Public Accounts Committee

Meeting
Thursday 27th June 2019

Opening Statement
by
Mr Paul Reid
Director General
Health Service Executive
Chairperson and Members, thank you for the invitation to attend today’s meeting to discuss the HSE Annual Report and Financial Statements for 2018 and Chapter 16 of the C and AG Report 2017.

As you may be aware I took up post 6 weeks ago and as this is my first meeting with you, in this role, I would like to state that I look forward to working with the Committee and to providing assistance to you with your important work. The senior management colleagues joining me today are:

- Ms Anne O’Connor, Deputy Director General - Operations
- Mr Stephen Mulvany, Chief Financial Officer
- Mr Joe Ryan, National Director, National Services
- Ms Mairead Dolan, Assistant Chief Financial Officer

We have submitted information and documentation to the committee in advance of the meeting and I will therefore confine my opening remarks to the following issues:

**Financial Outturn 2018**

The HSE’s Annual Financial Statements (AFS) record a final audited revenue income and expenditure deficit of €85.1m. Further detail is set out in the finance briefing paper provided to the committee in advance of this meeting, including around the movement in provisions, and how this figure can be related to the final HSE published quarterly performance report for 2018. The 2018 final position is arrived at after dealing with the €140m 1st charge in relation to 2017 and after receipt of a supplementary estimate of €625m, the application of which has also been detailed. The AFS also records a €16m surplus on the capital account, which will be available to progress capital projects in 2019.

The most significant areas of financial pressure reflected in the year end position relate to the pensions and demand led areas including, the primary care reimbursement service.
Costs in these areas are generally driven by policy, legislative entitlements and demographic factors and as such they are not amenable to normal financial management controls.

Separately, our operational service areas experienced significant difficulty in reducing costs to meet savings targets, in controlling staffing levels and in responding to demand within budget. Disability services were the area of greatest financial pressure within community services. This pressure largely related to the costs of providing residential care to people with an intellectual disability, with the evolving needs of existing clients as they age, and the demand for new places, exceeding our funded capacity. We also experienced similar pressures within our acute hospital services where activity was ahead of planned and funded levels with a very high proportion of total activity arriving via our emergency departments.

**Financial Management 2019**

The HSE’s 1st priority for implementing its 2019 National Service Plan (NSP) is to maximise the safety of the services it can deliver within the available budget. Thereafter the priority, consistent with the Sláintecare programme, is to deliver on the activity, access, improvement and other targets set out in the NSP albeit this must be done within the affordable staffing level and without exceeding the overall budget.

Delivering on these priorities will require a significantly enhanced focus on financial management. This includes better controls on the management of agency, overtime and overall staffing levels and pay costs. Senior Managers will be supported and held to account in this regard.

The HSE’s financial position for year to date March 2019 shows a revenue deficit of €82.7m which represents 2.2% of the available budget. Of this, €44.8m is in respect of greater than expected expenditure on operational service areas, which includes €17.6m on community services, mostly in respect of services for people with a disability, and €28.4m, in respect of acute hospital services.
In cases where deficits appear in operational service areas, the relevant national director, community healthcare organisation Chief Officer, or Hospital Group CEO, has been directed to identify and put in place additional measures to enable delivery of an overall financial breakeven by year end. This has been supported by a series of additional interim controls around agency, overtime and staffing albeit all 2018 and 2019 developments approved and funded by the Department of Health are proceeding.

There is also a deficit of €38m in pensions and demand led areas. Options to limit deficits in these areas are being explored albeit they are primarily driven by legislation, policy and demographic factors and, as mentioned earlier, are therefore not generally amenable to normal management control efforts. It is noted that if the effect of the 2018 1st Charge was reflected in the March results above it would increase the overall March year to date variance, by €20.5m, to €103.2m, the change being predominantly within the Pensions and Demand Led Areas. The overall 2018 Annual Financial Statement process came to an end on the 13th May and the full 1st charge will be reflected in the monthly accounts from May onwards.

The necessary focus on delivering financial breakeven reflects the HSE’s legal obligation. It will also benefit service users, patients and their families as it is consistent with the need to build trust and confidence in the organisation. This is necessary so that additional investment in our public health and social care services, over and above the “cost of standing still”, can be secured over the next 5 to 10 years. This will facilitate the vision set out in the Sláintecare report to be realised.

**Procurement**

I would now like to turn to the issue of procurement. The scale and complexity of the HSE’s overall procurement activity is such that it will take a sustained effort and continuing investment over a number of years in order to ensure high levels of compliance and this is a key focus for the HSE. The HSE incurs procurable expenditure in excess of €2.2bn annually.
The HSE continues to progress a transformational programme of reform of its procurement function to improve compliance with public procurement regulations and to increase the usage of contracts awarded by the HSE and the Office of Government Procurement. It has been highlighted and acknowledged at a previous PAC meetings that it will take a number of years to fully address procurement compliance issues. Health Business Service - Procurement has been engaged in a major transformational change programme and the HBS Strategy (2017-2019) continues this strategic and operational transformation of Health Sector Procurement.

With regard to procurement reform and in particular non health procurable expenditure the HBS function works closely with the Office of Government Procurement (OGP). This collaborative effort with the OGP is achieving value for money and contributing to an increase in overall procurement compliance and the development of the overall procurement reform program.

**C and AG Report 2017 - Chapter 16 – Control of private patient activity in acute public hospitals**

The HSE is undertaking extensive work in embedding the Consultant Contract Compliance Framework.

The framework seeks to support improved reporting, monitoring and overall Consultant Contract Compliance. The following elements will be reported on:

1. Compliance with Public Private Mix (monthly)
2. Compliance with work plan (annually)
3. Compliance with off-site practice (annually)

In line with the Performance and Accountability Framework monthly performance meetings are held within existing structures and a key element includes improving Consultant Contract Compliance. Actions to address the areas of individual consultant non-compliance in terms of hours worked, off site practice and public/private mix are progressed at local level.
A programme of internal audit has commenced and a number of hospitals are being scheduled, firstly Cappagh National Orthopaedic Hospital, Tallaght University Hospital and Naas General Hospital. Further sites will be scheduled for audit in the coming weeks.

Overall summary rates of compliance for public private mix are below the limit of 20% for private practice. The percentage for Acute Hospitals In-patients is 12.5% and 14.5% for Day Cases.

**Home Support Services**

With regard to outsourcing Home Support services, voluntary organisations have been engaged in, and have contributed significantly to the provision and on-going development of the health and social care services in Ireland over many generations.

The term ‘voluntary’ is often used when referring to Section 38 and Section 39 agencies. Sections 38 and 39 of the Health Act 2004 legally underpin (a) the provision of services by non-statutory providers on behalf of the HSE [Section 38] and (b) the provision of services similar or ancillary to a service that the HSE may provide [Section 39].

The HSE has a continuing reliance on voluntary agencies to deliver services across the domains of acute care, social care, mental health and primary care supports and services. The HSE funds approximately 2279 organisations, including 16 large Voluntary Hospitals via a contract or service arrangement process which is legally binding. This also includes funding for many smaller organisations such as local Meals on Wheels groups, who provide services through unpaid volunteers.

The HSE acknowledges that voluntary organisations largely funded by the State need to operate within defined policy and regulatory frameworks – for example HIQA, Charities Regulation and Company Law - as well as public pay policy.
We also have a responsibility to optimise value for money and to ensure that health resources are maximised to benefit the citizen. In line with Sláintecare, health service reform also includes voluntary organisations funded by the HSE.

Voluntary agencies that provide Home Support services have made significant progress in reforming their services. These organisations are significant partners in the provision of home support particularly in the Greater Dublin Area and in the Mid-West. These voluntary agencies have transitioned from a position where they were supported by the HSE through block grant arrangements, to the current tender model of service provision. This reform has improved the quality of Home Support, providing a model of service delivery that is more responsive to demand and more consistent across Community Healthcare Organisations (CHO's). Streamlining of Home Support services has resulted in a single application and assessment process. There is also clearer financial and activity reporting which provides for greater accountability and transparency.

This concludes my opening statement.

Thank you.