I outlined, is to reduce the incoming deficit for the HSE as it faces into a difficult year in 2013.

Conclusion

In conclusion, I seek the Committee's approval to the Supplementary Estimates for Vote 39.

Primary Care Reimbursement Service

Medical Cards

18 April 2013

1. Introduction

The HSE continues to provide a wide range of primary care services across the 12 community health schemes, including the Medical Card Scheme, to the entire Irish population. These services are provided to more than 3.4 million eligible persons by over 6,660 primary care contractors and involve approximately 80 million transactions each year, with planned expenditure in 2013 of €2.4bn.

The Primary Care Schemes form the infrastructure through which the Irish health system delivers a significant proportion of primary care to the general public. Challenging service level targets have been set for 2013 in the context of the range of cost saving initiatives totalling €353m. The preliminary Schemes budget for 2013 is €2.4billion.

The Primary Care Schemes are demand-led, with the number of card-holders a significant cost driver. The number of persons eligible for a medical card has increased from 1,694,063 at 1 January 2012 to 1,864, 320 at 1 April 2013. This growth results in an increasing pressure on Scheme costs. For example, the number of items reimbursed on the Medical Card Scheme has grown by over 3 million over the same period last year.

2. Medical Card centralisation

In 2011, a major change programme was initiated, planned and rolled out by the HSE which culminated in the centralisation of medical card processing within the PCRS on the 1 July 2011. The purpose of the centralisation project was to;

- Provide for a single uniform system of medical card application processing, replacing the different systems previously operated through more than 100 offices across the country.
- Streamline work processes and reduce the numbers of staff involved in medical card processing from approximately 450 to 150.
- Ultimately ensure a far more accountable and better managed medical card processing system.

The HSE undertook a comprehensive review of the medical card centralisation programme following its first six months of operation. The purpose of the Review was to assess the effectiveness of the implementation of the centralisation programme and to make recommendations for further improving the centralised medical card system.

The Review was undertaken during the first quarter of 2012 by a Steering Group established by the HSE and the work of the Review was supported by Price Waterhouse Coopers (PWC). The outcome of the review was a report that was adopted by the HSE and a significant work programme was undertaken to implement its recommendations, specifically as they relate to;

- Addressing the backlog of applications at the time
- Improving the experience of service users
- Improving Medical Card processes to make them more customer friendly
- Improving the overall controls in place

Much of this work has been completed:

- The backlog has been addressed. As a result, 96% of fully completed applications and reviews are now processed within the 15 day target turnaround time. A copy of the weekly processing report for 16 April 2013 is attached as Appendix 1. These turnaround times are published online on a weekly basis, at www.medicalcard.ie
- The experience of service users has been improved. Communications avenues have been improved for clients, query handling and escalation have been improved and the capability of local offices to support service users has been enhanced.
- PCRS has appointed a Head of Customer Services, at a senior management level
- The main Application Form has been redesigned and approved by the National Adult Literacy Agency (NALA). Work is well underway on the revision and improvement of all forms and letters, which will also be approved by NALA
- The existing online application facility continues to be enhanced to make it more user friendly
- All of the other initiatives introduced to date continue to be reviewed and improved as appropriate, these include:
    - Standardising eligibility period
    - Emergency medical cards process
    - Medical card renewal process
    - Additional flexibility for GPs
    - Revised National Assessment Guidelines

- Implementing Scanning and Document Management Systems.

- The Current Control Framework continues to be developed and improved, with a key component, the issue of Data sharing between the HSE, Revenue, and the Department of Social Protection, with legislation implemented in April 2013 to support this valuable initiative.

3. Moving forward – 2013

The HSE National Service Plan 2013 (NSP2013), approved by the Minister for Health, sets out the type and volume of services to be delivered by the Executive in 2013. The NSP2013 is informed by the Department of Health's (DoH) *Statement of Strategy 2011 – 2014* and *Future Health, A Strategic Framework for Reform of the Health Service 2012 – 2015*, both of which set out the Government's priorities for the health services. The PCRS Service Plan 2013 is consistent with the national policies, frameworks, performance targets, standards & resources set out in the NSP2013.

The rate of unemployment in the State rose from 4.6% in 2007 to 14.8% by October, 2012. Nearly 2 million people, (43% of the population), are now eligible for the range of health services covered by Medical/GP Visit Cards. This is a 74% increase since 2005 and is the highest number of people ever recorded in receipt of a medical card.

Delivery of health services under the Primary Care Schemes occurs in the context of a challenging macro-economic environment, which places growing demand on services at a time of limited funding.

The Key priorities set out in the PCRS Service Plan 2013 are to:

- Continue to reimburse approximately 6,660 primary care contractors across 12 primary care schemes for the services they provide to eligible persons under the Primary Care Schemes

- Participate in, and contribute to, the implementation of Reference Pricing and the development of new a GP contract to meet emerging service requirements. A project which is being led by the Department of Health.

- Advance the process of transforming primary care services provided by General Practitioner's by working with them to ensure their service arrangements support health service provision reconfiguration

- Deliver a range of challenging cost saving initiatives, in collaboration with the Department of Health, totalling €353million, some of which are dependent upon changes in policy / legislation

- Progress a number of key strategic actions with the objective of continuously enhancing the Schemes during 2013

- Harness community pharmacy expertise to build capacity in primary care and support the optimal medicines usage in the community

The PCRS Service Plan 2013 will be delivered through the collective efforts of our staff and the Primary Care Contractors, with collaboration and engagement with HSE and Department of Health Stakeholders. We have a strong tradition of delivering fully on our service plan targets. This is a reflection of the high calibre and the exceptional dedication and commitment of our individual staff, teams and Primary Care Contractors.

Appendix 2

Supporting Medical Card applications

Briefing note 18 April 2013

1. Medical Card applications

This document has been prepared as a briefing note describing the current arrangements in place for processing medical cards.

The processing of Medical Card applications has been centralised in the HSE's Primary Care Reimbursement Service (PCRS) in Dublin.

Applications can be made either online at ***www.medicalcard.ie*** or by post, by sending completed applications to the ***Client Registration Unit, P.O. Box 11745, Finglas, D 11***.

Application forms for a Medical Card and/ or GP Visit Cards are available online at ***www.medicalcard.ie*** or from the HSE's Local Health Centres or Local Health Offices.

Members of the public;

- Will find a help sheet in their application form, which will assist them in making their application.
- Who have any questions about their eligibility, making their application or who are following up on an application can phone ***lo-call 1890 252 919*** where a team of people are available to answer their queries or they can contact their Local Health Offices where staff are available to answer queries in relation to the application form or eligibility criteria.
- Who have any difficulties in filling in their form can call into their Local Health Office where local staff there will assist them.

2. Guidelines for Medical Card applications

Medical and GP Visit Cards

All medical card applications are dealt with on the basis of the income guidelines and the "Medical Card/G.P. Visit Card National Assessment Guidelines." These guidelines can be found on the HSE website at:

http://www.hse.ie/eng/services/Find_a_Service/entitlements/Medical_Cards/mcgpvcguidelines.pdf

See Section 11 below for details of recent changes.

Medical Cards for persons aged 70 years or older

Medical Card applications for ***persons aged 70 years or older*** are dealt with on the basis of the "Medical Card National Assessment Guidelines for Persons Aged 70 and over." These guidelines can be found on the HSE website at:

http://www.hse.ie/eng/services/Find_a_Service/entitlements/Medical_Cards/o70mcguideline.pdf

It is important to refer to these documents if you are assisting a medical card applicant, but particularly so if a case needs to be made for special circumstances. See Section 11 below for details of recent changes.

Medical Card Turnaround Times Publication

The HSE has arranged for the online publication of the turnaround times for medical card application processing.

An initial reporting format has been agreed and is available at www.medicalcard.ie through a simple link called "turnaround times". The link will serve up the PDF document, which is updated on a weekly basis

3. Ensuring completed applications

One of the main difficulties faced in processing applications is incomplete applications (for instance missing surname, GP details, PPS Number or supporting documentation). It is very important that all details and supporting documentation is included with the application form. The HSE redesigned the standard medical card application form last year, which received the approval of the National Adult Literacy Agency (NALA). The new application form is easier to complete and provides much clearer instructions to the applicant in terms of the supporting evidence that is required. In addition, staff in Local Health Offices are available to assist applicants in screening applications before they are submitted or to answer queries in relation to the application form or eligibility criteria.

4. New eligibility rules

The duration of eligibility for all standard medical cards for people under 66 is three years, and for people aged 66 years and over is four years.

In addition, all 16 year old dependants of a medical card holder now automatically receive a medical card in their own right. Eligibility is set to the expiry date on their parent's card.

5. Emergency Medical Cards

In cases where a medical card is required in emergency circumstances, an Emergency Medical Card will be issued. Examples of the type of emergency envisaged under these arrangements are;

- A person in receipt of palliative care, who is terminally Ill
- A homeless person in need of urgent or ongoing medical care
- A person with a serious medical condition in need of urgent or ongoing medical care that cannot be provided without the person having a medical card
- A foster child in need of urgent or ongoing medical care that cannot be provided without the person having a medical card
- An asylum seeker with a serious medical condition in need of urgent or ongoing medical care care that cannot be provided without the person having medical card

Emergency applications can be initiated through the Local Health Office whose manager has access to dedicated contacts in PCRS. Details of this procedure have also been made available to all GPs. Such cards will be issued within 24 hours. As before, no means test applies to an application by a terminally ill patient and all terminally ill patients will be provided with a medical card number for a period of six months once their medical condition is verified by a GP or a consultant.

In other emergency cases (e.g. where a person in need of urgent medical attention cannot afford to pay for it etc.), the HSE issues Emergency Medical Cards on the presumption that the patient is eligible for a medical card (i.e. that they satisfy the eligibility criteria in terms of a means test or on the basis of undue hardship), and that the applicant will follow up with a full application within a number of weeks of receiving the Emergency Medical Card. As a result, Emergency Medical Cards are issued to a named individual, with a limited eligibility period of six months.

An emergency Medical Card can only be issued to an individual named person, i.e. no dependants will be included unless a case is made separately for any other member of the family on medical emergency grounds.

6. Medical Card Renewals

Every Medical Card shows an expiry date before which the eligibility of the holder is reassessed by the HSE. A letter issues to the medical card holder three months before the expiry date (and again one month in advance of the expiry date). Once reviewed, and eligibility confirmed, the card is renewed. A Medical Card will remain valid, irrespective of the expiry date shown on the card, once the Medical Card holder is genuinely engaging with the HSE review process. The medical card holder does not need to take any action other than genuinely co-operate with the review process and communicate with the HSE on an ongoing basis throughout the process. Eligibility can be confirmed by any Doctor or Pharmacist, or by the Medical Card holder online at www.medicalcard.ie or through the GP practice systems. This means that a person can continue to claim drugs and GP services while they await a decision on their medical card renewal application by simply using the medical card number.

7. Appeals

Apart from medical card applications and renewals, there is a separate facility for people to appeal a decision to refuse a medical card. These appeals are dealt with in a separate office of the HSE, the Appeals Office.

A person who appeals a decision retains their original eligibility until an Appeal decision is reached.

8. GPs: Extending the period of eligibility

In February 2012, the HSE reached agreement with the Irish Medical Organisation (IMO) in relation to new flexibility around reinstating and prolonging eligibility in certain cases.

The new procedures allow GPs, in certain circumstances, to extend the period of eligibility where a vulnerable person has been unable to engage with the HSE on the renewal of their application. It also allows the GP to reinstate eligibility if a patient presents for medical care who has had their eligibility removed in error, e.g. due to a lack of response to the review process because of a change of address. It also allows GPs to add new-born babies to their GMS list where the baby's parent holds a medical card.

10. Useful Contacts for:

Medical Card Applicants

- Personal Contact: Local Health Offices or Health Centres.
- Phone: Lo Call 1890 252 919
- Online:www.medicalcard.ie
- Correspondence: HSE, PCRS, CRU Unit, 4th Floor, Finglas, Dublin 11
- Fax: 01 834 3589

Public Representatives

- Dedicated email address: Oireachtas.pcrs@hse.ie
- Dedicated Phone Line: 01 8647180
- Online: www.MedicalCard.ie
- Correspondence: HSE, PCRS, CRM Unit, 4th Floor, Finglas, Dublin 11

11. Recent changes:

The Health (Alteration of Criteria for Eligibility) Act, which was enacted on 28 March 2013, amended the rules for Medical Cards for persons aged 70 years or older. Its provisions are effective from 5 April 2013. This means that from 5 April 2013, persons aged 70 years or older with a gross income not exceeding €600.00 a week for a single person or not exceeding €1,200.00 a week for a couple are entitled to a Medical Card. Persons aged 70 years or older with a gross income over €600.00 and not exceeding €700.00 a week for a single person or over €1,200.00 and not exceeding €1,400.00 a week for a couple are entitled to GP Visit card.

However if a person, aged 70 years or older, with income in excess of these limits, has high medical expenses, they can still have their income and outgoings assessed under the general Medical Card Scheme, where all their circumstances will be considered in order to determine if they have entitlement to a Medical Card or GP Visit Card.

Copies of the amended Application Forms will be available from HSE Local Health Offices or at www.medicalcard.ie.

Further to the Budget adjustments the HSE is also amending the eligibility criteria relating to medical cards by removing Home Improvement Loan payments and excluding the first €50 per week from Travel-to-Work expenses from the standard medical card means test assessment from April 2013 onwards. For clarity, the exclusion of travel to work costs relates to removing the weekly amount of €50 allowed to cover standing charges (i.e. depreciation and running costs) used when considering travel to work costs as an outgoing where public transport is not available or suitable and a car is required. This means that the HSE will continue to consider the standard mileage costs and transport (bus/train) costs when assessing eligibility.

A person who does not have an entitlement to a Medical Card/GP Visit Card is entitled to avail of the Drugs Payment Scheme (DPS) and HSE Local Health Offices will assist with any queries the applicant may have on the Drugs Payment Scheme. Furthermore, persons with certain illnesses may qualify for medicines, and medical and surgical appliances directly related to the treatment of their illness, free of charge, through the Long Term Illness (LTI) Scheme. Details of the LTI Scheme are available at www.hse.ie

Advice and assistance in relation to these changes is available to members of the Oireachtas at the dedicated Oireachtas Phone Line: 01 8647180 or via the dedicated Oireachtas email address: Oireachtas.pcrs@hse.ie or through correspondence to: HSE, PCRS, CRM Unit, 4th Floor, Finglas, Dublin 11 or online at: www.MedicalCard.ie

Important information to ensure medical card queries are processed efficiently.

The four key pieces of information required to process a query efficiently are:

1. The client's name, address and date of birth, and at least one of the following:

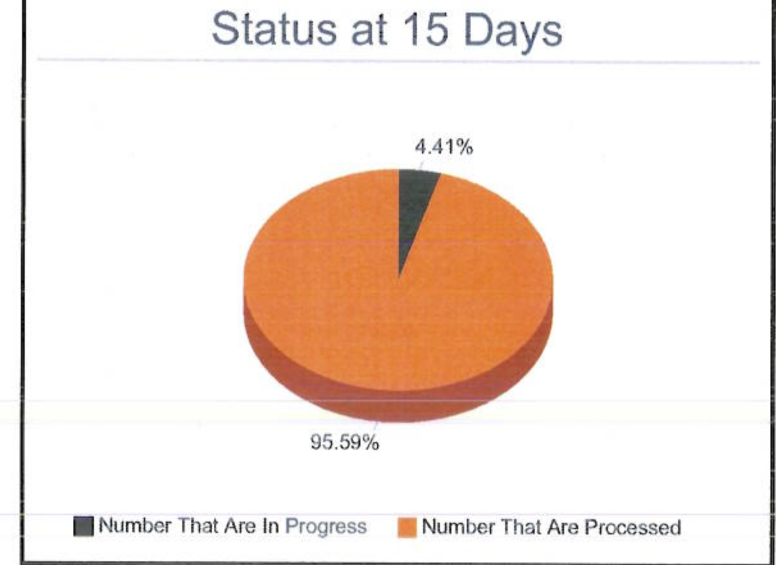
    - The client's current Medical Card number
    - The client's PPS number
    - The client's application reference number

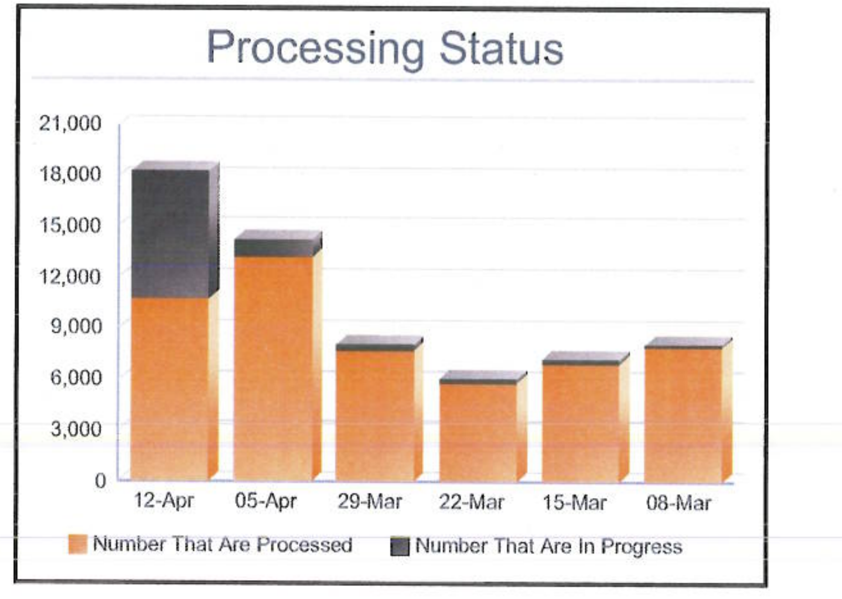
2. Clear details of the information required
3. Your full contact details, including the appropriate contact telephone number and email address, should further clarification on the request be required
4. Where possible, the contact details of the client, should further clarification be required.

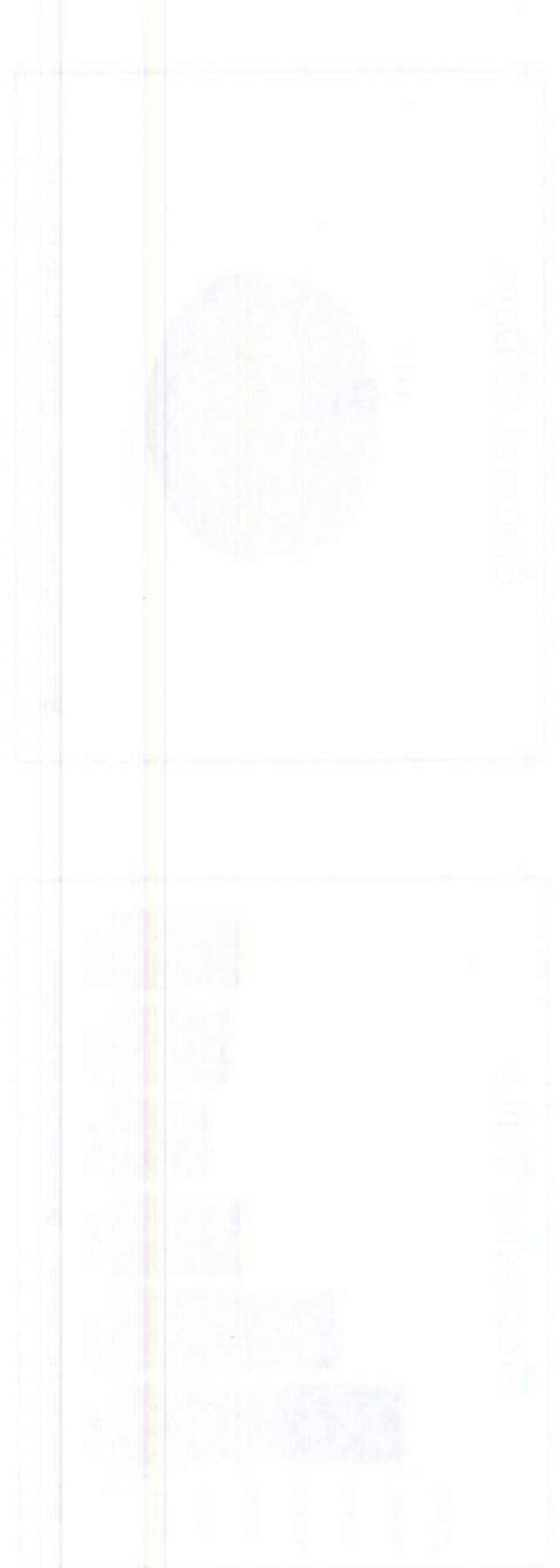
Primary Care Reimbursement Service (PCRS)

Medical Card Weekly Processing Report - 16 April 2013

Status Week ending Friday	12-Apr	05-Apr	29-Mar	22-Mar	15-Mar	08-Mar	All Others	**Total**
Total Applications and Renewals Received	9,151	7,109	4,057	3,011	3,570	4,059	813,244	**844,201**
Number That Are Processed	5,404	6,616	3,878	2,941	6,953	3,983	812,923	**842,698**
% That Are Processed	59.06%	93.07%	95.59%	97.68%	194.76%	98.13%	99.96%	**99.82%**
Number That Are In Progress	3,746	493	179	70	187	76	318	**5,069**
Applications that are missing something important	1,005	1,087	1,138	1,172	1,101	519	492	**6,514**







Health Service Executive

Briefing Note on Absenteeism
for
Committee of Public Accounts meeting on 25th April 2013

Note for the PAC/National Director of HR – National Absenteeism, Strengthening of Attendance Management and actions by the HSE

Absenteeism is the term generally used to refer to unscheduled employee absences from the workplace. Absenteeism is defined as *an absence from work other than annual leave, public holidays, maternity leave and jury duty.* Many causes of absenteeism are unavoidable — illness, injury at work for example—but absenteeism also can often be traced to other factors such as a poor work environment, work related stress or family care issues, and/or a lax attendance culture. If absences become excessive, they can have an adverse impact on organisations' operations and service delivery and, ultimately, its costs, as well on the individuals themselves. Any absence from work, aside from the direct impact on the individual unable to attend, may impact on their colleagues and service delivery capacity.

Overall absenteeism trends in the health services following a period of decline are stabilising and showed a small reduction in 2012 over 2011 – *down from 4.9% to 4.79%*. This follows a marginal increase over 2010 (4.7%) and must be view as a positive trend given the previous higher reported figures in 2009 (5.05%) and 2008 (5.76%). Please see extracts from the National Absenteeism Report for the Health Sector at the end of 2012 in appendix 1. For 2012, 88.4% of absenteeism was medically certified and the balance being self-certified. The national absenteeism rate for 2012 equates to approximately 1.1 million days or 10 ¾ days per WTE.

National and international benchmarking of absenteeism reported rates can be somewhat problematic in that methodologies used may not always be fully compatible. However based on available data, the figure of 4.79% for 2012 would put the Health Services generally in-line with the figures reported for large organisations in the private sector here in Ireland and for other large public sector organisations both in Ireland and internationally. Latest available data for Local Government is 5.09% (2012), Northern Ireland Health Services; 4.86%, NHS Scotland; 4.74%, NHS England; 4.04% although some trusts have rates 5.5%+, and An Post (2011) 5.12%. The downward trend seen in the NHS over recent years has been against a back-drop of a number of significant Government interventions, reports and studies.

The HSE continues to review its current sick leave policies and procedures as well as having a range of current supports and interventions to address challenges being encountered in the whole area of attendance management and absenteeism through ill health, and with the key objective of reducing the cost of absenteeism. Current specific actions in place within the HSE include the following:

- National target in place since 2009 to reduce absenteeism levels to at least 3.5%. This has been enshrined in National Service Plans.
- Monthly reporting on absenteeism levels in National Performance Reports. Absenteeism is a key performance indicator (KPI) and is a feature of all management engagement at national, regional and local levels. It is a standing agenda item for all management meetings at all levels.
- An agreed suite of enhanced actions, monitored on a monthly basis within the Integrated Services Directorate, were put in place in 2012 and include:
  - Data at regional and sub-regional levels are analysed and discussed each month at the Performance Review Meetings between the National Director for Integrated Services and the Regional Directors of Operations. It was agreed that a number of areas need to be closely examined including a renewed focus on the national target of sickness absence rate of 3.5%, ensuring a systematic approach to reviewing absence issues, focusing attention on areas of greatest need / potential impact and reducing the direct and non-direct costs associated with high levels of employee absence.
  - Detailed action plans are developed and monitored on each site for management of all absences in excess of the 3.5% target. This includes regular meetings/ conference calls with local HR and other relevant staff to devise appropriate strategies
  - Ongoing analysis of levels and patterns of **certified** and **self-certified** sick leave in each hospital site and community area

- Analysis of levels of adherence to the **HSE Attendance Management Policy** in terms of return to work interviews, counselling of staff, referral to Occupational Health etc.
- A number of staff have been brought through the disciplinary process due to poor attendance. These can and have ultimately resulted in removal from payroll due to findings of incapacity to work due to absenteeism.
- Investigations of local understandings on behalf of front line managers of current absenteeism rates pertaining to local hospitals and community services (For example, in the past Dublin North East have developed a Poster Campaign to advise the absence rates in each area to inform staff how they are performing against the national target).

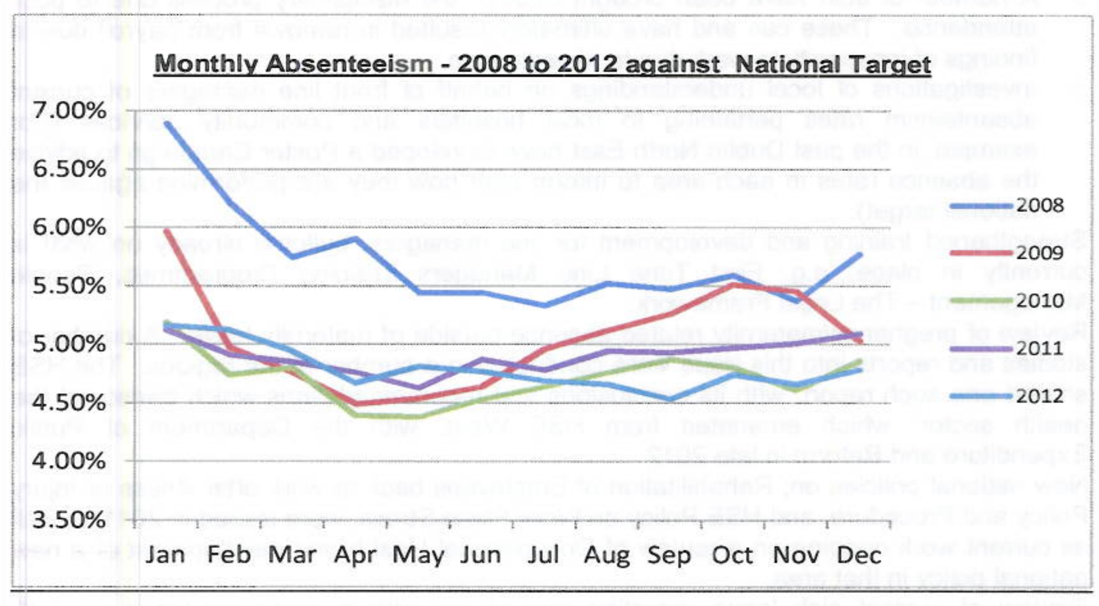
- Strengthened training and development for line managers, building already on what is currently in place; e.g. First Time Line Managers Training Programmes, People Management – The Legal Framework.
- Review of pregnancy/maternity related absence outside of maternity leave. A number of studies and reports into this issue were conducted in a number of the regions. The HSE shared one such report, with its conclusions and recommendations which transcend the health sector, which emanated from HSE West, with the Department of Public Expenditure and Reform in late 2012.
- New national policies on; Rehabilitation of Employees back to work after illness or injury Policy and Procedure, and HSE Policy on Work Place Stress, were issued in 2011 as well as current work ongoing on a review of Occupational Health and development of a new national policy in that area.
- Review of current sick leave reporting procedures with a particular focus on self-certification. In 2012 access to paid self-certified sick leave has halved to a maximum of seven day in a two year period in line with changes in paid sick leave arrangements across the public sector. From the start of 2014, a full suite of revised paid sick leave arrangements will come into effect across the public health sector in line with changes in the Public Sector at large.
- HR and Occupational Health Interventions to support line managers in managing attendance. These include direct support from HR to line managers in managing attendance more effectively, intervention teams focusing on particular areas or staff groupings where there are variances with national absenteeism targets.
- In HSE West they have created a specific Absence Management Intervention Taskforce to further support and assist line managers in this area.
- Replacement of staff unable to attend due to illness is authorised only in exceptional circumstances and is confined to critical front-line staff.

Effective attendance management is central to cost containment planning and people management throughout the sector. In terms of opportunity cost/notional cost of absenteeism, based on 2012 HR and financial data, the notional cost of 1% has been assessed as being of the order of €46.5 million and the overall notional cost in 2012 was assessed as being in the order of €223 million. This notional figure should not be interpreted that there would be a net direct corresponding financial saving if absence rates were to be reduced, but which would of course deliver additional hours/capacity to deliver services Additional direct costs can arise from replacing absent front-line staff through illness, primarily through overtime and agency usage. It is not possible at present to quantify this cost but it should be noted that such expenditure is only authorised in exceptional circumstances and is subject to budget compliance. This is currently assessed as being only a small portion of such overall expenditure in the staff categories representing front-line staff delivering critical services. However, clearly more effective attendance management of such front-line staff to reduce the levels of absenteeism and the impact of absence through illness on front-line services would reduce the demand for overtime and agency staff.

The objective of all these actions is to enhance the health sector's capacity to address and manage more effectively absenteeism levels, support people managers in better managing the issue, while also supporting staff regain fitness to work and resume work in a positive and supporting environment.

Appendix: Extracts from National Absenteeism Report December 2012 and 2008/2012

Extracts from December 2012 National Report on Absenteeism in the Health Services and Monthly Absenteeism Reports 2008 to 2012



Health Service Absenteeism - by Service/ Region, Service Staff/ Category & Sector: YTD Dec 2012

Service/ Sector/ HSE Region YTD [Dec 2012]	Dublin Mid-Leinster	Dublin North-East	South	West	National	Total	Certified
Hospital Care	5.31 %	5.52 %	5.01 %	5.25 %	4.29 %	5.21 %	87.42 %
Primary & Community Care	5.58 %	4.87 %	5.40 %	5.49 %	7.80 %	5.39 %	90.46 %
Ambulance Services					5.73 %	5.73 %	84.82 %
Population Health	2.40 %	3.49 %	4.31 %	5.00 %		3.91 %	87.54 %
Environmental Health	2.13 %	1.49 %	2.87 %	5.37 %	4.53 %	4.38 %	85.62 %
Corporate & Shared Services	3.72 %	4.05 %	4.23 %	4.59 %	5.05 %	4.40 %	90.57 %
Health Service Executive	**5.43 %**	**5.07 %**	**5.16 %**	**5.34 %**	**5.53 %**	**5.27 %**	89.06 %
Voluntary Hospitals	**3.61 %**	**3.72 %**	**3.85 %**	**4.38 %**	**4.60 %**	**3.68 %**	84.97 %
Voluntary Agencies P&C Services	**4.01 %**	**4.04 %**	**4.72 %**	**4.50 %**		**4.24 %**	89.17 %
Total	**4.41 %**	**4.50 %**	**5.01 %**	**5.24 %**	**5.47 %**	**4.79 %**	**88.40 %**
Certified	86.45 %	88.81 %	89.25 %	89.84 %	85.65 %	88.40 %	

Staff Category/ HSE Region YTD [Dec 2012]	Dublin Mid-Leinster	Dublin North-East	South	West	National	Total	Certified
Medical Dental	1.37 %	0.90 %	1.22 %	1.28 %	0.21 %	1.20 %	85.35 %
Nursing	4.69 %	4.77 %	5.63 %	6.22 %	5.00 %	5.30 %	87.92 %
Health & Social Care Professionals	3.81 %	3.88 %	5.05 %	4.70 %	4.02 %	4.27 %	88.79 %
Management Admin	4.26 %	5.04 %	4.46 %	5.05 %	5.66 %	4.75 %	89.39 %
General Support Staff	5.43 %	5.50 %	5.54 %	5.65 %	4.95 %	5.52 %	88.22 %
Other Patient & Client Care	5.55 %	5.62 %	5.50 %	5.43 %	4.77 %	5.44 %	88.17 %
Total	**4.41 %**	**4.50 %**	**5.01 %**	**5.24 %**	**5.47 %**	**4.79 %**	**88.40 %**
Certified	86.45 %	88.81 %	89.25 %	89.84 %	85.65 %	88.40 %	

Health Service Executive

Public Accounts Committee Report March 2013

Briefing note on Recommendations

April 2013

The following information provides an update on the recommendations relevant to the HSE in the Committee of Public Accounts ***Report on the Health Service Executive March 2013.*** It should be noted that there is on going work in many of the areas outlined in the recommendation of the Committee's report.

Report on the Health Service Executive March 2013 - update on recommendations relevant to the HSE

3. The Department of Health having completed its review of the Odgen Report which examined the financial management capacity of the HSE should publish an implementation report which will outline the investment strategy on financial management infrastructure so that the State has a robust and workable system for the management of the health budget.

Following consideration of the Ogden Report the Department of Health commissioned PA Consulting to carry out further work to focus on implementing change with regard to key deficiencies identified by Ogden.

This work provided an outline strategy in relation to improving financial management system within the health sector.

A key priority of the Director General Designate upon appointment in August 2012 was to stabilise HSE finances and to implement the actions outlined in the PA Review commissioned by the Department.

Following a tender process, PA Consulting was appointed by HSE to support a programme to take the first steps in the delivery of Financial Reform. In this regard, the HSE is working closely with the Department of Health to ensure that the necessary infrastructure is identified and the appropriate investment strategy is put in place to deliver this infrastructure thus ensuring that a more robust Performance Management & Accountability regime is established.

4. The HSE should establish, based on usage and on-going need, the number of posts that could be filled directly rather than through use of agency workers on a cost neutral basis.

The health services do not have a capacity to convert agency expenditure/usage into recruitment of new employees due to the requirements of the general moratorium on recruitment across the public sector, in place since March 2009 by government direction, the current employment control framework, and the constraints of the assigned approved employment target of 98,995 WTEs for the end of 2013. The current employment levels as returned in the Health Service Personnel Census at the end of March 2013 is 101,604 WTEs, some 2,649 WTEs above the end-of-year target.

6. The application form for the medical card should be reviewed to make it straightforward and user friendly.

The main Medical Card Application Form has been redesigned and approved by the National Adult Literacy Agency (NALA). Work is well underway on the revision and improvement of all forms and letters, which will also be approved by NALA.

7. The HSE should establish whether information on applicants for medical cards which is held by other Government agencies can be made available online to the HSE in order to streamline the application process and should take steps to obtain such information on-line where it is possible to do so.

A key component of the control system regarding medical cards is the capacity to share data between the HSE, Revenue, and the Department of Social Protection. The Department of Health has implemented legislation in April 2013 to support this valuable initiative. The plan agreed with the Department of Health provides for a supply of data from Revenue which will facilitate the initiation of renewals, taking into account, the most recently available total gross income across all income sources. A detailed specification for this exchange of data has been developed by Revenue in collaboration with the HSE and work is ongoing to deliver this project.

8. The recommendations made in the HIQA Report on Tallaght Hospital (AMNCH) in respect of governance and oversight should be set as the minimum standard expected of all voluntary hospitals and the service level agreement between the HSE and the relevant voluntary hospital should reflect these requirements.

Future Health: A Strategic Framework for Reform of the Health Services

In November 2012, The Minister for Health published ***Future Health: A Strategic Framework for Reform of the Health Service 2012-2015***. The primary goal of the reform programme is to improve services for patients and clients across all sectors including the acute hospital system.

Underpinning the reform programme articulated in Future Health is a recognition that the current system of governance of the Irish hospital sector requires strengthening. It also points out that the historical distinction between the voluntary and statutory hospitals *"has created an uneven terrain for optimising patient care and has restricted the development of the management systems and leadership"* within the sector. Future Health commits to the establishment of the required governance and leadership capabilities on a phased basis starting with the establishment of administrative hospital groups during 2013, leading to the introduction of independent hospital trusts for all hospitals by the end of 2015.

The HSE is working with the Department of Health on the introduction of these proposed structural changes. It is in the context of these changes that a review of individual charters and the status of individual hospitals will be undertaken.

The Chairs of the Interim Hospital Boards already established now report to the Director General (Designate) of the HSE as recommended in the HIQA report.

Performance management within the HSE

The HSE is introducing a number of management changes during 2013. These include;

- The appointment of a number of National Directors, including a National Director for Acute Hospitals.
- A strengthened performance management framework.

These changes will ensure that there is focused leadership for both the day to day management and reform of the acute hospital sector. In addition one feature of the new performance management arrangements will be the ability at national and regional levels to commission formal interventions in underperforming services.

Governance framework for HSE Funded services

Service Arrangements/ Contract

A significant development in the relationship between the HSE and the voluntary hospital sector occurred in 2010 with the introduction of formal standard Service Arrangement or 'contract' with the 16 voluntary hospitals in the State. These Service Arrangements specify not only the range of general terms and conditions governing the relationship but also the funding levels, service levels, quality standards and performance monitoring arrangements that are in place.

Since 2010 the HSE has continued to strengthen governance arrangements through;

- Specifying further responsibilities on HSE Managers to oversee and manage the services which the HSE is funding.
- Improving and strengthening the Service Arrangement to ensure it serves as a robust instrument for managing the relationship with the voluntary provider.

In January 2012 the HSE also introduced a set of minimum requirements for managing the relationship with each voluntary hospital. These included,

- A requirement to assign specified named managers with responsibility for each Hospital.
- Ensuring that there is an explicit link in the Service Arrangement between the funding provided and activity expected of each hospital.

- An enhanced performance review process with a minimum of 10 review meetings to be held each year and which will include the HSE Area Manager, Assistant National Director Finance, Regional Quality and Risk Manager, and other senior staff as appropriate.
- Audited Accounts to be reviewed by an appropriate finance officer.

In addition, the Service Arrangement documentation was enhanced in a range of areas including the specification of services, linkages with the HSE's National and Regional Service Plans, access to information, staffing and procurement and a strengthened approach to monitoring the implementation of quality standards.

<u>*Service Arrangements and specific governance measures*</u>
There is now an explicit requirement on all voluntary hospitals to comply with the Code of Practice for the Governance of State Bodies. Each hospital is also required to have a code of governance in place that is compliant with the Framework for the Corporate and Financial Governance of the HSE.

10. The HSE, in consultation with the Department of Health, should conduct a review of the oversight arrangements in respect of the 2,500 agencies who receive funding under Section 39 and should examine whether a system of random audit of a percentage of those bodies would enhance oversight.

The HSE undertakes audits in specified Section 38 and Section 39 agencies, particularly where issues of significant concern to the HSE are identified. Plans are in place to extend this programme of audits in 2013.

During 2012 the HSE's Internal Audit Department undertook a comprehensive review of the governance of a range of HSE funded agencies. The outcome of this review fed into the further development and strengthening of the HSE's Service Arrangement process.

HSE funded agencies are required annually to submit their audited accounts to the HSE for review.

An audit report in respect of salaries paid in section 38 Agencies is being finalised and will be considered shortly by the Board of the HSE.

11. The HSE should examine the scope it has to publish the names of those Hospital Consultants who are holding up the collection of income due to the HSE from private insurers.

The HSE has examined the option of publishing the value of private health insurance claims that require consultant completion and signature for each consultant that has a significant backlog.

The HSE's legal advisers have outlined a range of material legal risks associated with publishing including, in particular, that a consultant who is named in the list could potentially ground a claim against the HSE for (a) defamation (b) breach of confidentiality and / or (c) breach of data protection laws.

Based on this legal advice, the HSE is focusing primarily on:

- Continuing to improve our internal processes:
  - Introduction of Electronic Claiming - Twelve sites are currently using the electronic claims system representing 51% of overall national claims. A further eleven sites will go live by July'13 representing an additional 22% of claims. The plan is that greater than 80% - 90% of claims will be electronic by Dec'13.
- Embedding the 14 Working Day (20 Calendar Days) standard for consultant signoff.
  - The number of days taken for consultant sign-off has reduced as follows –
    - 2010 – 62 days
    - 2012 – 44 days
    - 2013 Plan – 20 calendar days (Note 1 – This represents 14 working days. The goal is to achieve the target by year end i.e. for all claims raised in the last months of the year. The overall days will average approx 30 days as the overhanging backlog is reduced).
- Setting out National Standards for all stages of the Collection Process.
  - The number of days taken to prepare claims by hospital staff and ancillary consultants has reduced as follows –
    - 2010 – 27 days
    - 2012 – 20 days
    - 2013 Plan – 15 days
- Working with the Department of Health and the Private Insurance Companies to bring about changes to modernise the payment terms so that payments to the HSE are made quickly without any reduction in the level of scrutiny by insurers of the treatment, length of stay and ultimately costs.

12. The practice of paying allowances to retiring hospital consultants in lieu of untaken rest days should be reviewed. A provision should be introduced whereby consultants can carry forward untaken rest days within a three year cycle, similar to the civil service provision relating to annual leave.

Context for historic rest days

Consultant Contract 1997 and the Academic Consultant Contract 1998 provided for 'historic rest days' as a means of settling a number of claims made by Consultants that they had not benefitted from their full rest day entitlement under Consultant Contract 1991 and earlier contracts.
This allowed them to take up to a year of such rest days – on full pay – immediately prior to retirement. Consultants who had established an entitlement to historic rest days under Consultant Contract 1997 and the Academic Consultant Contract 1998 maintained this entitlement under Consultant Contract 2008.

Based on Consultant staffing in 1998 – when Consultants had to establish their entitlement to historic rest days – the extent to which Consultants in various specialties and sub-specialties participated in on-call and providing for deaths, resignations and retirements in the interim period, approximately 450 Consultants remained eligible for historic rest days as of October 2012. The large majority of these were eligible for the full year of historic rest days.

In many cases, the need to maintain services required that for a year prior to their retirement and the introduction of a permanent replacement, HSE and HSE-funded agencies had to pay both for the Consultant and – if services were to be maintained – for a second locum Consultant. In some instances, in preference to taking their entitlement to historic rest days as leave, the Consultant sought to continue as their own locum and received the locum salary in addition to their normal pay. Assuming an average Consultant employment cost of approximately €230,000, this represented a potential cost to the health service of €103.5m in the period up to 2027, when the last of the cohort of eligible Consultants was set to retire.

Dispute between the parties

The dispute between the management side and the IHCA and IMO on historic rest days arose from the Employer's proposal that as part of a series of reforms relating to implementation of the Public Service Agreement 2010-2014 by Consultants employed in the public health service that the amount of such leave to be taken by Consultants be reduced by 50% with a period up to 2018 for any Consultant holding this entitlement to make use of it.

Labour Court recommendation

In September 2012, the management side (HSE, DoH, DPER) concluded an agreement on implementation of the Public Service Agreement by Consultants with the IMO and IHCA. As part of this agreement, the dispute regarding historic rest days was referred to the Labour Court for arbitration.

The Court heard the issue on 26th October 2012. The subsequent recommendation issued on 6th November.

Labour Court Recommendation 20403 provides for a 25% reduction in Consultants' entitlement to historic rest days and that all such leave must be taken by 31st December 2020. Historic rest days must be taken prior to retirement and no payment can be made in lieu of same. Taking this into account, the HSE has issued guidance to hospitals and agencies that where:

a) A Consultant commenced historic rest days prior to 16th November 2012, his/her entitlement remains unchanged;

b) A Consultant has not yet commenced historic rest days, his/her entitlement is reduced by 25%;

c) A Consultant is due to retire in the next two years, the reduction of 25% may mean that they commence historic rest days at a later date than previously anticipated;

d) A Consultant is due to retire in later years, any historic rest days not taken prior to 31st December 2020 are forfeit. In that context, each Consultant must agree a schedule for taking historic rest days during the period up to 31st December 2020 in a manner which eliminates to the greatest extent possible the requirement to engage a locum to replace the Consultant. For example, a Consultant who previously had an entitlement to a year of historic rest days now is entitled to 9 months. Such historic rest days could be taken as slightly over a month a year in the period up to 31st December 2020.

15. The Department of Health and the HSE should review the GMS contract with a view to establishing whether criteria relating to GP participation on primary care teams can be a factor in determining the award of new contracts.

The current contract does not give the HSE the power to set, as a condition precedent, a requirement that a new GMS contract holder has to commit to participating on PCT(s). Such a requirement has not been agreed as a contractual term between the Minister for Health and the IMO as would be required under clause 41 (i) of the GMS contract. The nearest the existing contract does come to imposing such an obligation is to be found in clause 11 (5th bullet) where a GP contractor is required to utilise the appropriate support services including community and diagnostic services.

However there is no mention of or recognition of PCTs as the main unit of service delivery within the existing contract (which has its origins as far back as 1989). This contractual deficit can only be remedied by (i) a legislative provision (ii) an agreed amendment to the contract between Minister and IMO or (iii) as a key requirement under a new GMS contract.

The HSE understands that discussions are still in process between the Departments of Health, Enterprise, Trade and Innovation and Public Expenditure and Reform on a competition law compliant process within which engagement with relevant stakeholders, including the IMO, on a new GP contractual framework could take place.

16. The GMS contract should provide that medical card entitlement of babies be established from the date they first attend a GP and not the date they were born.

This issue can only be addressed through an agreed amendment to the contract between the Minister for Health and the Irish Medical Organisation (IMO). The HSE has been advised that discussions are still in process between the Departments of Health, Enterprise, Trade and Innovation and Public Expenditure and Reform on a Competition Law compliant process within which engagement with relevant stakeholders, including the IMO, on a new GP Contract could take place.

However there is no mention of or recognition of PCTs as the main unit of service delivery within the existing contract which has its origins as far back as 1989. This contractual deficit can only be remedied by (i) a legislative provision (ii) an agreed amendment to the contract between Minister and IMO or (iii) as a key requirement under a new GMS contract.

The HSE understands that discussions are still in process between the Departments of Health, Enterprise, Trade and Innovation and Public Expenditure and Reform on a competition law compliant process within which engagement with relevant stakeholders, including the IMO, on a new GP contractual framework could take place.

15. The GMS contract should provide that medical card entitlement of babies be established from the date they first attend a GP and not the date they were born.

This issue can only be addressed through an agreed amendment to the contract between the Minister for Health and the Irish Medical Organisation (IMO). The HSE has been advised that discussions are still in process between the Departments of Health, Enterprise, Trade and Innovation and Public Expenditure and Reform on a Competition Law compliant process within which engagement with relevant stakeholders, including the IMO, on a new GP Contract could take place.