Response to the Committee of Public Accounts

A Issues raised at meeting of 2nd February 2023

1. The number of cases in relation to the health repayments scheme, from 2013 onwards, brought by residents in private nursing homes or their families that were settled (pg. 6).

Please see the following table which summarises the status of litigation cases involving the Minister for Health where the claims related to pre-2005 long-stay nursing home charges.

"Long-stay" litigation (pre-2005 nursing home charges)	Private	Public	Mixed & Other *	TOTAL
Unresolved	**176**	**22**	**12**	**210**
Resolved of which	***132***	***146***	***28***	***306***
Settled via Health Repayment Scheme		*100*		*100*
Settled - Other	*102*	*36*	*17*	*155*
Discontinued	*30*	*10*	*11*	*51*
TOTAL	**308**	**168**	**40**	**516**

** The Mixed / Other column relates mainly to claims relating to <u>both</u> public and private facilities. It also includes a very low number of cases where public or private status of the facilities concerned cannot be determined based on documentation provided to the State to date.*

Of the 210 cases that remain formally unresolved, the Department's records indicate that:

- no Statement of Claim was filed in almost two/thirds of these cases;
- very few cases (20 or less) have been active over the past decade;
- no case has been active during the past 5 years.

2. The total legal fees associated with the cost of defence or litigation in relation to the health repayments scheme or to those who fall outside the scheme (pgs. 7-8).

As is normal practice, external Counsel fees connected to the defence of litigation against the State are met for the most part centrally from the Vote of the Office of the Attorney General. We are engaging with the Chief State Solicitor's Office in relation to this aspect of the requested information.

The Department has directly incurred certain specialist advisory costs connected with a small number of these cases, for example fees and expenses of external documentary counsel and other professional experts, amounting to less than €100,000 since 2008.

3. A breakdown of the nature of the legal cases against the Department in 2020 and 2021. (pgs. 7-8).

This is still being collated and will be forwarded as soon as possible.

4. The date for substantial completion of the national children's hospital, e.g. before its commissioning (pg. 34).

The National Paediatric Hospital Development Board (NPHDB) and the main contractor (BAM) are working to ensure the timely completion of the New Children's Hospital.
The last construction programme received from BAM suggested substantial completion of the project could be achieved by the end of March 2024 and the NPHDB are working to ensure that the contractor can achieve this.
BAM recently submitted an updated programme, as it is required to do, and the NPHDB and its advisors are currently reviewing this to validate it. Extensive discussions are ongoing between the NPHDB and BAM to get certainty on this substantial completion date.

5. A briefing note on linking the roll-out of digital health records to the national children's hospital (pgs. 35-36).

Early in 2017, DOH engaged with DPER to discuss the intention to bring a Memo for Government seeking approval and funding for a single, national, single, enterprise level Electronic Health Record system.
The outcome of these discussions was that the delivery of a single electronic health record for all citizens could best be achieved through the delivery of a programme made up of three interlocking components, which would help mitigate risks inherent in managing the delivery of such a large and complex programme. On that basis, attention was then focussed how best to secure the necessary funding, with separate business cases prepared for each of the three interlocking components, namely:

- An Acute EHR suitable for deployment across all acute hospitals.
- A Community based EHR system that would support all community based healthcare professionals in the management of care to patients.
- An integration layer that would link acute and community based digital healthcare records and provide key deliverables such as a Shared Care Record that would be accessible by healthcare professionals and patients alike.

Based on this agreed approach, in early 2018, the Department of Health received an Acute EHR business case from the HSE, and this was submitted to DPER in April 2018. Following further engagement with the DPER during 2018, and recognising the fact that the first deployment of the national acute EHR was going to be in the new Childrens Hospital, a specific business case for an electronic health record for the Children's hospital was requested by DPER and agreement in principle was reached to decouple this single deployment from the procurement start milestone for the wider National Acute EHR system.
In December 2018, an Acute EHR Implementation Plan for deployment into the new children's hospital was submitted to the DPER. Following further engagement in January and February 2019 between the Department of Health and DPER, it was agreed that government approval for EHR deployment in the NCH would be sought before proceeding with seeking further approval for an acute EHR to be deployed nationally.
Whilst the opportunities presented by electronic health records were acknowledged as self-evident at the time, it was also recognised that the deployment of a single, national, enterprise acute EHR system, represented significant risk, and it was on that basis that a stepwise approach was pursued. Following the engagements between Department of Health and Department of Public Expenditure and Reform (DPER), a memo was issued to Government to secure a decision to proceed with the procurement of an Electronic Health Record (EHR) system for Childrens Hospital Ireland (CHI), subject to the Government to be informed of the outcome of that procurement when actual costs were known. This was followed by a subsequent memo to Government, informed by actual (tendered)

costs that secured a decision to contract for the delivery of the EHR based on the outcome of that procurement.
The provision of an EHR System at the New Children's Hospital is currently underway with a contract now in place and staff being recruited over the past 6 months to support its roll-out. When complete, this will be the most extensive EHR deployment in Ireland to date.
The primary vendor and CHI teams are now in place for the delivery of the EHR at Childrens Hospitals so that it will be ready for commissioning well in advance of the opening of the new campus.
HSE and CHI teams have all been involved in the development of the business case, procurement documentation, procurement process and contracting for the EHR.
As this is the largest, most extensive EHR deployment in Ireland to date, there is strong consensus that there have been huge learnings throughout this process which will inform our strategy for wider EHR deployments that are aligned with the establishment of the new regional health areas.
There is no doubt that the pandemic and subsequent cyberattack in the health service that diverted all available resources from progressing important eHealth programmes such as the delivery of EHR systems, has cost us more than two years.
Given the impact of these events, the acknowledgement in the **2018 Slaintecare Implementation Strategy** that the HSE should pursue a modular (stepwise) approach to mitigate deployment risks associated with the delivery of large complex HER systems, the subsequent emergence of the **Regional Health Areas**, , and evidence gathered from jurisdictions across the globe on how best to deliver digital health records for all citizens, the DoH and HSE are now well positioned to progress an EHR procurement approach in line with central guidance, a phased deployment plan to support RHAs, and a hosting model that mitigates cyber threats to the greatest possible extent, whilst factoring in interoperability with EHRs that have been or are currently being rolled out.

Programme for Government

The PFG states that digital health services are key enablers to delivering care more effectively, empowering patients in accessing their own medical records and manage their care and providing more services in patients homes and the community. To advance these services, we will:

- Invest in a modern eHealth and ICT infrastructure, in line with Project Ireland 2040 and the eHealth Strategy for Ireland.
- Build on the progress already made in responding to COVID-19 to improve eHealth measures and provide for the secure electronic sharing of patient information.
- Implement an Electronic Health Record system in the new National Children's Hospital and prepare to roll it out nationwide.

6. Whether the Department has considered employing a cohort of salaried GPs at any point? If not, why is that the case (pg. 42).

The Irish model of general practice is based on private practice; all GPs providing GP services in Ireland currently are private practitioners.

The Health Act 1970 provides that persons who are unable, without undue hardship, to arrange GP services for themselves and their family can qualify for a medical card or GP visit card. Since 2015, all children under the age of 6 years and all persons aged 70 and over are automatically eligible for a GP visit card.

Over 2,500 GPs hold a General Medical Scheme (GMS) contract with the HSE to provide GP services without charge to medical card and GP visit card holders, more than 500 further GPs hold contract(s) with the HSE other than a GMS contract, such as for childhood vaccinations or screening services. GPs are reimbursed under the GMS scheme through capitation fees, as well as fee per service payments and practice supports. The remaining population access general practice on a private basis and pay the relevant fees to their GPs.

This model has allowed the State to make provision for access to care for the most vulnerable while also allowing GPs to develop their practices and sub-specialisations (e.g. women's health, chronic disease, etc.) in line with the needs of their patients and their own career ambitions. It has also allowed us to avoid any distinction in treatment between public and private patients.

Sláintecare states that the recommendation to provide primary care and universal access to GP care without charges will be facilitated by a new GP contract for private practitioners and the direct employment of salaried GPs by the HSE.

It should be noted that if the HSE were to employ a cohort of salaried GPs, it would also have to provide the staffing and logistical infrastructure required to run general practice effectively and efficiently. Any proposed model involving salaried GP positions would also require careful consideration to ensure the required level of service could be provided for medical card and GP visit card holders.

The Department and the HSE are now commencing a strategic review of GP services to examine how best to ensure the provision of GP services in Ireland for the future. The review will examine the broad range of issues affecting general practice, including an examination the circumstances under which use could be made of salaried GPs.

B Issues raised at meeting of 9th February 2023

1. A detailed note on the record, in the March 2004 minutes of the Department's management committee, that the Attorney General was sent a signed letter by the Secretary General; whether this occurred. If not, why not and why was it recorded in the Committee's minutes (pgs. 12-15).

The matters referred to were fully addressed in the Traver's Report 2005 (Chapter 4 - *"Legal Concerns With Respect To Charges: Response Of The Department Of Health And Children: Actions & Decisions"*).

2. A note on the additional funding for the ICT network infrastructure in the national children's hospital (pg. 22).

The funding for the New Children's Hospital Project currently includes €170.3m for digital planning and associated commissioning. This includes capital funding of €97.7m for software, hardware and other ICT implementation costs, and revenue funding of €72.6m for programme resources, pay costs and other such costs. Of this funding, to date CHI has drawn down a total of €44.1m, comprising €28.2m in revenue funding and €15.9m in capital funding.

3. The date on which the Sláintecare report was approved by Government in 2018 (pg. 23).

The 2018 Sláintecare Implementation Strategy (not Sláintecare Report as set out in the question) was approved by Government on 17 July 2018.

4. The expected number, over the next four years, of both GP graduates, and GPs due to retire (pg. 42).

GPs are private practitioners, most of whom hold a GMS contract with the HSE for the provision of GP services without charge to medical card and GP visit card holders. The retirement provisions under the GMS scheme were changed since July 2015 to allow GPs to hold GMS contracts until their 72nd birthday. GPs who have retired from the GMS scheme may continue to provide GP services on a private basis.

As GPs are private practitioners, and outside of the 72 years of age GMS scheme retirement provision, they themselves determine when to retire. As a result, it is possible only to estimate the numbers likely to retire over the next four years.

Based on information received from the Medical Council in November 2022 on the age profile of doctors registered to a Medical Council register who self-describe their current role as that of a General Practitioner, approximately 25% were aged 60 years or over, approximately 6.8% were aged 70 years or over.

At the beginning of April, 2,539 GPs held a GMS contract (a further 568 GPs held a contract(s) with the HSE other than a GMS contract). The number of GMS GPs with a full contract who will turn 72 from the years 2023 to 2026 is 92, and is broken down by year as follows:

- No of GMS GPs who will turn 72 this year (DOB 1951) - 25
- No of GMS GPs who will turn 72 during 2024 (DOB 1952) - 21

- No of GMS GPs who will turn 72 during 2025 (DOB 1953) - 21
- No of GMS GPs who will turn 72 during 2026 (DOB 1954) – 25

The number of doctors entering GP training has increased approximately ten percent year on year from 2019, rising from 193 in 2019 to 258 in 2022, and a further large increase is planned for this year. Following the transfer of responsibility for GP training from the HSE to the Irish College of General Practitioners (ICGP), it is aimed to have 350 training places available for new entrants per year by 2026.

In addition, the ICGP has increased the number of Recognition of Prior Learning (RPL) places from 7 in 2018 to 51 in 2023. Successful RPL applicants have a full year of training recognised, shortening the GP training period from 4 years to 3 years.

The ICGP currently estimate that 890 GPs will graduate from GP training over the years 2023 to 2026, a breakdown per year is provided below.

Year	Intake	Projected Graduates
2019	193	
2020	208	
2021	233	
2022	258	
2023		198
2024		209
2025		226
2026		257

5. A note on the situation regarding salaried GPs for primary care in the community (pg. 42).

The Irish model of general practice is based on private practice; all GPs providing GP services in Ireland currently are private practitioners.

The Health Act 1970 provides that persons who are unable, without undue hardship, to arrange GP services for themselves and their family can qualify for a medical card or GP visit card. Since 2015, all children under the age of 6 years and all persons aged 70 and over are automatically eligible for a GP visit card.

Over 2,500 GPs hold a General Medical Scheme (GMS) contract with the HSE to provide GP services without charge to medical card and GP visit card holders, more than 500 further GPs hold contract(s) with the HSE other than a GMS contract, such as for childhood vaccinations or screening services. GPs are reimbursed under the GMS scheme through capitation fees, as well as fee per service payments and practice supports. The remaining population access general practice on a private basis and pay the relevant fees to their GPs.

This model has allowed the State to make provision for access to care for the most vulnerable while also allowing GPs to develop their practices and sub-specialisations (e.g. women's health, chronic

disease, etc.) in line with the needs of their patients and their own career ambitions. It has also allowed us to avoid any distinction in treatment between public and private patients.

Sláintecare states that the recommendation to provide primary care and universal access to GP care without charges will be facilitated by a new GP contract for private practitioners and the direct employment of salaried GPs by the HSE.

It should be noted that if the HSE were to employ a cohort of salaried GPs, it would also have to provide the staffing and logistical infrastructure required to run general practice effectively and efficiently. Any proposed model involving salaried GP positions would also require careful consideration to ensure the required level of service could be provided for medical card and GP visit card holders.

The Department and the HSE are now commencing a strategic review of GP services to examine how best to ensure the provision of GP services in Ireland for the future. The review will examine the broad range of issues affecting general practice, including an examination the circumstances under which use could be made of salaried GPs.

6. A copy of the Department's value-for-money reviews or processes in relation to beds delivered in the health service (pg. 48)

While there haven't been any system wide bed capacity reviews carried out, there have been a number public spending reviews carried out by IGEES over the past number of years that are publicly available.

7. In relation to parliamentary questions 20023/18 and 20063/18 on 8th May 2018, whether the statement in the reply from the then Minster for Health that 'there has been no crystallisation of a contingent liability for the Department in the past ten years' is correct (pg. 50).

The HSE reports its financial performance in line with Financial Reporting Standard 102 (FRS102) issued by the Financial Reporting Council, subject to certain exceptions to Generally Accepted Accounting Principles (GAAP) directed by the Minister for Health in relation a number of areas where the HSE has been directed to diverge from GAAP in how it accounts for depreciation, pensions, capital grants, clinical claims. Costs of contingent liabilities are not provided for or funded in the HSE's determination until such time as the cost is incurred- for example in relation to clinical and non-clinical claims dealt with by the State Claims Agency on the HSE's behalf, the liability only crystallises each year when the claims are actually settled. These costs are detailed in note 11 to the HSE's 2021 annual financial statements which sets out the current year costs incurred together with the estimated overall liability associated with the Clinical Indemnity Scheme.

It should be noted that one aspect of the response to the Parliamentary Question response detailed on 8 May 2018 that 'There has been no crystallisation of a contingent liability for the Department in the last ten years' should be amended to note as follows:

The costs of contingent liabilities are not provided for or funded in advance but are instead funded on a 'pay as you go' basis when the costs of the liabilities are settled. In the case of clinical and non-

clinical claims dealt with on the HSE's behalf by the State Claims Agency, the crystallisation of such liabilities occurs when the claims are settled and appropriate levels of funding are provided within the HSE's determination each year to meet the costs of claims settled within the year.'

8. A note on the management structure of maternity units in the State, including:
• the person in charge of each of the units aside from the Rotunda, The Coombe and Holles Street hospitals,
• how long is each person in place, and
• whether the appointment structure differs from that in the Rotunda, The Coombe and Holles Street hospitals (pgs. 55-56).

Explanation of the management structures in the maternity services.

The National Women and Infants Health Programme; NWIHP, was established in 2017 to lead the management, organisation and delivery of maternity, gynaecology and neonatal services within the HSE. This includes the implementation of the National Maternity Strategy (2016-2026). There are 4 strategic priorities in the National Maternity Strategy, one of which is Governance and Leadership.

Under this strategic priority NWIHP has led the establishment of six maternity networks, one in each of the hospital groups. Each Maternity Network has a Clinical Lead, and these have been in place since 2017. The model of governance is similar to the Dublin Maternity Hospitals in having a Clinical Lead, Director of Midwifery and Business Lead at hospital level.

- At unit level, there are Clinical Leads in each unit and these posts usually rotate every two years. The Directors of Midwifery were a result of a HIQA recommendation in 2015. These roles were recruited across 2015 and 2016.
- The role of the Business Manager is currently being implemented on a phased basis. These roles have been successfully recruited into some of the maternity units.

9. A note on the dental treatment services scheme, school dental scheme and the public PRSI-based scheme, to include the following:
• The 2023 budget for the schemes
• Who will provide treatment under the schemes
• Who is in charge of the schemes
• What is being done to address the issues encountered in these schemes
• Whether it is Department policy to instruct the HSE that where it cannot get a private dentist to engage, it should directly employ a dentist. If not, is there any direction from the Department in that regard
• The position in CHO 8 on these schemes (pgs. 57-58).

N.B. The Minister for Social Protection is responsible for the PRSI-based Dental Treatment Benefit Scheme

Budget for dental services, 2023

Service/Scheme	Budget 2023 – National	Budget 2023 – CHO 8	Expenditure in CHO 8 – January & February 2023
Dental Treatment Services Scheme (DTSS)	**€66.8 million**	***No cap on spending in CHO areas***	**€2 million**
Public Dental Service	**€64.4 million**	**€9.9 million**	**€1.1 million**
Orthodontic Service	**€23.8 million**	**€4.2 million**	**€0.5 million**

The HSE is responsible for the administration of the Dental Treatment Services Scheme (DTSS); the Public Dental Service (PDS); and the HSE Orthodontic Service.

The Dental Treatment Services Scheme (DTSS) provides dental care, free of charge, to medical card holders aged 16 and over. Services are provided by dentists who have a contract with the HSE. Since May 1st 2022, there has been additional prevention treatments included in the DTSS and a 40-60% increase in fees across most treatment items. More complex care, such as dentures, and a broader range of treatments for patients with additional needs and high-risk patients are also available. This has led to an increase in the numbers of treatments provided and the number of patients being seen.

Where access to a dentist is difficult, local HSE services assist patients who make inquiries and make lists of DTSS contractors available to medical card holders. In exceptional circumstances the HSE directly assists patients to access emergency dental treatment by contacting private contractors or arranging treatment through HSE-employed dentists.

The salaried HSE PDS provides care to several groups of patients. A screening and necessary treatment is provided for children approximating to second and sixth class and, in some cases, fourth class. Emergency care is provided for children of all ages up to 16 and for those with complex and additional needs.

Those with additional needs, who cannot receive care in a general dental practice, may need special care services provided by the HSE Public Dental Services. These patients are given an oral health examination and where necessary have their treatment provided using additional supports.

Orthodontic treatment is provided by HSE orthodontists to patients referred before their 16th birthday and who have the greatest level of need.

Additional funding of €5 million has been allocated through Budget 2023 on a one-off basis to support the HSE Public Dental Service to provide care this year, included to address backlogs in the targeted programme for children and to provide a “safety net” service for DTSS patients who are in need of emergency care and are having difficulty accessing this through a local dentist.

An additional €4 million has also been allocated in Budget 2023 to target waiting lists for orthodontic care. Under the Waiting List Action Plan 2003, a further €6 million has been allocated. Those who have been waiting the longest to access orthodontic treatment will be prioritised.

10. A copy of the department's workforce plan (pgs. 59-60).

We understand that this question related to the HSE's workforce plan which we have requested and which will be forwarded as possible.

11. An update in relation to the rollout of the €1,000 Recognition Payment to those entitled to it (pg. 60).

Background

Last year, the Government announced a generous tax-free COVID-19 recognition payment for frontline public sector healthcare workers, to recognise their unique and exceptional role during the pandemic. The payment of €1,000 is not subject to income tax, USC, or PRSI.

Eligibility guidelines were first published online by the HSE on 19/4/22 following extensive union consultation. To be eligible, staff must have:

- ✓ Been in COVID vaccination cohorts 1 or 2, and
- ✓ Worked ordinarily onsite in a COVID-19 exposed healthcare environment, and
- ✓ Worked in such an environment for at least 4 weeks in the 1/3/20 – 30/6/21 period, and
- ✓ Worked in such an environment in a HSE/Section 38 organisation, or one of the following:
    1. Private sector/independent nursing homes and hospices;
    2. Eligible staff working on-site in Section 39 long-term residential care facilities for people with disabilities;
    3. Agency roles working in the HSE;
    4. Health Care Support Assistants (also known as home help / home care / home support) contracted to the HSE;
    5. Members of the Defence Forces redeployed to work in frontline Covid-19 exposed environments in the HSE;
    6. Paramedic staff employed by Dublin Fire Brigade to deliver services on behalf of the HSE.

Current position

So far, payments have been made in respect of more than 205,000 workers. This breaks down as follows:

For eligible **HSE and Section 38** staff, rollout is substantially complete. Figures from the HSE show that as at 06/4/23 142,694 staff were paid (90,004 HSE staff, and 52,690 Section 38 staff).

For eligible **Defence and Dublin Fire Brigade** staff, on 1/11/22 the Department of Health transferred funding to the Department of Defence (€1.265m) and Dublin City Council (€0.84m) to cover payments in respect of their eligible staff. Payment of these staff is a matter for those bodies but is understood to be substantially complete.

For eligible **non-public sector staff**, the HSE and external contractor KOSI Corporation are rolling out the payment at pace. As of 06/4/23, funding to 634 organisations for 61,074 staff has totalled €56.02m:

Roughly 90% of submissions received to date have included errors which require correction before payment. KOSI Corporation's validation process has saved €3.34m thus far, by identifying and averting duplicates and incorrect claims. KOSI also operate a dedicated helpdesk to assist employers

with queries on the application process. The KOSI PSRP team has dealt with more than 6,000 emails and more than 3,000 calls.

Appeals outcomes are now complete from a joint HSE management/union committee. The HSE advise that over 3,500 appeals were lodged.

Remaining to be paid

It is not possible to assess accurately how many eligible staff remain to be paid. The Department and HSE do not collect payroll or staff details from private companies in the normal course. Self-assessed data from employers with eligible staff is required before recognition payment funding can be released, and as such it is not known in advance how many eligible staff work in the organisations whose claims have not been processed yet before this data is received.

In March 2023 KOSI established a separate portal for employees who do not have an employer to claim a PSRP on their behalf. To date invites to the portal have been issued to 257 employees across 9 organisations to enable them to claim their PSRP (if eligible).

12. A note providing an update on the MRI scanner in Wexford General Hospital (pg. 64).

The Ireland East Hospital Group has advised that currently, the MRI Service provided on the campus on Wexford General Hospital (WGH) is owned and operated by a private diagnostic company Alliance Medical Diagnostic Imaging. Wexford General hospital has a service level agreement in place with this company for the provision of public inpatient and some outpatient MRIs on three days per week.

Alliance medical also provides a private service on other days to other healthcare providers outside of the hospital and outside of the service level agreement with the hospital.

Regarding a publicly owned MRI in WGH, approval to proceed to stage 1 of the design process was given by the National Capital & Property Steering Committee.

Stage 1 preliminary design is now complete- as of end of January 2023. Stage 2a/b design has commenced.

Construction is expected to start by end of year.

13. A note, in relation to the health repayments scheme, outlining whether money that was not paid by residents in nursing homes was ever collected by the Department, and if not, why not (pgs. 65-66).

During the period in question, former Health Boards were responsible for the collection of long stay charges. Each Health Board had their own policy in relation to debt collection, bad debt management and write-off of such debts in respect of long-term residential care. Given the passage of time, it is not possible to provide a detailed analysis of debt management in respect of long stay charges by the Health Boards over that period.