DÁIL ÉIREANN

AN COISTE UM CHUNTAIS PHOIBLÍ

COMMITTEE OF PUBLIC ACCOUNTS

Déardaoin, 5 Iúil 2018

Thursday, 5 July 2018

The Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Bobby Aylward,	Deputy Alan Kelly,
Deputy Peter Burke,	Deputy Marc MacSharry,
Deputy Shane Cassells,	Deputy Catherine Murphy,
Deputy Catherine Connolly,	Deputy Jonathan O'Brien,
Deputy David Cullinane,	Deputy Kate O'Connell.

DEPUTY SEAN FLEMING IN THE CHAIR.

Mr. Seamus McCarthy (*An tArd Reachtaire Cuntas agus Ciste*) called and examined**.**

Business of Committee

Chairman: Before we commence our business, Deputy Cullinane wants to raise a point of order.

Deputy David Cullinane: We have an hour on CervicalCheck and maybe more if we raise it ourselves during the second round of questions. Is Mr. McCallion present today and, if not, why not?

Mr. John Connaghan: Mr. McCallion is on leave today. That leave was booked some time ago. He has a family holiday and is away for a week. He will be back early next week.

Chairman: We are joined by the Comptroller and Auditor General, Mr. Seamus McCarthy, as a permanent witness to the committee. He is joined by Ruth Foley, deputy director of audit. Apologies have been received from Deputy Pat Deering. We are dealing with the Department of Health and the HSE under the Department of Health appropriation accounts, Vote 38 for 2016 and the HSE financial statements 2017. However, the committee decided to provide up to one hour at the beginning of the meeting to deal specifically with the cervical cancer crisis issue. We will proceed with our examination of the financial statements after that. We will take the routine business of the committee in the afternoon.

There are a number of items relevant to this morning's meeting in correspondence which I am putting on the record so they can be discussed in detail in public. The first is Nos. 1452 A and 1457 providing briefing documentation for today's meeting from the HSE. We will note and publish that.

Correspondence No. 1453 from Mr. Connaghan is his opening statement for today's meeting. We will note and publish it. Correspondence Nos. 1458 and 1459 from Mr. Derek Finnegan of the Department of Health are providing briefing documents and a note on the Scally report. We note and publish them. Next is correspondence No. 1460 from Mr Jim Breslin, Secretary General of the Department of Health, providing his opening statement. It is noted and published.

Correspondence No. 1427 from Mr. Ciarán Breen, director of the State Claims Agency, dated 25 June 2018, provides information on the management of legal costs and open disclosure as requested by the committee on 14 June 2018. Mr. Breen's correspondence deals with the State Claims Agency management approach to CervicalCheck cancer misdiagnosis litigation; and details including the status of screening and non-screening cancer misdiagnosis claims for cervical cancer, bowel cancer and breast cancer. We note and publish this.

Correspondence No. 1432 from Mr. Ray Mitchell of the HSE is in respect of Dr. Scally's access to CervicalCheck records. It is noted and published. Correspondence No. 1438 from Mr. Ray Mitchell, dated 29 June 2018, is in respect of the attendance of particular officials at today's meeting. We have a relevant note on the screen. We are not having a discussion; it is

just by way of information. It states in respect of the point about CervicalCheck attendees that at this point it is important to advise the committee that Charles O'Hanlon is on sick leave and certified unwell and, therefore, will not be in a position to attend the committee.

In respect of Dr. Gráinne Flannelly, she is employed by Holles Street and indicated that she is no longer with the HSE. Since our meeting last week we have written to Dr. Flannelly in her course of employment and she sent an email back to the committee, reference 1451, which we note and publish. Dr. Flannelly was the clinical director of CervicalCheck. In her email, she thanks the committee for the invitation to appear before it on a voluntary witness basis to address the issues regarding the CervicalCheck programme. She states that she is at present preparing to meet with Dr. Scally as part of his investigation next week, and that she is currently in the UK where she has work commitments until the middle of next week. That is now this week. She goes on to state that she would value the opportunity to help our committee by attending as per our request on a voluntary basis but in view of the above she requests that this be rearranged to a different date. She states that she will liaise with the clerk in respect of rescheduling it.

I want to put on record that while she is not here today, Dr. Flannelly has given a definite commitment that she is happy to meet with us at a more suitable time. I think we will have to come back to that. We will discuss the timing of our meetings as part of our work programme in the afternoon. We will not set the time now.

Deputy Alan Kelly: We should ask if she will come in next week.

Chairman: We made a request last week for specific individuals. One is on certified sick leave and the other will come on another date.

Correspondence No. 1439 provides follow up information from the HSE in respect of the National Treatment Purchase Fund, NTPF. Correspondence Nos. 1440 and 1441 are from an individual making inquiries about HSE circulars not circulated or implemented and HSE employees who did not make the criteria for the first round of the Haddington Road regularisation process. All those items of correspondence are relevant to our discussion this morning, which is why I referenced them in advance.

Implications of CervicalCheck Revelations (Resumed)

Mr. John Connaghan *(Director General, Health Service Executive)* and **Mr. Jim Breslin** *(Secretary General, Department of Health)* called and examined.

Chairman: For this session we are joined by the HSE director general, Mr. John Connaghan; Dr. Peter McKenna, acting clinical director of CervicalCheck; Mr. Ray Mitchell; and from the Department of Health, we are joined by Mr Jim Breslin, Secretary General and Ms Tracey Conroy, assistant secretary, acute hospitals division. I remind members, witness and those in the Public Gallery to switch off their mobile phones or put them into airplane mode as they interfere with the recording system when merely switched to silent.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject mat-

ter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable. Members are reminded of the provision under Standing Orders that they shall refrain from inquiring into the merits or policies of a Government or a Minister of the Government or the merits of the objectives or such policies.

While we expect witnesses to answer questions put to them by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and considerations at all times in accordance with the witness protocol. We are allocating up to one hour for this session so there will be five minute slots. I think people will understand that the topic might come up again as part of the general discussion with the HSE over the course of the afternoon.

I will put one question to Mr. Connaghan before the clock starts for this hour. He got a request from us for information but I do not see the response. Perhaps he can point it out to me. We asked specifically for a note in advance of today's meeting regarding the three CervicalCheck laboratories and who signed off on the forms when they were returned to the HSE. We asked for details of whether the person or persons were administrative or medical staff with relevant medical qualifications and we asked for the HSE to provide a sample of such forms, redacted as appropriate, and to explain what sign-off process was involved. Can Mr. Connaghan tell us those details?

Mr. John Connaghan: I think we have sent in what the process is, including a flow chart, for the receipt and sign-off of samples that go to the collection point in Ireland and are then transmitted to the laboratories and what happens thereafter. It might be better if I ask Dr. McKenna to take the committee through that. The correspondence and flow chart that we gave the committee contain the answer to that question.

Chairman: Time is tight and I am being generous, so the hour will only start after I have finished my bit, in fairness to the other members. That flow chart, which is now up on the screen, does not answer the question. It starts talking about the GP surgery and the whole way along, the forms going out and coming back. All we want to know is when the laboratories that were contracted by the HSE to work for CervicalCheck sent results back to CervicalCheck and who signed off on them on behalf of CervicalCheck to confirm the HSE was happy with the work the contractors did. Can Mr. Connaghan show me the spot where that is shown on the flow chart? He understands my simple and straightforward question.

Mr. John Connaghan: Yes, I understand the question.

Chairman: We do not need to know of the process before that.

Mr. John Connaghan: There might be a simple misunderstanding here. Once the samples are read and the reports are available, they are directly sent back by electronic means or by post to the doctor or clinician who requested them. That is detailed on the flowchart.

Dr. Peter McKenna: It is entirely possible that a smear could be taken and the report returned a medical practitioner having direct sight of it. Smears are read by laboratory techni-

cians and may be taken by a practice nurse. If the reading is normal, the result is returned to the programme and the woman informed without any input from a medical practitioner. That is the system which is in place.

Chairman: That is exactly my point. For those who cannot see the chart, it details that women participating in cervical screening go to the general practitioner, GP, clinics and the laboratory has a collection system involving a pre-addressed envelope being sent to the laboratory for processing. The laboratory reports are then sent to the GPs or clinics. Are the witnesses saying that when the work comes back from the three laboratories, which are essentially contractors to the HSE, nobody in CervicalCheck looks at the results from a medical point of view? Do I understand that correctly?

Dr. Peter McKenna: If the results are normal, they would not, no.

Chairman: We are discussing the misdiagnoses which were marked as normal and in which cases the results do not correspond with the conclusion. Are the witnesses stating that smears went from a doctor to the laboratory and back and CervicalCheck had no medical involvement in the results?

Dr. Peter McKenna: If a result is normal, there might be no input from a medical practitioner between the taking of the smear and the result being filed.

Chairman: Why did the senior people in the HSE not have a quality assurance mechanism in place to verify from the point of view of the HSE and CervicalCheck that the work carried out by the contractors was valid? Nobody in a public organisation for which a contractor is doing a job accepts that the work is done satisfactorily on the basis of the contractor sending back a report. Rather, the results of the work are checked. I am putting it as simply as I can. The witnesses are stating that the contracted laboratories did the work but no check on that work was carried out by the HSE.

Dr. Peter McKenna: Quality assurance was built in at the start of the contract. As part of the contract, each laboratory has agreed in-built quality assurance mechanisms.

Chairman: Should CervicalCheck have a role in checking the results that come back from contracted laboratories?

Mr. John Connaghan: There is a set of quarterly metrics, although I do not have it to hand.

Chairman: I am asking about individual cases. I do not wish to waste time. The witnesses were asked a very specific question. I am dealing solely with a question asked on the previous occasion the witnesses were before the committee and also submitted in writing. The witnesses stated that it is possible that no medical staff may be involved in the process. The committee asked for the sample of forms sent back to CervicalCheck by the laboratory rather than a summary report on the number of tests carried out. Does CervicalCheck get a copy of results which are sent to doctors? Is the laboratory report for each patient sent to CervicalCheck? Does anybody in CervicalCheck review the forms sent back by the contracted laboratories from a medical point of view?

Dr. Peter McKenna: Almost certainly not. Some 250,000 tests came into CervicalCheck, the majority of which are reported as normal. As part of the quality assurance an agreed sample of, for example, one in 50 or 100 cases are sent to another laboratory, which would be sufficient.

Chairman: The patient results sent to CervicalCheck are not usually checked by a medical professional in the HSE, which writes the cheque for the work to be done on behalf of the individual patients. That is my understanding of the situation and it is part of the problem.

Mr. John Connaghan: The Chair is correct. However, there are accredited quality assurance checks in place on a quarterly basis which look at overall quality. The Chair is correct in regard to individual cases but such cases are sent back to the doctor or practising clinician who requested the samples in the first place.

Chairman: Okay. The hour to be spent on CervicalCheck will start now. The following speakers have indicated: Deputies Alan Kelly, David Cullinane and Catherine Murphy. Each Deputy will have a five-minute slot.

Deputy Alan Kelly: May I take the same amount of time as did the Chair?

Chairman: I was doing my work as Chairman on behalf of the committee in bringing up the request for information we sought but did not receive.

Deputy Alan Kelly: I was joking. The comment was in jest.

Chairman: Deputy Kelly's five minutes begins now.

Deputy Alan Kelly: The witnesses will be delighted to learn I will probably only have time to ask three questions in this round. As of 9 o'clock this morning, how many women have been identified as having been affected? That figure was at 209.

It has been reported that the independent review of the cases of 3,000 women will not be completed on schedule and is only commencing now. What is the reason for that? Why has it taken so long? If there were 300,000 slides per year and it takes five minutes to review each, a team of ten people could carry out the analysis in a few weeks even if each slide is surveyed twice and the women's slide history examined. Why was there a commitment to complete the review within a timeframe which has not been followed? Why was information on the delay not made public? Why is the review only starting now? It will not be possible for it to form part of the Scally review, which must be completed by the end of August. The Minister for Health, stated that the final Scally review must be completed by the end of August. However, these 3,000 slides will not be part of it because of the delay. Stephen Teap and Vicky Phelan, who gave evidence to the committee, are extremely disappointed and upset this morning that the review of the slides will not form part of the Scally review. Why was the review committed to on the basis of an unrealistic timeframe? When will it be completed? How in the name of God can we have a situation where Dr. Scally must report by the end of August to ensure credibility but this review will not form part of his report because of the delay? How will his review be complete without that information? How in the name of God did we end up in this situation? Who committed to those unrealistic timelines?

I have a third question which I had better ask before the Chair cuts me off. It relates to the legal cases, of which I understand there is a significant number. I remind the witnesses that the State Claims Agency, SCA, will appear before the committee next week. As I understand it, the HSE hired a legal firm, the identity of which I know, to draft a protocol for how cytology slides are given to the women affected. That protocol has been in use for several weeks. Solicitors for several affected women have gone to court to seek the release of the slides and in such cases the HSE has handed them over without the protocol being followed. These are urgent cases. All present know what that means: the women are in difficult health situations. Why is a protocol

needed for the release of slides to which the women are entitled? Why is it taking so long? Why can the protocol be bypassed when a woman goes to court and takes on CervicalCheck and it or the SCA is so embarrassed that it hands over the slides? Some 80 to 90 women have sought their files from CervicalCheck and some have received access thereto. When it comes to getting their slides they are being blocked by a protocol, which I doubt anyone has heard of up to now. Given what the Taoiseach and the Minister, Deputy Harris, said in the Dáil and the evidence given to this committee and the Joint Committee on Health, of which I am also a member, why is this protocol necessary? What is its purpose? If it can be bypassed in urgent cases why can it not be bypassed in this instance and these slides given to the women and their solicitors immediately? As I understand it, Quest Diagnostics is releasing the slides but Clinical Pathology Laboratories, CPL and MedLab Pathology Limited are in discussions in that regard in light of this protocol. According to the laboratories, the HSE, through the SCA, and this legal protocol, is holding up the provision of information to which these women are entitled.

Mr. John Connaghan: On the first question, we advised the committee on the previous occasion that there were 209 women affected and that there could be a further 12 women affected. As of today, there are 221 women affected.

Deputy Alan Kelly: As of now, there are 221 women affected.

Mr. John Connaghan: Yes.

Deputy Alan Kelly: Is that figure likely to increase?

Chairman: I ask Deputy Kelly to allow Mr. Connaghan to respond as there are other members waiting to contribute.

Deputy Alan Kelly: I am just seeking clarification.

Mr. John Connaghan: As of today, there are 221 women affected. I will ask Ms Conroy to respond to the other questions.

Ms Tracey Conroy: The international clinical expert panel review is being carried out by the Royal College of Obstetricians and Gynaecologists, RCOG, with expertise also sourced through the British Society for Colposcopy and Cervical Pathology. There is ongoing daily engagement between the Department and RCOG on the details and complexities of this review. It was never intended that the RCOG review would be completed in advance of the Scally review. It was made clear from the outset, in terms of engagement with RCOG, that given the complexities of the review it could take four to six months to complete. We always knew that it would not be possible to complete it sooner and we were clear in this regard, including to Government.

Deputy Alan Kelly: It was not made clear to anyone else.

Ms Tracey Conroy: The review is an independent clinical review. RCOG will review all of the diagnoses of cervical cancer since the programme was established in 2008, including the 1,482 cases that were notified to CervicalCheck since then and the further 1,630 registered by the National Cancer Registry which had not been notified to CervicalCheck. The review will examine the women within this cohort who were screened by the programme, which is approximately 1,856 women from within the total but that is subject to final validation within the review. The review will examine the cases of women who developed cancer and were screened by CervicalCheck. All of their screening histories will be examined. This involves reviewing all of the smears. The panel will have an algorithm for examining the smears and it will identify

the number of cases in which there are discordant results. A report in each case will be provided to the women involved. The panel has its own quality assurance system and it wants to work systematically so that it can stand over this process. We have been engaging with RCOG on a daily basis since it agreed to come on board with this review.

Deputy Alan Kelly: This was not communicated----

Ms Tracey Conroy: The work is progressing very well.

Deputy Alan Kelly: This was not communicated outside of Government.

Ms Tracey Conroy: We are very conscious of the need for good communications around this matter. Over the past number of weeks, RCOG has been working down through what will be involved in terms of examining the smears, files, cases histories and so on. It has been working with its own expertise in this regard while also engaging with the HSE and the Department on getting a handle on what is involved in terms of costs, timelines and so on. We are very close to finalising those matters. We have also engaged with RCOG on how best to communicate the review to all stakeholders but most importantly the patients involved. That is imminent.

Chairman: I call Deputy Cullinane.

Deputy Alan Kelly: Excuse me, my third question has not been answered yet.

Chairman: The Deputy had a five-minute slot and he spent it putting questions with no opportunity for answers. The five minutes allocated to each speaker is inclusive of questions and answers. I will allow a quick response to the third question.

Deputy Alan Kelly: This is ridiculous.

Deputy David Cullinane: I do not mind waiting until the Deputy's third question has been answered.

Deputy Alan Kelly: I thank the Deputy.

Chairman: I remind members that there is not five minutes allowed for questions and ten minutes for answers. We have only one hour on this topic.

Dr. Peter McKenna: The third question concerned the return of the slides. It would be a new departure from practice that patients would look for their slides so it does not come as a surprise to me that a process would be instigated nor would it come as a surprise to me that if there are legal teams involved this process could be quite tortuous. As regards the specifics of what the process entails, I cannot tell the Deputy that but I will find out and revert to him.

Chairman: I ask Dr. McKenna to revert to the committee on the matter before next week.

Dr. Peter McKenna: Yes. On the principle, if it is the woman's slide, it belongs to her and there is no disagreement from our point of view.

Deputy Alan Kelly: Eighty or 90 women are waiting eight weeks or more.

Dr. Peter McKenna: On the principle, there is no disagreement.

Chairman: Will Dr. McKenna come back to us on the timescale?

Dr. Peter McKenna: Yes.

Deputy David Cullinane: I will be distinct with my questions. I am conscious in putting questions about process and cost that there is a human side to this issue and women who face a struggle every day, some in serious health difficulties. I want to send solidarity greetings to all of them. As a committee, we have a job to do. Our remit is to examine spend and value for money. If a mistake is made in the spending of State money, we have to follow up on it. That is the reason we focus on these issues but we are conscious of the human side of the matter as well.

Information we received from the National Treasury Management Agency, NTMA, on the national incident management system sets out the number of cases being taken under different categories. Under the heading, National Screening Service, it shows that there are 22 claims, 20 active, one closed and one potential claim. This information was provided a number of weeks ago. I am assuming that information has changed as Emma Mhic Mhathúna has since settled. Of the 22 claims listed, how many are still active?

Mr. John Connaghan: As of today, there are 28 cases but I will need to check that with my SCA colleagues. According to *The Irish Times* today, there are 28.

Deputy David Cullinane: I would rather Mr. Connaghan told me the correct figure rather than rely on what is stated in *The Irish Times*. Mr. Connaghan is the director general of the HSE. Will he come back to me with the exact figure before the meeting concludes?

Mr. John Connaghan: I will.

Deputy David Cullinane: I raise this issue because there are more women coming forward. We know from media coverage that in Emma Mhic Mhathúna's case the settlement was in two parts, against the laboratory, Quest Diagnostics, and the HSE. The media coverage states that the HSE accepted liability. Can Mr. Connaghan explain for what the HSE accepted liability and, also, is this the first time the HSE has accepted liability in court in any of these cases?

Mr. John Connaghan: The HSE has accepted liability for not communicating the results of the audit.

Deputy David Cullinane: That is all I wanted to know.

Mr. John Connaghan: That is in the case of Emma Mhic Mhathúna. The HSE also accepted responsibility for not communicating the results of the audit in the case of Vicky Phelan.

Deputy David Cullinane: My understanding was that the settlement for Vicky Phelan came almost exclusively from the laboratory. Is Mr. Connaghan saying that there was a cost to the State in respect of Vicky Phelan's settlement?

Mr. John Connaghan: No.

Dr. Peter McKenna: There was a modest contribution by the State of, I think, €25,000.

Deputy David Cullinane: In terms of Emma Mhic Mhathúna, it could be more substantial.

Mr. John Connaghan: In the case of Emma Mhic Mhathúna, the total sum has yet to be apportioned between the HSE and the laboratory in question. This matter is still under discussion.

Deputy David Cullinane: This is an important point. As for where this might leave us when this sorry saga is eventually complete and when every woman gets the justice she de-

serves, I note 28 cases are potentially before the courts and 209 women were not informed of the results. If it is the case that the HSE has accepted liability for not informing Ms Mhic Mhathúna of her incorrect smear test, as Dr. McKenna put it, does that admission of liability apply to all 209 women? As for those women who are not before the courts, how will they be compensated by the HSE? I am asking a straight question, that is, was the acceptance of liability only in the case of this individual or was it in respect of all the women? In answering that question, I want Dr. McKenna to bear in mind that when Mr. Gleeson, who was one of those people with responsibility for overseeing the process of informing or not informing the women, appeared before this committee, he did not and still to this day does not accept any mistake was made but yet in court, the HSE accepted liability that a mistake was made. There are two parts to my question. First, does the admission of liability apply only to this individual or does it apply to all 209 women? In the latter case, how will they be compensated given there is no class action opportunity in this State? Second, given that the individual who was responsible for the failure does not accept there was any failure, how will Mr. Connaghan, as the director general, deal with that problem?

Dr. Peter McKenna: I am a little reluctant to speak about an individual case without having all the details, but my understanding is there may have been a clinical component outside of the smear programme that may have contributed to the HSE being involved.

Deputy David Cullinane: That is fine but Mr. Connaghan said the admission of liability, certainly in part, was because of the failure to inform this particular individual. If that is the case, 209 women were not informed. Is the HSE accepting liability that it was a mistake, in respect of all 209 women, that they were not informed? If that is the case, how will they be compensated? Notwithstanding the other 209 cases, which Dr. McKenna can address shortly, there was an acceptance of liability in this case. The person with responsibility for this process in the HSE, however, is still to this day saying he does not accept any failure on his part, which means there was no failure on the part of the HSE. How does Mr. Connaghan square that with-----

Chairman: I will ask Mr. Connaghan to answer that question and then I will call Deputy Catherine Murphy. If Deputy Cullinane is not happy with the answer he gets, he might have an opportunity to come back in at a later stage.

Mr. John Connaghan: I will deal with Deputy Cullinane's question quickly. In regard to taking an opinion on one case, I would not like to venture an answer to his question without taking further legal advice on this. I do not think an individual settlement - without having legal advice on this - would tell me it applies to 209. Morally, I understand from where the Deputy is coming on this.

As regards responsibility and liability or accountability, the Scally review is currently under way and it will report by the end of August. We need to wait to see what it will state in regard to accountability.

Deputy Catherine Murphy: This whole debacle started off about mandatory disclosure and women not being told their results. We are still at this point months later and people are not able to get their files. Why are they not able to get them? We have been constantly told that the HSE will give them their files. Why are we still hearing they are not able to get their files?

We now know the number of cases is 28. Is that from a cohort of 209 or 221, or are they made up from a different component?

The clinical review will require information to be transferred to be evaluated. Will that prove to be an impediment to others getting their files or are duplicates available? What issues will arise from the point of view of people getting the information that they own?

Mr. John Connaghan: Generally, the evidence we have had, from a number of appearances before this committee on the provision of documentation, advises that this will be done against a 30-day standard for turnaround, and we are generally observing that. The last report the committee had on this indicated there is one case where we are outside that standard. I do not have an update on that as at the end of last week, but generally we are providing information that is required within a 30-day turnaround standard.

Deputy Catherine Murphy: Is it true that at this stage 80 women, or their legal representatives, in that cohort of 209 women have not got their files?

Mr. John Connaghan: We need to understand where we are against the 30-day cycle. If it involves original slides, I guess those might need to come from the laboratories, particularly if they are overseas. Regarding the provision of the documentation, the reports we have made to this committee, and the reports I have had, indicate that we are generally keeping within that 30-day standard, but we will certainly check out the detail.

Deputy Catherine Murphy: Is there a difference between the HSE providing the women's files or the laboratory providing the information. Who has the information?

Mr. John Connaghan: In the case of original smear slides, these are held by the laboratory.

Dr. Peter McKenna: Yes. There should be no difficulty in the HSE with respect to any person who requests their chart, or a copy of their data, to get it. That should be available either through the medical legal channel or freedom of information. If they are waiting for anything it is likely to be a physical slide - Deputy Kelly referred to this - there may be a difficulty in getting that material back from the laboratory.

Deputy Catherine Murphy: With which the HSE has a contract.

Dr. Peter McKenna: That is right.

Deputy Catherine Murphy: Why would there be a difficulty with that?

Dr. Peter McKenna: I am not sure if that was covered in the contract. I genuinely do not know that but I think it is being worked out. We said we would see what the problem was and that we would revert to Deputy Kelly on this.

Mr. John Connaghan: Regarding Deputy Murphy's third question concerning impediments we may have, a clinical review of the documentation is under way. There should be no impediments in terms of physical documentation or physical records. I guess there could be an impediment if the Royal College of Obstetricians and Gynaecologists is looking at original slides and somebody has requested that information. There can only be one original slide, which I guess would be the impediment to which the Deputy referred.

Deputy Catherine Murphy: Therefore, people could be waiting for months. Is that the case?

Mr. John Connaghan: The Royal College of Obstetricians and Gynaecologists has not yet started this.

Ms Tracey Conroy: We had a tripartite engagement with the Royal College of Obstetricians and Gynaecologists. The people in the HSE were involved in this process during the week and the HSE was very clear that it did not see any impediment in providing the smears within a timely fashion to the college.

Deputy Catherine Murphy: However, there is an impediment. The HSE has a contract with these laboratories to carry out work. It is not that the laboratories own the slides afterwards. I cannot understand why there would be an issue with retrieving those slides or demanding that they be retrieved?

Mr. John Connaghan: There is no issue in principle.

Deputy Catherine Murphy: There is an issue in practice.

Mr. John Connaghan: If there is an issue in practice, we have heard that perhaps between 80 and 90 women are waiting for physical slides to come back. If that is the case, we will check that out and report back in short order. We have already said that today. However, there should be no impediment in principle.

Deputy Catherine Murphy: We hear there are 28 cases and that number is increasing, is that from a cohort of 209 or 221 women?

Mr. John Connaghan: First, we need clarify that figure of 28. Even though we have press reports that this is the number, we still need to be able to provide clarify on that after checking that with the State Claims Agency. Once we do that we will also answer the Deputy's query on where the 28 lie against the 221 cohort.

Dr. Peter McKenna: There is another confounding variable in the figure of 28. I do not know if that number refers to cases the State Claims Agency is aware of or that it is involved in, as they could be slightly different. If the laboratory has taken over the liability, then the State Claims Agency may not be a party to the settlement.

Chairman: I will move on to the next speaker, Deputy Marc MacSharry, and I remind him these are short time slots.

Deputy Marc MacSharry: Regarding CervicalCheck, have confidentiality agreements been abolished or abandoned? Are we still seeking those in terms of any-----

Mr. John Connaghan: Confidentiality agreements have not been deployed for several years. The briefing I have on this is that those confidentiality agreements have, by and large, been at the request of the plaintiff. The director of the State Claims Agency, Ciarán Breen, will appear before the committee next week and should be able to supply it with chapter and verse on that.

Deputy Marc MacSharry: We will ask him about that but Mr. Connaghan is saying the HSE is not looking for them.

Dr. Peter McKenna: I also understand that it is standard practice in mediation that confidentiality would be sought. I do not know how this translates into an individual case but I understand that it is a general principle of mediation that there is confidentiality.

Deputy Marc MacSharry: Is that while mediation is ongoing?

Dr. Peter McKenna: No, I think it is meant to be part of the standard agreement.

Mr. Jim Breslin: I think Ciarán Breen will walk all the way through this with the committee. What would often happen in mediation is that-----

Chairman: That is just for people like Ciarán Brennan-----

Mr. Jim Breslin: Ciarán Breen.

Chairman: -----next week when the State Claims Agency appears before us.

Mr. Jim Breslin: Exactly. What would often happen in mediation would be that the process itself would be confidential so people could try to reach an agreement and offer positions that would allow that to happen. What can happen at the end of that, particularly where dependents are involved, is that the outcome would be registered in the court so the actual outcome would be a public outcome. The State Claims Agency, which has claims delegated to it and handles all the mediation and court processes, will be able to work this through with the committee next week in full detail.

Deputy Marc MacSharry: We will ask it. However, the point is that we are not looking for-----

Mr. Jim Breslin: Absolutely not. The confidentiality aspect of a plaintiff is really that the individual does not want his or her name out there but details of the settlement could be out there without divulging the person's identity. That is the person's right. It is not something the State would impose. The principle of open disclosure requires us not to push confidentiality agreements. I think the State Claims Agency has clarified that in recent days.

Deputy Marc MacSharry: With the audit happening, if a woman is unfortunate enough to be diagnosed, is there now a working protocol in place for informing that woman? Who is telling these women?

Dr. Peter McKenna: I think the audit has been suspended pending the outcome of the Scally review.

Deputy Marc MacSharry: If somebody is diagnosed now, is there a very clear protocol in place whereby the physician or CervicalCheck tells the patient? What is the protocol and is it working? Has a new one been put in place since this debacle?

Dr. Peter McKenna: An audit process is not in place so if someone is diagnosed and previously had a smear, that smear would not be subject to an audit process at the moment.

Deputy Marc MacSharry: Is that a "No"?

Dr. Peter McKenna: On an individual basis, the clinician may request it, which would not be unusual. It would then be up to the clinician to inform-----

Deputy Marc MacSharry: Is it fair to say that despite the debacle we have had, we are waiting until everything is over before we put a definite protocol in place?

Dr. Peter McKenna: It would be fair to say that the audit has ceased.

Deputy Marc MacSharry: And no protocols have been put in place in the mean time.

Dr. Peter McKenna: Good clinical practice would say that if one has an interval cancer, one would request the results to be looked at and then inform the patient. That would be good clinical practice.

Deputy Marc MacSharry: That did not really happen, as we know. What I am trying to establish is whether the HSE at management and director level has said that if this happens again, "You will do this and I will do that and this is how it will work out." Has that happened?

Dr. Peter McKenna: No, it is awaiting the Scally review.

Deputy Marc MacSharry: I think, as a recommendation, we could be pioneering, not to have to wait for the Scally review, apply basic common sense - I have no clinical training - and put a protocol in place notwithstanding the good recommendations of Scally or anybody else. At this point, has anyone in the HSE been held to account or is it the same answer in terms of waiting for Scally and other reviews? Are any disciplinary proceedings under way? Are there any issues being dealt with in that regard?

Mr. John Connaghan: I have had some discussions on this very briefly with Dr. Scally. The HSE is currently considering a post-Scally review and how we will put in place a conduct investigation. We have a national protocol agreed with our staff representatives that generally applies to any conduct investigation. We must be very careful about how we observe that national protocol. We will wait until after the Scally review. These remarks are entirely neutral.

Deputy Marc MacSharry: The answer is-----

Mr. John Connaghan: After Scally.

Deputy Marc MacSharry: It is possible, if not likely, or likely.

Mr. John Connaghan: Likely.

Deputy Marc MacSharry: That is all for now.

Deputy Catherine Connolly: On the last occasion Mr. Connaghan was here, we talked about the general answering service and how it was overwhelmed. Is it still overwhelmed?

Mr. John Connaghan: Is that the answering service for women?

Deputy Catherine Connolly: It is for general queries from women who are worried and are ringing in.

Dr. Peter McKenna: The short answer is that there were 14,500 phone calls, the vast majority of which have now been returned as of the end of last week. I think there were only about 200 phone calls outstanding. We expect that these will be dealt with this week. There are a further 50 calls that are not call backs. They are clinical consultations. These clinical consultations are much more detailed and involve a lengthy conversation with a consultant. These will take a bit of time to get through but the call back for the generality has been addressed.

Deputy Catherine Connolly: With regard to the suspended audit, there is no ongoing audit at the moment. Is that right?

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: This arose as a result of the Vicky Phelan case following an

audit, the results of which were not communicated. Is that not right?

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: There was an ongoing audit. Results came forward, there was then the debacle about who should tell the women and nobody told the women. Is that correct?

Dr. Peter McKenna: That is correct.

Deputy Catherine Connolly: That is it in a nutshell.

Dr. Peter McKenna: Yes.

Deputy Catherine Connolly: At the moment, nobody is reviewing smear tests. The results are coming back from the lab and CervicalCheck is just accepting those. Is that right?

Dr. Peter McKenna: The generality of smear tests are negative.

Deputy Catherine Connolly: No, just listen to my question. We know all of that. When CervicalCheck carried out its audit, it found things that were wrong. There is no audit at the moment so who is finding out what things are wrong at the moment?

Dr. Peter McKenna: In other words, if a patient develops a cancer-----

Deputy Catherine Connolly: CervicalCheck discovered matters from the audit. There is no audit at the moment so what quality assurance is in place? How is CervicalCheck finding out whether something is wrong?

Mr. Jim Breslin: There are two things. One is the quality assurance programme while the other is a retrospective audit by-----

Dr. Peter McKenna: The retrospective audit has ceased and will-----

Deputy Catherine Connolly: I understand that. As a result of the retrospective audit, we have these cases. How many women are affected?

Dr. Peter McKenna: A total of 221 women are affected.

Deputy Catherine Connolly: At the moment, could there be another 221 cases if another retrospective audit was done?

Dr. Peter McKenna: What will inevitably happen is that each month, there will be some women who will be diagnosed with an interval cancer. They will have been screened, the screening will have failed and they will be diagnosed with an interval cancer. They should be looked at and they should be informed. That will be done outside of the screening programme. How that is doing within the screening programme will await direction from Scally, which should report on that matter shortly.

Deputy Catherine Connolly: That is worrying. The audit is suspended so nobody is checking.

Dr. Peter McKenna: It is not that there is nobody checking. The diagnosis has been made.

Deputy Catherine Connolly: But when the diagnosis is wrong, as was the case in 221

cases, that was discovered by a retrospective audit.

Dr. Peter McKenna: No, the diagnosis of cancer was not-----

Deputy Catherine Connolly: Sorry, I beg your pardon - the retrospective audit identified that the analysis was wrong.

Dr. Peter McKenna: It identified that the smears had mis-called the problem - correct.

Deputy Catherine Connolly: That is not happening now.

Dr. Peter McKenna: It is not happening with the screening service.

Deputy Catherine Connolly: So let us go back to quality assurance, which was teased out earlier on. When the results come back from the labs with which CervicalCheck has the contracts, it simply accepts them because they have their own quality assurance. Is that right?

Dr. Peter McKenna: Their quality assurance gets external validation.

Deputy Catherine Connolly: Where does it get that from?

Dr. Peter McKenna: From the organisations in their country that validate them. It would be the equivalent of our ISO.

Mr. John Connaghan: These are picked up in the quarterly monitoring reports for each laboratory to ensure it accords with what was expected in respect of the standards of detection.

Deputy Catherine Connolly: I understand all that and we get that every week - that all the processes are in place. What happened though was that 221 women did not benefit from that. It was quite the opposite. What I am trying to get here is that the system accepted the results of the smear tests coming from the labs and now there is a serious question over the quality assurance and the checking of that. Is that right? There has to be a serious question on quality control with 221 women affected and more going to come to light. Am I using the wrong language?

Mr. John Connaghan: I wonder if we are mixing up a couple of things. Perhaps I can explain this better from a clinical point of view. In any screening programme, there will always be a question about false positives and false negatives-----

Deputy Catherine Connolly: No, Mr. Connaghan, I have only five minutes and we have been through that a thousand times. We are talking about the women affected. Despite everything Mr. Connaghan talked about and despite the quarterly reports, something has happened here that this has failed. That was not picked up by CervicalCheck nor by the HSE. It came to our attention as a result of Ms Vicky Phelan speaking out and more women then coming forward. Is that not right? The internal mechanisms have not worked.

Dr. Peter McKenna: What failed was not telling the patients, not communicating that their previous smears had been misread - that was the failure.

Deputy Catherine Connolly: That was part of the failure but it came from the retrospective audit.

Dr. Peter McKenna: I think the difficulty is in distinguishing what is considered "an acceptable rate of failure" from what is an unacceptable rate of failure. Where women are being compensated, on the look-back it is considered that, possibly, there was no reason this should

not have been noted or the number of times in which it was overlooked was unacceptable.

Deputy Catherine Connolly: On the confidentiality agreements, and this is my last question, it was said that they have not been used in the last number of years. Is that in every case and not just in cervical smear tests? I understand, first of all, that Ms Vicky Phelan said that she was asked to have a confidentiality clause. Is Mr. Connaghan saying, openly, that the HSE has not used confidentiality clauses for years?

Mr. John Connaghan: I think the State Claims Agency will tell the Deputy exactly where we are in respect of the chapter and verse on that. My understanding is that confidentiality clauses have not been used for a few years.

Chairman: Would the involvement of the laboratory have been an issue?

Mr. Jim Breslin: That is the core of the Ms Vicky Phelan case. The laboratory insisted or put forward a confidentiality clause but the State Claims Agency did not and argued against that. Ms Phelan - and we all owe her great credit - stuck by her guns and insisted that there would be no confidentiality clause. The State Claims Agency did not seek that clause and I think it will confirm that when it is before the committee next week.

Chairman: I call Deputy Jonathan O'Brien.

Mr. John Connaghan: I am sorry, I have some information. It is just as well that we do not rely totally on the popular press for information.

Chairman: I thank Mr. Connaghan.

Mr. John Connaghan: The position on claims is that three have been settled, 35 are active-----

Deputy Alan Kelly: How many?

Mr. John Connaghan: Three have been settled, 35 are active and there are two potential cases.

Chairman: I thank Mr. Connaghan and I call Deputy O'Brien.

Deputy Jonathan O'Brien: I have two questions. The first one is on human papillomavirus vaccine, HPV, testing. The proposed roll-out date we were looking at was in October. Will Mr. Connaghan give us some information on whether we are still working towards that timeline?

Mr. John Connaghan: There are three or four elements on the critical path for that roll-out. The first is the service specification, the second is the preparation of tender documentation and the third part is, after tender, mobilisation. Those are three things on the critical path. I am not able at this stage to tell Deputy O'Brien the time elements of each of those. There are some things in play which we are going to try to deploy to speed things up. Regarding tendering, there is a possibility that we can go for a negotiated contract which would truncate the tendering process. We are considering that right now.

We need to tidy up the service specification and the tender documentation needs high level clinical input, so we need to have a clinical director for the CervicalCheck part. We are working on that and we might have some news next week. If that is the case, once we get that clinical

input, authority, accountability and responsibility, it will allow us swiftly to close off the position in the service specification and to tender. If we can go to a negotiated contract, then that might be the best way forward in getting HPV testing in place quickly. There is also an element here of the capacity of each of the labs. On what we want in respect of resilience, I have already given advice in response to a question raised by Deputy Catherine Connolly earlier. My view is that we should have at least three or four.

Deputy Jonathan O'Brien: There are a number of things in play, we are still working towards the October roll-out, but that is based on progress over the next couple of months. Is that right?

Mr. John Connaghan: That is correct.

Deputy Jonathan O'Brien: I just want to check something Mr. Connaghan said earlier about the original 209 women. I think my colleague, Deputy David Cullinane, asked if the HSE had accepted liability for any part or role in respect of those 209 women, outside of Ms Vicky Phelan and Ms Emma Mhic Mhathúna. Mr. Connaghan said that is correct to the best of his knowledge. Is that right?

Mr. John Connaghan: Yes. My advice to Deputy Cullinane was that I know that the HSE has accepted liability for not providing the audit results. Dr. McKenna has got further advice that there may be a clinical element to that and I would need to study all of the judgments to be able to give Deputy O'Brien a proper answer to that question.

Deputy Jonathan O'Brien: As far as Mr. Connaghan is aware, did one of those 209 women settle a case in March 2017?

Mr. John Connaghan: I am not aware of that.

Deputy Jonathan O'Brien: I suggest that we should look at those 209 women because the information I have is that at least one of those women settled a case against the HSE in March 2017. It was not against the labs, it was against the failings of the HSE in not referring her to a gynaecologist-----

Mr. John Connaghan: Was that in respect of CervicalCheck?

Deputy Jonathan O'Brien: Yes, it was in respect of smear tests. She was also asked to sign a confidentiality agreement. That was in March 2017. One person I have met personally has told me that. It is my information that there are a number of other women in similar situations. I have yet to meet them but I am in the process of meeting with them. If we are giving out information then we need to be 100% sure that it is accurate because I am sure Deputy Alan Kelly also has information that some of those 209 women have settled previously, before Ms Vicky Phelan's case became public knowledge, and have also been asked to sign confidentiality agreements.

I know that at least in one instance, the woman that I met, a case has been taken against the HSE for failings in CervicalCheck in not being referred to a gynaecologist and then developing cancer. She is now, thankfully, in remission but she took a case, settled in March 2017 and signed a confidentiality agreement. Perhaps the witnesses could come back with some additional information on those 209 women as regards exactly how many of them have taken cases against the HSE previously and been awarded settlements? Those are the only questions I have at the moment.

Chairman: We are finished at this stage but we have a quick five minute slot for Deputy Kelly and Deputy Cullinane, and then Deputy Catherine Murphy as well. It is a strict five minutes because the time is up.

Deputy Alan Kelly: I have a couple of comments. I find it unbelievable that the witnesses cannot provide the information relating to this protocol today. Why is the protocol being pushed legally, particularly when it is preventing women from getting their slides? Why can some solicitors representing women go into court and get the slides, thereby bypassing this protocol? I do not understand how Mr. Connaghan cannot provide that information.

I understand what Ms Conroy is saying regarding the review of the 3,000 cases. That is fine. These are the words of Vicky Phelan and Stephen Teap this morning. They are surprised and disappointed and they were not aware of this. It is not me or any other member of the committee saying this. Whatever is going on, it had been expected that this would be completed by the end of May and would form part of the Scally inquiry. It was not completed by the end of May. When will it commence? We now know that it is not part of the Scally inquiry. Scally is already incomplete and a large chunk of the inquiry will be irrelevant.

On the previous occasion he was here, Mr. Connaghan said that he had to catch up with and meet Dr. Scally. I presume he has done so on numerous occasions. Has he visited Limerick? Will Mr. Connaghan confirm that when Dr. Scally reports, he will not say that one reason he could not complete his report - which he will not be able to do - is because he was not provided some information by the HSE? I want Mr. Connaghan to guarantee that Dr. Scally's review will not be able to say that at the end of August and that the HSE will have provided everything.

On the admission of liability in respect of non-disclosure of information, we know from Emma Nic Mhathúna's case that this has been admitted. Will that be the standard for all other cases?

Given what was said by a previous speaker, my next question is very important. The State Claims Agency's clinical risk advisers met CervicalCheck in March 2017. Why did the HSE not reveal the risk of this audit at that point?

Mr. John Connaghan: On the provision of information, there is no intention to hold anything back. Everything we have in our remit or within the HSE will be provided to the Scally inquiry. The Deputy may not be aware that we sought and received agreement from the Minister that we will deploy section 40(c) of an Act, the name of which I have forgotten at this moment, that will allow us to send everything to Dr. Scally on an unredacted basis, save matters covered by patient confidentiality. I have recently advised Dr. Scally of that. The answer to the first question is that we will not hold anything back.

Will the Deputy remind me of the second question?

Deputy Alan Kelly: I asked for clarification on meetings with Dr. Scally and with the lads in Limerick.

Mr. John Connaghan: We met, and have been in regular communication with, Dr. Scally in recent weeks.

Deputy Alan Kelly: My other questions relates to the protocol on the slides and the issue of the review of the 3,000 cases, which, I presume, Ms Conroy will answer. The third question relates to the meeting in March 2017 regarding clinical risk and admission of liability.

Mr. John Connaghan: I am not aware of the March 2017 meeting. I will need to look at that.

Deputy Alan Kelly: That is not what I asked. The State Claims Agency and the clinical risk advisers met with CervicalCheck in March 2017. Why did the HSE not tell them that there was a risk?

Mr. John Connaghan: I am not aware of that meeting. I will have to look at the detail of it.

Deputy Alan Kelly: It is public knowledge.

Chairman: Mr. Connaghan will need to check that out because it has been mentioned extensively here in the past. Mr. Connaghan will need to come back with a written response to that in the next week.

Deputy Alan Kelly: I am sorry, Mr. Connaghan should know this information.

Ms Tracey Conroy: On the RCOG communications-----

Deputy Alan Kelly: Ms Conroy might explain what RCOG means.

Ms Tracey Conroy: I am referring to the international review being conducted by the Royal College of Obstetricians and Gynaecologists-----

Chairman: In the UK, it is not the Irish royal college.

Ms Tracey Conroy: Yes. We fully accept the need for clear communications with patients and all stakeholders. We have been working through, with the RCOG, the detailed processes, costs and timelines. Its finalisation is imminent. We have been engaging with the RCOG on the need for clear communications and for it to work on that. It includes a narrative that explains exactly what the review is, its scope, what it will involve, its timelines-----

Deputy Alan Kelly: Will it refer to Vicky Phelan and Stephen Teap?

Ms Tracey Conroy: Absolutely. We expect to be in a position to do that.

Deputy Alan Kelly: How is it that the two people who have inspired this most - who appeared before this committee and sat where Ms Conroy is sitting - came to believe that this would be completed by the end of May? How can Ms Conroy think that Departmental or HSE communications are working?

Ms Tracey Conroy: We are genuinely cognisant of the need for communications.

Deputy Alan Kelly: It is not working.

Ms Tracey Conroy: One thing is that we need to finalise the exact timelines with RCOG and then we can communicate that.

Deputy Alan Kelly: My other questions relates to admission of liability and protocol.

Chairman: Those are the Deputy's final questions.

Deputy Alan Kelly: I presume Mr. Connaghan will respond to the question on admission of liability and the protocol. I asked how he does not know about the protocol when I know about it? Why is it necessary? Is admission of liability standard for non-disclosure of informa-

tion in all cases of this nature. Those were my specific questions.

Mr. John Connaghan: I said that I would return to those.

Deputy Alan Kelly: No. As the chief executive of the HSE, Mr. Connaghan, when asked to come before the committee to discuss this matter, cannot say "I will get back to you". That is not acceptable to the public or to the women affected and their families. He is not doing his job if he cannot at least give basic answers to these questions.

Mr. John Connaghan: We should be able to get answers on the protocol to the Deputy today. If he will allow me a little time to do the research-----

Deputy Alan Kelly: What about the admission of liability?

Dr. Peter McKenna: The HSE has apologised to the patients who did not get the disclosure, and for the delay. It is a different thing to issue an apology and attach a monetary value to that.

Deputy Alan Kelly: I am not asking that; I am asking whether it is standard practice in order that people will know whether this is the case. A precedent has already been set. I presume that the answer is "Yes", but I just want clarification.

Chairman: It will be clarified before the day is out.

Mr. John Connaghan: We will clarify it before the day is out.

Deputy David Cullinane: We have our job to do. I understand that much of this information is changing constantly. There are court cases that are quite complex, with different nuances in individual cases. I accept that. Nevertheless, we are trying to establish the facts at any given time.

I return to the number of claims. *The Irish Times* reported a figure, which was accurate at that time, to the effect that there were 28 active cases, two potential cases and one that was settled, so a total of 31. When Mr. Connaghan helpfully provided clarification to the committee earlier, he said that he has since had an update and that there are now 35 active cases, two potential cases and three have been settled, which is 40 in total. Am I correct in assuming that the number of new cases is increasing quite rapidly with each passing week?

Mr. John Connaghan: It is increasing. I do not know how rapidly, but it is certainly going up.

Deputy David Cullinane: It has gone up by nine cases in this instance.

Mr. John Connaghan: Yes.

Deputy David Cullinane: Has the figure of for the women affected increased?

Mr. John Connaghan: I clarified that already. There were 209 plus another 12 cases, which is 221.

Deputy David Cullinane: Earlier, when I put the question of admission of liability, Mr. Connaghan said that he understood the moral thinking behind the question. That is fine but we are not here to discuss either his moral thinking or mine for that matter. We are here to discuss process failures which led to potential liability and what the cost might be to the State. I understand that he might not have the full details of each case. In the case of Emma Nic Mhathúna,

however, Mr. Connaghan clarified and accepted that there is liability on the part of the HSE and that an element of what happened was due, perhaps, to medical negligence - he does not have full details in that regard - and that another aspect involved her not being informed of the result of her smear test on foot of non-disclosure. A monetary value was attributed in respect of the latter in court. How many of the other 221 women were not informed of the results of their smear tests?

Mr. John Connaghan: I think that information has been given to the Committee of Public Accounts already.

Deputy David Cullinane: Will Mr. Connaghan give it to us again?

Mr. John Connaghan: The women involved in the 12 cases which came out of the most recent audit have all been informed.

Deputy David Cullinane: No, prior to this.

Mr. John Connaghan: It was 46.

Deputy David Cullinane: What Mr. Connaghan and Dr. McKenna have said in the course of this discussion is that a mistake was made in not informing the women concerned.

Mr. John Connaghan: Correct and we have apologised profusely for it.

Deputy David Cullinane: Dr. McKenna has stated the HSE is not in a position at this point to put a monetary value on it. However, in at least one of the court cases a monetary value was put on the individual not being informed of her smear test results. Logic dictates that, for all of the women among the 220 plus who were not informed, a monetary value will attach at some point. Forty cases have been or are before the courts. What about the women who are not before them? How will they be compensated?

Dr. Peter McKenna: I am unaware of the components that comprise the settlement. I am unaware of whether the failure to inform formed part of the monetary compensation. I do not know that for sure.

Deputy David Cullinane: I am sorry, but will Dr. McKenna say that again?

Dr. Peter McKenna: I do not know whether the failure to inform was assigned a monetary value in court.

Deputy David Cullinane: I find it extraordinary that no one in the Department or the HSE-----

Mr. Jim Breslin: No-----

Deputy David Cullinane: Mr. Breslin might be of assistance.

Mr. Jim Breslin: I can tell the committee what I know as of last week about the case in question. However, I do not want to go too far into just one case. My briefing by the State Claims Agency is that from the start it conceded liability for the non-disclosure of the clinical audit. To try in the particular circumstances of the case to reach a settlement as quickly as possible, the State Claims Agency and the laboratory agreed to reach an overall settlement with the plaintiff to allow the case to be closed.

Deputy David Cullinane: I understand it was an overall settlement. I do not want to go into the details of the figures for an individual-----

Mr. Jim Breslin: No, but, as of last week, the actual apportionment had not been negotiated between the two. The State Claims Agency will obviously be relying on the indemnity clause in respect of the laboratory's actions, but it will require some monetisation of the non-disclosure.

Deputy David Cullinane: Will a monetary value be put on the admission of liability for not informing the individual?

Mr. Jim Breslin: I think so.

Deputy David Cullinane: If the answer is "Yes," why would it not apply to the cases of all 220 women?

Mr. Jim Breslin: Dr. McKenna has also stated there may be features. We do not go into this level of detail of clinical and personal issues in individual cases, but there may be an issue above and beyond the non-disclosure in terms of clinical management, of which I was not aware. The Deputy is quite right, that there is a sequence, but we need to be careful not to get to the end before we work through all of the issues with the State Claims Agency. We have one case and it was last week. We have to stand back, consider and assess it and then come to conclusions. Doing it in the rapid way that might across the floor here could lead to us ending up in a place where none of us would want to be.

Deputy David Cullinane: I am sorry, but if-----

Mr. Jim Breslin: We want to see good recompense for all persons who have had harm done to them. We always want to see the laboratories, if there are issues for which they are responsible, paying out fully for same.

Deputy David Cullinane: I accept that. I have a further question on this matter and I will then finish. I have no difficulty in stepping back, evaluating and learning from the court judgment in this case, but the committee has to consider the potential cost of an accepted failure by the HSE. Can a note be given to the committee to help us understand it? My question is valid and obvious. If a monetary value is attached to non-disclosure in at least one case, it may also be attached in others. That is my point.

I have a question for Mr. Breslin-----

Mr. Jim Breslin: May I say something about that matter? The legitimacy of the Deputy's question is plain to me. The only risk is in doing it in real time. Being fully apprised of the matter, having a clear understanding of the liabilities and where they fall between the laboratory and the State - the State Claims Agency will be part of it - and then accounting to the committee is the right thing to do. However, if we do it in real time, we risk misstepping.

Chairman: We will ask the State Claims Agency to address this matter in advance of next week's meeting. As we are running out of time, I will ask our final two speakers, Deputies Catherine Murphy and Catherine Connolly, to put their questions one after the other and the witnesses to take them together in their final answers. There will be a further opportunity in the afternoon.

Deputy Catherine Murphy: It might not be that easy to do.

Chairman: Okay.

Deputy Catherine Murphy: I want to discuss the point I pursued with the witnesses previously regarding the slides. They separated two elements, telling us that the medical files were one matter, while the slides were another. I have examined the contracts with Quest Diagnostics and MedLab Pathology. They are similar, if not identical. Under the heading of "Storage and Disaster Recovery" on page 12, the contractor shall at the request of the national screening service forward eligible samples stored by the contractor or on the contractor's behalf to the national screening service or any third party specified by the service in a manner prescribed by it within three working days. It seems clear from this that the national screening service is in control and ownership of the slides. Why is there any question of a delay when the contract is clear about the contractors' obligations and the service's rights?

On radio in the past half hour, the solicitor for Vicky Phelan stated the HSE was holding up the protocol to agree to the release of slides and that, until this occurred, they could not be reviewed by clinical cytologists. Is the HSE holding it up and, if so, why?

Someone made reference to an apology, but an apology is hollow if it is not followed through with actions that will give it meaning. We are being given the runaround on some of our questions. The contract is clear, but we are not being given clear answers about the protocol. If it is being held up, any claim about dealing sincerely with people who may have been harmed by the State is hollow. Will the witnesses answer my question on the protocol?

Chairman: I will call Deputy Catherine Connolly afterwards.

Mr. John Connaghan: If there is a requirement to provide slides within a timely period, we should do so. I am not aware of the individual circumstances of the case outlined by the Deputy in terms of a hold-up. That should not be the case. I advised previously that, in respect of the 80 to 90 cases that may be in train, we would look at that issue immediately.

Deputy Catherine Murphy: Does the HSE talk to the laboratories? Does it tell them that it wants the slides to be made available within three days as per the terms of the contract?

Mr. John Connaghan: Does the Deputy mean provision of the original slides?

Deputy Catherine Murphy: Yes.

Mr. John Connaghan: If that is included in the contract and we are requesting the original slides, we expect to get them back.

Deputy Catherine Murphy: Has the HSE done that?

Mr. John Connaghan: It would have been done via CervicalCheck management asking for the provision of slides.

Deputy Catherine Murphy: Therefore, CervicalCheck is separate from the HSE. To whom am I speaking about responsibility today?

Mr. John Connaghan: No, CervicalCheck is a part of the HSE. What I am saying is that local managers would request the slides directly from the laboratories for provision for the patients.

Deputy Catherine Murphy: Have they done that?

Chairman: Will Dr. McKenna help? He is the acting clinical director.

Deputy Alan Kelly: Why was a separate legal firm hired to do this?

Dr. Peter McKenna: We will inquire immediately as to why there is a delay and why the legal team is perceived as holding up the process and try to expedite it.

Chairman: Will Dr. McKenna do his best to get an answer for us during the course of the meeting?

Dr. Peter McKenna: Yes.

Chairman: We expect Dr. McKenna to make some inquiries-----

Deputy Catherine Murphy: About the protocol.

Chairman: -----after the break.

Deputy Alan Kelly: He has already said he will revert to us. I have asked for it twice.

Chairman: During the course of the day. We will have time to revert to this matter. Deputy Catherine Connolly can make a final comment.

Deputy Catherine Connolly: I have a comment and a question. As a process, we dragged out the three memorandums that existed. Thanks to Ms Vicky Phelan and the other brave women who came forward, things are emerging. Now we are quoting a solicitor. It does not build confidence. When Mr. Connaghan was before us a few weeks ago, I made this point to him. It is not helpful. Moreover, Dr. Scally had to come forward publicly and state he was not getting co-operation and he was not getting the information. Bit by bit is the way this is proceeding.

My specific question is on the audit. I am trying to tease this out. Is the audit process now suspended?

Dr. Peter McKenna: Yes.

Deputy Catherine Connolly: It was the audit process retrospectively that discovered the mistakes.

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: If there is no audit process, there is no discovering of mistakes.

Dr. Peter McKenna: Not necessarily, no. In an individual clinical case, if an integral cancer develops, it would be appropriate for the clinician, or indeed, the patient, to request that these would be looked at. Then, if they have been misread, that should be communicated.

Deputy Catherine Connolly: We wait for the cancer to develop.

Dr. Peter McKenna: Pardon?

Deputy Catherine Connolly: Dr. McKenna waits for the cancer to be caught?

Dr. Peter McKenna: No, no, I am sorry.

Deputy Catherine Connolly: There is a misunderstanding here on my part. The cases that are increasing all of the time, which in number are now up at 221, have come to light as a result of the audit process.

Dr. Peter McKenna: That is correct.

Deputy Catherine Connolly: Okay. That audit process has now been suspended.

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: Why has it been suspended?

Dr. Peter McKenna: It has been suspended because the process of the audit has come in for a huge amount of criticism, in that at the start of the audit process it did not have built into it full disclosure to the patient. When the process started, it did not engage with the clinicians who were subsequently delegated to inform the patient that her previous slide had been re-categorised.

Deputy Catherine Connolly: We saw all that from the memorandums.

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: It was all outlined in the memorandums. It was more concerned about the communication process-----

Dr. Peter McKenna: Yes.

Deputy Catherine Connolly: -----and avoiding screaming headlines. Notwithstanding those difficulties, those memorandums are totally unacceptable. At the time, I asked Mr. Connaghan had he read them.

I will stick with the audit. Is it correct that the HSE is suspending an audit process that discovered problems because the protocol around who should talk to the patients has not been agreed?

Dr. Peter McKenna: Nobody's treatment is being delayed by stalling the audit process. The patients in whom the cancer has been diagnosed are getting their treatment in any event.

Deputy Catherine Connolly: As happened, smear test results might come back saying "All clear" but that was not the position. They were not all clear. There was cancer but the result of the smear test said it was clear.

Dr. Peter McKenna: But that would not be apparent until-----

Deputy Catherine Connolly: Until the audit was done.

Dr. Peter McKenna: No. There may be a misunderstanding here. Perhaps I have not made myself clear. The patient would be diagnosed with cancer clinically and then there would be a look-back and it would be seen that the smears could be re-categorised into a more severe level of abnormality. But the patient is diagnosed with cancer.

Deputy Catherine Connolly: On the cases that the audit was done.

Dr. Peter McKenna: Yes, correct.

Deputy Catherine Connolly: In looking back, it was discovered then that they were not informed in time.

Dr. Peter McKenna: In looking back, it was found that their smears should have been re-categorised and that is what they were not told about.

Deputy Catherine Connolly: That whole process has been suspended now, pending sorting all of this out.

Dr. Peter McKenna: Correct.

Deputy Catherine Connolly: I thank Dr. McKenna.

Chairman: At this stage, we will move on to the main item of business. I understand it might require some change of witnesses. It is 10.45 a.m. The intention is to proceed until the Dáil voting session. I propose we suspend for ten minutes because we cannot go from 9 a.m. to 1 p.m. without some break. Is that agreed? Agreed.

The witnesses withdrew.

Sitting suspended at 10.44 a.m. and resumed at 11.03 a.m.

2017 Financial Statements of the HSE

2016 Annual Report of the Comptroller and Auditor General and Appropriation Accounts

Vote 38 - Department of Health

Mr. John Connaghan (*Director General, Health Service Executive*) and **Mr. Jim Breslin** (*Secretary General, Department of Health*) called and examined.

Chairman: We are now going to consider the 2016 Appropriation Accounts for the Department of Health, Vote 38, and the HSE's Financial Statements for 2017. From the Department of Health we are joined by Mr. Jim Breslin, Secretary General, Mr. Colin Desmond, Ms Fiona Prendergast, Ms Aonraid Dunne, Ms Pamela Carter and Mr. Kieran Harrington. From the HSE we are joined by Mr. John Connaghan, director general, Mr. Stephen Mulvany, chief financial officer, Mr. Liam Woods and Ms Mairéad Dolan. From the Department of Public Expenditure and Reform, we are joined by Mr. Peter Brazel, Mr. Kieran Dollard and Mr. Terry Jennings. They are all very welcome to today's meeting.

I remind all present in the room that all mobile phones must be put onto aeroplane mode as merely putting them on silent mode can interfere with the recording system.

I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence on a particular matter and continue to so do,

they are entitled thereafter only to a qualified privilege in respect of the evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or persons or entity, by name or in such a way as to make him, her or it identifiable.

Members are reminded of the provisions within Standing Orders that the committee shall also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions put by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and consideration at all times, in accordance with the witness protocol.

We will start by hearing the opening statement of the Comptroller and Auditor General.

Mr. Seamus McCarthy: The HSE incurred expenditure totalling €15.2 billion in 2017, representing an increase of around €727 million, or 5% up on 2016. As shown in Figure 1, on members' screens, HSE direct expenditure on pay and pensions accounted for over one third of the expenditure, totalling €5.36 billion. This included around €300 million paid for agency staff services. Grants to section 38 and section 39 agencies accounted for just over a quarter of the expenditure and totalled €4 billion. Expenditure on primary care and medical card schemes, including drugs refund schemes, accounted for a fifth of the expenditure, or just under €3 billion.

The HSE recorded income for the year totalling €15.1 billion. The bulk of this - 94% - came in the form of a revenue grant paid to the HSE out of the Vote for the Department of Health. The balance of the income comprises charges to patients using HSE services, and a range of miscellaneous sources, including employee pension contributions paid by HSE staff and the proceeds of pension-related deductions in the health sector, which the HSE retains.

Notwithstanding the increase in income in 2017, the HSE's outturn for the year was a net operating deficit of €140 million - a significant deterioration year on year. The 2016 deficit was €10 million. The operating deficit in a year represents an effective first call on the following year's recurrent grant funding provided from the Vote.

The HSE financial statements also include a capital income and expenditure account. For 2017, this recorded income of €462 million, mainly comprising capital grants from the Vote. Expenditure in the year totalled €454 million, resulting in a net capital surplus of €8 million, which the HSE carried forward to 2018. A capital surplus of €15 million was brought forward from 2016 into 2017 but the HSE had not obtained formal ministerial sanction to do so**,** as is required under the Health Service Executive (Financial Matters) Act 2014.

The audit report on the HSE's 2017 financial statement drew attention to a continued significant level of non-competitive procurement by the HSE. We found a lack of evidence of competitive procurement in regard to 36% of a sample of €51 million worth of goods and services procured in 2017, spread across five HSE locations. This is consistent with our findings in similar testing for many years past. The HSE's statement on internal financial control outlines the steps it is taking to deal with this problem but states that it will take a number of years to fully address procurement compliance issues.

The audit report also drew attention to inadequate monitoring and oversight of HSE grants to outside agencies, which is a continuing concern.

Members will recall last October examining chapter 19 of the Report on the Accounts of the Public Services 2016, which reviewed the HSE's framework for monitoring grants to service providers in the context of the audit of the 2016 financial statements of the HSE. Our work for the 2017 audit, and that of the HSE's own internal audit, found that similar weaknesses recurred in 2017. The HSE acknowledges the audit findings in the 2017 statement on internal control.

The appropriation account for Vote 38 - Health - before the committee relates to 2016. As a result, the financial periods of the two sets of financial statements on today's agenda are out of step. However, the substance of the relationship between them is the same during both years.

The majority of the Department's expenditure comprises recurrent and capital grant funding paid to the HSE. This is accounted for across 17 subheads of the Vote, reflecting the historic basis for allocation of resources, rather than the programme-based type of presentation used in other Votes. This is accounted for across 17 subheads of the Vote, reflecting the historic basis for allocation of resources rather than the programme-based type of presentation used in other Votes.

Non-HSE related expenditure under the Vote for health includes grants paid to a range of research, development and advisory bodies; payments in respect of hepatitis C compensation and other legal claims against the Department; and the Department's own administration costs.

Mr. Jim Breslin: As Accounting Officer for the Department of Health's Vote 38, I am pleased to be here today to deal with the 2016 annual report and appropriations accounts of the Comptroller and Auditor General. The other item on today's agenda, the HSE financial statements 2017, will be addressed in the first instance by Mr. Connaghan, as the accountable person for those accounts.

Since 2015, under the provisions of the Health Service Executive (Financial Matters) Act 2014, funding of the HSE is provided from the Vote of the Minister for Health - Vote 38. Accordingly, in 2016 the Department was responsible for a budget of €13.649 billion for the salaries and expenses of the office of the Minister and certain other services administered by that office, including grants to the HSE and to research, consultative and advisory bodies. The budget includes the additional €500 million provided by Government in 2016 to the health Vote, by way of mid-year adjustment, to improve the base funding of the Department of Health. This succeeded in 2016 with the health Vote coming in under budget by €2.221 million without recourse to a Supplementary Estimate.

I will now set out the main points of the 2016 accounts as they pertain to Vote 38. Funding is allocated to the Department of Health in respect of its own costs and in respect of grants to a number of bodies under the aegis of the Department such as the HSE, the Mental Health Commission, the Food Safety Authority of Ireland, the HIQA and a range of other bodies. In 2016, the Department had 400 staff. The Department's role is to provide strategic leadership for the health service and to ensure Government policies are translated into actions and implemented effectively. We support the Minister and Ministers of State in their implementation of Government policy and in discharging their governmental, parliamentary and departmental duties.

Much of the public debate tends to be on weaknesses in our health services. Identifying measures to address these in association with our colleagues in the HSE undoubtedly demands continuing work on the part of the staff of the Department. However, we also have other roles. Importantly, we seek to frame policies and legislation to promote health. Under the Healthy Ireland umbrella, we work cross-sectorally to achieve this objective. Our life expectancy, at

81.8 years, is now one year above the OECD average but there is much more that can be done to better promote health and prevent ill-health. We also work internationally with EU colleagues and the World Health Organization on health issues. Considerable work is under way with the EU and the United Kingdom to address the health challenges caused by Brexit and to ensure that North-South and east-west co-operation on health matters is maintained. We also support the Minister and Ministers of State in their work including their legislative priorities and their public and parliamentary accountability. For example, in 2017 the Department processed over 11,000 parliamentary questions, representing 22% of all parliamentary questions tabled to Ministers across Government.

The 2016 gross provision, current and capital, for Vote 38 was €14.109 billion. The 2016 outturn was almost €14.107 billion, leaving an overall saving of €2 million. Of the 2016 gross provision for current expenditure, €205 million was provided to the Department-related subheads in respect of its own costs and in respect of grants to agencies under the aegis of the Department, other than the HSE. The 2016 outturn for these subheads was €176 million, giving an underspend of €29 million, and €13.387 billion of the 2016 gross provision for current expenditure was provided to HSE related subheads. The 2016 outturn for these subheads was €13.405 billion giving an overspend of €18 million. The overspend primarily related to funding the existing level of service in both acute and community services and pension costs. This overspend was met from savings elsewhere in the Vote. The 2016 provision for capital expenditure was €516 million and the 2016 outturn was €525 million. However, funding was transferred by means of virement to the capital subheads from savings elsewhere in the Vote to provide for capital developments at mental health facilities. The 2016 appropriations-in-aid to the health Vote was on profile at €460 million. The end year net outturn for current and capital was €13.647 billion against a net provision of €13.649 billion, resulting in a saving to the Exchequer of €2 million.

The Department continues to develop its policy and performance oversight in respect of a range of complex services falling within total public health expenditure. We are working on a significant reform agenda in line with the report of the Oireachtas Committee on the Future of Healthcare. This includes, as an initial important step, legislative proposals approved by Government to improve governance within the HSE through the introduction of a competency-based governing board this year. Subsequent policy development is likely to see a strong national centre but with greater devolution of decision-making and accountability, including financial accountability, to regional integrated care organisations. The further development and linkage of corporate and clinical governance at all levels within the health service, again in line with the Sláintecare report, will be a priority in ensuring the delivery of effective, safe and accountable health services.

I look forward to continuing to work with the committee and with the Oireachtas generally on this objective and am happy to take any questions.

Mr. John Connaghan: I will introduce the senior management members with me today. They are Mr. Stephen Mulvany, Mr. Liam Woods and Ms Mairéad Dolan. We have submitted information and documentation to the committee in advance of the meeting and I will therefore confine my opening remarks to a number of issues, the first of which is the financial outturn for 2017. A Revised Estimate for health was approved and notified by letter of determination of 29 December 2017. The HSE received once-off revenue funding of €208.3 million to cover winter initiatives, State Claims Agency increased costs, the shortfall of acute hospital private patient income and central pay awards. The HSE's annual financial statements for 2017 record

a combined revenue and capital deficit of €131.5 million. Within this there is a capital surplus of €8.3 million and a revenue deficit of €139.9 million. The total 2017 revenue deficit when deficits in section 38-funded providers are taken account of is €165.9 million.

The most significant area of deficit in 2017 relates to the acute hospital division which was €139.7 million. The majority of this deficit - €73 million - is attributable to income shortfalls and associated bad debt costs primarily related to hospital private maintenance charges. In addition, there are cost overruns of 0.4% equivalent to €13.4 million on pay and €54 million or 3% related to non-pay of which the majority - €44 million - relate to clinical non-pay. A significant driver of these cost overruns is the provision of additional activity in response to service demand, the complexity of that activity and the growing age and related needs of hospital inpatients. As evidenced within the health service capacity review 2018, Ireland reported the second highest occupancy rate of those countries reporting to the OECD. This indicates a hospital system that is operating under considerable stress and which is short of the necessary capacity.

Social care services reported a deficit of €24.5 million. A significant element of the deficit in this area relates to the costs of providing residential care to people with an intellectual disability, including the provision of emergency placements which continue to be a significant pressure in 2018. Individual placements can cost up to €0.5 million. The costs of compliance with HIQA residential standards in the intellectual disability sector has also been a contributory factor in the deficit.

To put the HSE's financial performance in context, if we look back over the ten years from 2008 to 2017, there has been 0.68% or €838 million in net Supplementary Estimates provided to the HSE in respect of areas directly related to service pressures and financial performance challenges. The balance of supplementary funding over this period has been in respect of Exchequer-related or technical items outside of the HSE's control. That is equivalent to 1.56% or €1.9 billion. It includes the PCRS at €0.791 million or 0.64%, whose costs are largely driven by policy, legislation and related demographic and societal factors not amenable to normal financial management.

I will turn now to matters of exception reported on by the Comptroller and Auditor General in respect of 2017. In the Comptroller and Auditor General's audit certificate which accompanies the annual financial statement the Comptroller and Auditor General has drawn attention to concerns about the monitoring and oversight arrangements for grants to outside agencies, non-competitive procurement issues and also noted that the HSE had not received sanction from the Minister for Health for the capital surplus brought forward from 2016. The HSE acknowledges these matters of concern and is progressing medium to long-term plans required to bring about improvements as follows.

I shall turn first to the issue of non-compliant procurement. The HSE incurs procurable expenditure in excess of €2.2 billion annually. Given the scale and complexity of the HSE's overall procurement activity, it has been highlighted and acknowledged at previous meetings of the Committee of Public Accounts and by my predecessor that it will take a sustained effort over a number of years to ensure high levels of compliance. This is a key focus for the HSE. The HSE, through its health business services, HBS, procurement function, continues to progress a transformational programme of reform of its procurement arrangements to improve compliance with public procurement regulations, increase the usage of contracts, put frameworks in place by it and liaise with the Office of Government Procurement. The HBS procurement function works closely with the Office of Government Procurement. There have been a number of successful tender outcomes, particularly in the utilities category such as electricity, fuel oil, gas,

telecommunications and vehicles. We also know that there is a considerable amount of work ahead in cleaning, security and professional services. This collaborative effort is achieving value for money and contributing to an increase in overall procurement compliance and the development of the overall procurement reform programme.

The HSE is implementing a number of initiatives which are organised around three key themes: supporting infrastructure; sourcing and compliance. Further detail of the steps being taken to address the issue of non-compliant procurement are published in the statement of internal control within the 2017 annual financial statements.

On the monitoring and oversight of grants to outside agencies, the HSE has consistently acknowledged the positive role the voluntary sector plays in the development and delivery of health and personal social services. The HSE is also acutely aware of the need for the appropriate level of oversight of the grants provided for outside agencies. In 2017 just under €4.1 billion of the HSE's total expenditure was related to grants to more than 2,000 outside agencies. The agencies range from the large voluntary hospitals and disability organisations to small local community-based agencies.

The HSE's governance framework is consistent with the management and accountability requirements for grants provided from Exchequer funding as set out in the Department of Public Expenditure and Reform's Circular 13/2014. Weaknesses in the monitoring and oversight of grants to outside agencies have previously been identified. The HSE continues to take the necessary actions to address these weaknesses. The national compliance unit which was established in 2014 supports the development of improved grant oversight by community healthcare organisations, CHOs, and hospital groups which have delegated responsibility for the management of the relationship with outside agencies at operational level.

Improved oversight has raised the level of compliance by grant funded agencies. An example of the actions already taken is the external review of governance arrangements for section 38 providers which is under way. The purpose of these reviews is to confirm that appropriate governance arrangements are in place and aligned with those set out in the annual compliance statements provided by section 38 agencies for the HSE. The main compliance issues identified in the review process relate to procurement, HR legacy issues and a need, in some instances, to establish an appropriate internal audit function. It is expected that the external reviews commissioned will be completed by October. Agencies will provide status reports on the progress made in addressing issues and such issues will be included in local operational oversight. The HSE is committed to implementing a five year rolling programme that will prioritise section 38 agencies not reviewed in the current programme. It will be extended to include the larger section 39 agencies. Further details of the steps being taken to address the issue of weaknesses are published in the statement of internal control within the 2017 annual financial statements.

It would be remiss of me not to look ahead and consider the role of healthcare transformation and how we employ the HSE's assets and resources. As is the case in many developed health systems, we face the challenge of growing user expectations, unmet need and core infrastructural deficits. For many years we have been aware of the need for a shift in health service delivery in order to move from the more traditional focus of treatment and cure to that of prevention and treatment, when required. The current arrangements for service delivery in Ireland are characterised by an over-reliance on more costly, hospital-based care, with continuing opportunities to deliver care more appropriately in primary and community settings. There are challenges in responding effectively to the planned, unplanned and emergency needs of patients in hospitals.

Similar pressures are faced by services in primary and community services, including services for people with disabilities and people who need mental health support, with demand outstripping supply in many areas. In addition, there is a growing need to maintain or replace our current infrastructure and equipment. I am pleased to note that I am a personal supporter of the Sláintecare report which signals a new direction of travel in relation to eligibility, delivery and the funding of health and social care in Ireland into the future. We are implementing a range of programmes to prepare the ground for longer term transformation in line with Sláintecare. There are tens of thousands of dedicated staff working in health services, changing practices, improving care for patients, advocating for and driving service improvements day in and day out. Staff and management working locally are providing leadership and support for nationally supported initiatives, with the aim of reforming services and seeking to deliver higher value care. A number of transformational programmes are continuing in 2018, with a particular focus on four key themes, the first of which is improving population health and well-being by keeping people well and reducing the incidence of ill health and supporting people to live as independently as possible. The second theme is delivering care closer to home, with the intent of meeting the vast majority of the population's healthcare needs in more local settings, with institutional and hospital-based care being reserved for only those individuals who require complex, specialised, emergency care and even then only for the shortest time possible. The third theme is the development of specialist hospital care networks by progressing numerous workstreams in our national clinical and integrated care programmes. The fourth theme is the improvement of quality, safety and value by building support for effective care that is delivered according to best evidence of what is clinically effective in improving health outcomes by reducing variations in how care is delivered and developing skills and capacity for quality improvement in healthcare delivery settings. In addition, we are developing structures and reconfiguring teams within the HSE to strengthen our approach to population need assessment, demographic analysis and the utilisation of service design in order to develop more equitable and effective resource allocation models, particularly for primary and community services. This goes hand in hand with Mr. Breslin's statement on geo-alignments and local devolved responsibility.

Ireland's public health service was designed for a time when we had a different demographic profile. Today the expectations surrounding clinical governance and standards have never been higher. The population, however, is older. Modelling forecasts tell us that the number of people aged over 65 years will increase by nearly 110,000 in the next five years. The fact that people are living longer is great news, but a large proportion of this older age group now live with two or more chronic conditions which make many of them more vulnerable and frail. This has a consequential impact on resources. In that context, the imminent publication of the Department of Health's Sláintecare implementation plan provides a powerful opportunity to create much needed strategic certainty for the health and social care delivery system in Ireland. We are committed to working with the Government and the Department to do this and implement the Sláintecare plan.

Chairman: We shall start the question and answer session with Deputy David Cullinane who has 20 minutes. He will be followed by Deputies Catherine Murphy, Jonathan O'Brien, Bobby Aylward and Alan Kelly in that sequence who will have ten minutes each. Members will have a second opportunity to come back in as the meeting progresses.

Deputy David Cullinane: I welcome all of the witnesses. Members will need the two slots as there are a lot of issues to be raised. I have, at least, six that I want to raise and will certainly not get to raise all of them in the first round of questions. Most of my queries relate to national, but there are two regional issues. Mr. Connaghan is aware that all politics is local. While there

are two issues that are important to me, they have wider implications for the State. The problems we have in the south east also seem to manifest elsewhere. I will, therefore, offer them up as examples more than anything else.

I shall start with the deficit. In his opening statement the Comptroller and Auditor General said the deficit was €140 million. Mr. Connaghan has said total the revenue deficit was €165 million, but that it includes funding to section 38 organisations. Is that correct? Is it the case that the overall deficit is €165.9 million?

Mr. John Connaghan: Yes. The annual financial statements show the HSE's overall deficit. It shows what we paid out to voluntary organisations. When we include the section 38 agencies and the deficit they are running we arrive at that figure of the €166 million. We wanted to give a more representative figure. Even though that extra bit is outside of our own annual financial statements, it is part of the overall health system.

Deputy David Cullinane: Does the Comptroller and Auditor General agree with that? It is €165.9 million when we include the deficit for section 38 agencies.

Mr. Seamus McCarthy: I can only give an opinion in respect of the figures that are on the HSE's financial statements. That is an estimate that they have prepared. I have no reason to dispute it.

Deputy David Cullinane: Okay. Whereas in the past we would have had supplementary budgets if there was an overspend in health, we are led to believe they are gone, or at least in practice they should be gone. I am trying to understand why there is a deficit, if Mr. Connaghan could help me with that first of all. Is it because the HSE has increased capacity or is it because the costs of doing healthcare - the demand from the public - have increased? Is it because the HSE is simply standing still while it costs more to provide the level of service that was provided in 2016? Is the deficit there because the HSE is spending more to increase capacity? Is it both?

Mr. John Connaghan: I will start off with a couple of comments on that and then ask Mr. Mulvany and Mr. Woods to add some colour to the question. It might be better if I start with the position over the last six months to a year. Let us understand the impacts of what we have seen over the last winter, going back to the last part of 2017. We know we had the worst flu season for ten years. The health service coped adequately with that but it did drive additional costs in terms of isolation, intensive care unit, ICU, costs and extended lengths of stay and intensity. That is one factor. We also had some of the worst trolley figures ever over the course of the last six months, although taken year on year, as Mr. Woods stated to the health committee yesterday, we are roughly the same. That period drove some really quite exceptional costs. I had to make some decisions during that time in the interests of patient safety in terms of sourcing additional capacity, authorising things like weekend and overtime work just to ensure we could get people out of hospitals appropriately. There were some decisions made around some of the winter pressures we had. With that in mind and as an introduction to the kind of pressures that the health service faces, I will turn to Mr. Woods to add some colour to that in respect of 2017.

Mr. Liam Woods: In terms of the question about the key drivers in the hospital system of pressure on budget and cost overruns, in 2017, as was referenced in the director general's opening statement, there were two big factors, namely, the position relating to income and the charging and collection of statutory maintenance charges for people who opt to be treated privately. The behaviour of insurers around that gave rise to a probable €73 million of the total, which was €139.7 million. On the service delivery side, the biggest driver last year both in terms of

growth year on year and against budget was the non-pay clinical costs of treating patients. That was a €44 million figure within a total service deficit of €67 million. Driving those costs are two factors, namely, the volume of care provided, which is increasing, and the complexity of care. They underlie what is going on in the hospital system operationally.

The other factor the director general mentioned is that there was a €13 million challenge against the pay budget. That is against a pay base of over €3 billion. There are a couple of factors driving pay. One is that it would include agency and locum costs, so the specialing within the hospital system of cases that have high-intensity need around the clock is a factor. That is growing as an element of cost. Clearly, effective movement to community of people who are fit for discharge is an important piece in managing that. That is a driver. The other is to control the total numbers of those employed within the health environment.

Deputy David Cullinane: I thank Mr. Woods and Mr. Connaghan. That gives me answers as to why there was a deficit. Essentially, Mr. Woods is saying the two main drivers in terms of acute hospital spend were that the volume of care has increased as has the complexity, which I imagine is things like unexpected flu outbreaks and so on, resulting in greater isolation and containment needs.

Mr. Connaghan also mentioned the trolley figures. I imagine they reflect increased demand with more people looking for beds when there are not enough beds. We know that. The more demand and pressure on hospitals, the more spend there will be. However, why is that not forecast? Why was it not built in to the estimation of the spend? Were the circumstances really exceptional? Were they outliers or were they potentially foreseen? Did we just not allocate enough money in last year's voted expenditure to health to cover what should have been the amount given to make sure we were in a position to properly treat patients?

Mr. John Connaghan: To give a direct answer to a very direct question as to whether the activity was expected, in terms of emergency department, ED, attendances over the period, I am talking about those who were over 75 years old because when we look at the cost we tend to think there is more cost associated with the elderly than with those who are perhaps in their 30s. Over the time period, ED attendances of people aged 75 years and older were up 6.7% and ED admissions over that period were up by 6.4% for the over 75s. ED attendances across the whole population were up 4.8% so there is considerable pressure that I do not think was anticipated at the start of the year. The other factor, which is important in relation to those who are over 75, is that it is quite clear - and this is very welcome - that with the population living longer, there are more patients presenting with more complex needs inside our hospital system. There are some marvellous studies available about the level of comorbidity or multiple chronic conditions currently in the population. I think I said in my opening statement that this is a factor, so the complexity of care is also increasing.

Deputy David Cullinane: I want to come now to agency staff, which Mr. Woods mentioned as being one of the issues. According to figures I have from parliamentary questions submitted by one of my colleagues, agency spend by all of our acute hospitals has doubled since 2011, going from €158 million to €293 million. We seem to have a greater dependency on agency staff. Mr. Woods may be in a position to answer my question as to whether we are getting good value for money. Is this the best way to deliver healthcare, having such dependence on agency staff? Why has expenditure gone from €158 million to €293 million since 2011?

Mr. Liam Woods: They may be whole system numbers, not just acute services. However, in terms of the core of the Deputy's question, our overall approach is to seek to reduce agency

staff figures and in 2017 in the acute system there were reductions. The three main components of agency costs in the acute system are medical, nursing and healthcare assistants.

Deputy David Cullinane: Does it cost more? Do the witnesses have the figures in overall terms or per whole-time equivalent post? How much more in percentage terms does it cost either in acute settings or outside of them to hire an agency worker over the course of a year?

Mr. Liam Woods: It does and we do. It does cost more.

Deputy David Cullinane: What is that figure on a yearly basis, on average?

Mr. Liam Woods: It varies but, on average, we would be looking at maybe up to 20% of an increase on the basic labour costs.

Deputy David Cullinane: In that case, if the HSE was hiring more staff directly it could save 20%.

Mr. Liam Woods: Up to that. To explain what we were doing in 2017, the year of account, we did reduce the medical agency staff spend by €7.5 million and hospitals reduced their nursing agency staff spend by about €7 million as well. There was some success but, returning to the Deputy's core point, there is a requirement for us and we continue to pursue converting.

Deputy David Cullinane: Mr. Woods said he would be aware of the potential savings if we were to use staff who were directly employed rather than agency staff, an average of 20%. Where does that figure come from?

Mr. Liam Woods: Where does the analysis-----

Deputy David Cullinane: Yes.

Mr. Liam Woods: -----that gives rise to the 20% come from? It is based on comparison of the cost of direct employment versus-----

Deputy David Cullinane: Who does that? That is my point. Can that be supplied to the committee? Have reports for either the director general or Mr. Woods been done on this-----

Mr. Liam Woods: We could provide information on the cost variation by staff type. It varies by staff type.

Deputy David Cullinane: Can that be provided to us?

Mr. Liam Woods: Of course.

Chairman: We will make a note of that.

Mr. Stephen Mulvany: If I may be helpful, we have recently done an agency contract. For example, in medical agency the cost has gone down by 10%, but there is no doubt that there is a premium cost attached to agency. As Mr. Woods said, about 6% of our total pay cost is agency, so about 94% of it is not but is our own staff. Agency is essential at times, but there are parts of the country where the cost premium - Mr. Woods talked about the average - can be higher, particularly in respect of medical agency. The issue is the market and the availability. To be very clear for Deputies, our aim is to reduce as much as possible the cost of agency. Not only are there cost issues associated with it, there is also not as much continuity of care. We sometimes end up with agency costs because there is a demand to open or maintain capacity at short notice.

Deputy David Cullinane: I understand that and I look forward to getting the data share. My final point on this is that notwithstanding that, it strikes me as odd that agencies can provide staff for many of these services but we cannot recruit those staff into the public sector. If there is a premium and an increased cost, how is it that agencies can recruit these staff yet hospitals or non-acute settings cannot? I ask that this be addressed in the context of whatever briefing paper is given to us as well.

On a related matter, I wish to come to one of the regional issues. I gave prior notice to Mr. Connaghan that I would raise this issue. A briefing note on child and adolescent mental health services, CAMHS, was given to Oireachtas Members in the south east. Waterford and Wexford form one catchment area for CAMHS. We had five child psychiatrist positions at University Hospital Waterford last year. One of the psychiatrists retired and three resigned citing workload, poor infrastructure and not being listened to. They resigned out of frustration and annoyance at not getting answers to questions they were putting. The briefing note I have been given by the Department states that with effect from Friday, 6 July, there will only be one consultant paediatric psychiatrist employed in the Waterford area and that person will be on annual leave from 9 July 2018, which was pre-booked in April. In other words, we will have no child psychiatrist at all in Waterford - none. The only service being supplied at the moment is an agency consultant coming from Galway to do a clinic at weekends. The actual child psychiatrist provision and the resultant care they would give to people is almost non-existent.

How did it get to the sorry state that we are left with one child psychiatrist in one hospital? This is an issue throughout the State. The briefing note also states there is difficulty in recruiting child psychiatrists. How did we end up in a situation whereby three psychiatrists resigned, with the reasons they have given, not on Mr. Connaghan's watch but certainly on the HSE's watch, and whereby for a period there will be no cover whatsoever in one of our major acute hospitals? How did this happen?

Mr. John Connaghan: I will start nationally and then go more local in terms of where we are. Nationally, we have 2,900 consultants of all types in the Irish health service. We have more than 300 current vacancies across that complement. Regarding the questions the Deputy has raised about excess costs around locums, in many ways one can see the relationship there in terms of what we need to do to try to fill service slots to keep services running with expensive agency, locum and overtime rates. When the Deputy gets the analysis, I hope he recognises that.

Regarding the position in the south east, I will start with budgets. The south-east community health care mental health budget was increased from €83.5 million in 2012 to €99.4 million-----

Deputy David Cullinane: I will have to stop Mr. Connaghan there. To be fair, I am not interested in overall figures, and that is not the question I asked.

Mr. John Connaghan: Let me try to answer the question.

Deputy David Cullinane: I ask Mr. Connaghan to bear with me for one second. I do not want to be rude in any way. My questions were very specific. Notwithstanding whatever money was allocated, we now do not have the staff. Money might have been allocated, but three psychiatrists have left. They have walked out on his organisation. They have left. They are gone. They have said they have had enough. They have been raising issues for years. They have not been listened to, so they are gone. Now children in Waterford and Wexford and elsewhere are being left without cover. I will read out to Mr. Connaghan from one of the newspa-

pers one quote from one of the children involved. She said:

> Just giving people medication and telling someone 'we'll see you in two weeks' isn't enough ... And what was given to me first wasn't even right for me as things turned out. They definitely need to do [an awful] lot more.

This issue was echoed by the three consultants who resigned. Why did they resign? Why did it take their resignations for the HSE to listen to their concerns? Does Mr. Connaghan accept that it is unacceptable that this has left children in Waterford and the south east with mental health issues with no cover or very little cover?

Mr. John Connaghan: I accept that any service with no cover is unacceptable, but perhaps what the Deputy wants to hear from me is what we are doing about it and what the action plan is, so I will give him a couple of bullet points on that. What I am going to give him here is not new because we have been aware that there have been issues since at least October 2017 and I think much earlier in terms of the provision of the service. First, we have a national and international search and recruitment under way to fill these posts. Tomorrow will be an important date for that because we have a teleconference with a number of interested candidates from the UK. This is new news. We think we might be able to get at least two of those to come on board very quickly.

Deputy David Cullinane: That is great, but I ask Mr. Connaghan to bear with me for a second. What is extraordinary about his response is that while every effort is being made by the HSE to get replacements, which is fine, and I have a briefing note in which all that is covered, it should not have come to this. We had three psychiatrists providing a service and they walked out, and what we are hearing is that more will do exactly the same in other parts of the country. This is leaving CAMHS in crisis. Mr. Connaghan said himself that the HSE was aware of these issues going back to 2017 and before that. I am asking Mr. Connaghan, as director general, why were these people not listened to then? Why was corrective action not taken? Now the HSE is left scrambling to look internationally, doing conference calls and all the other work to fill the posts whereas the HSE had people in posts and they felt it was so bad that they walked away. In fact, I heard one of them on national radio in a very distressed state, almost feeling guilty that he walked away from his post, but felt he had no choice because people in power, people with responsibility for delivering services, were not listening to him. How does Mr. Connaghan respond to him and to the patients who are now being left without a service? Whatever is being done now is great, and the HSE has to do its job to fill those posts, but Mr. Connaghan has to account for why those people left in the first place and why, as we sit here, patients in Waterford and elsewhere, young people, are not getting the services they should get.

Mr. Liam Woods: The Deputy needs to be aware of the reasons for that. We are in the process of conducting, or have conducted, exit interviews with each of those consultants to find out the issues. Clearly, we cannot recruit new people into a service if we have not listened to the concerns of those who have been in post in the past. If it is an issue of minor capital, we will address that. If it is an issue of major capital, clearly, we cannot turn that on overnight. I would expect that the first port of call would be that local discussion on the issues that require improvement and need to be put in place swiftly.

Deputy David Cullinane: I will come back to this in my second round because I want to be fair to the other-----

Chairman: We are on time.

Deputy David Cullinane: I will ask one last question and then come back in the second round on some of those issues. I accept Mr. Connaghan is new to the post. I must say he is very forthright and very upfront in answering questions, and I commend him on that. I gave him prior notice that I would raise this issue because it is very important and will have wider national implications. I spoke to one of those psychiatrists myself, and he said many of his colleagues across the State feel exactly the same and could make the same decision. It will be a very serious situation.

My final question relates to section 38 agencies and organisations. The Comptroller and Auditor General has done some work on this issue and we have had to deal with a number which have come before the Committee of Public Accounts where there were serious issues and breaches in governance arrangements, how money was spent and so on. Mr. Connaghan said in his opening statement that €4.1 billion of the total expenditure is spent by these agencies, which in itself is incredible. We seem to have an increased dependency on section 38 organisations, which is possibly part of the problem. In some respects, we are over-reliant on them and we cannot pull back when there are problems because there is no one there to pick it up. The HSE itself cannot pick up the slack if corrective action is taken.

Mr. Connaghan said in his opening statement that the purpose of these reviews is to confirm that appropriate governance arrangements are in place. I would argue that the weaknesses in governance are not the problem. They are part of the problem. Enforcement is a problem. If these organisations do not see any sanction, there will be more and more of this. How many of them have come before the Committee of Public Accounts? We have not even heard from some. One is the hospice in Harold's Cross. There is a report on that which we have not got to yet, though we will. Is Mr. Connaghan satisfied that the sanctions are robust enough to make sure that we do not have recurring issues with governance failures and misspending of money by these section 38 organisations? The Comptroller and Auditor General has reported on this. Is he satisfied that we have seen improvements in compliance and governance generally across this system? Are we in a better place now than when we, as the Committee of Public Accounts, first examined this issue? I will leave it at that until I get the response.

Mr. John Connaghan: For the record, there is a €3 billion spend on section 38 organisations, with roughly €2 billion for the acute sector and €1 billion for the non-acute sector. The acute sector includes voluntary hospitals etc. I am assured that we have a comprehensive control and oversight mechanism in place. It looks very different from what I understand was in place a couple of years ago. We have a service arrangement in detail and an annual agreement with penalties for late completion in place for section 38 and larger section 39 bodies. We have grant aid agreements for section 39 organisations. Against that background, we have an annual compliance statement which covers things like governance, risk, pay policy, tax and procurement which comes from each of these organisations. Annual financial statements for the larger organisations are audited and approved. We monitor that through an annual financial monitoring return. The process that is in place is fine.

The Deputy will ask me how effective it is. One might have the greatest process in the world and if it delivers something, it is fine. All of that is good on paper. We then come to what we have put in place over the course of the past year, as I understand it. I can only go back to my knowledge from the past six months to a year. We have fully established a compliance unit at national level and we are in the process of rolling out the work of that compliance unit to more local situations so that each locality has the capability to have oversight and compliance locally. That also covers the external review for the section 38 bodies, which is under way at

Deloitte. There are 40 reviews. Some 31 have been finalised and recommendations will be put back to the organisations. We are tracking these through. Lastly, we have internal audit. I have recently taken the decision to extend the internal audit capability for the HSE such that, when we come to 2019, there will be greater capability. For me, we have enough processes on paper. We need to make that work as we proceed into 2019.

Mr. Seamus McCarthy: I agree with the chief executive's presentation with regard to the matter. The systems are improving. The great value of having systems and the kinds of reviews that he is talking about is that there is a systematic focus on all of the issues rather than one issue becoming a popular issue that everybody is focused on, then it moves on and things fall back into process. The governing organisations within section 38 and 39 bodies will be forced by the systems that have been put in place to address this and to provide assurance on a routine basis. The one area where it is very important that the HSE keeps a focus is on its own internal review escalation and dealing with the issues as they come out of the reporting process.

Chairman: We are into ten minute slots but people will no doubt have second opportunities.

Deputy Catherine Murphy: I have a small question to begin with so that I do not forget about it. Mr. Breslin said that in 2017, the Department processed more than 11,000 parliamentary questions, 22% of all parliamentary questions for Ministers across Government. I know from my experience that practically everything I table in parliamentary questions to the Department of Health receives a one line reply, referring it to the HSE. I am not asking Mr. Breslin to do it now, but will he give us a breakdown of that 22%, indicating how many go to the HSE? It probably overstates the amount of work that falls on the Department and understates the work that falls on the HSE in responding to questions. Many of the questions that I pose which go to the HSE can take some time to come back. It would be useful to hear from the HSE the quantum of work relating to parliamentary questions. If that is not available now, it would be quite useful for us to get information.

I have a number of questions relating to how money is spent when people are in an acute hospital because there is inadequate provision of home care packages, although I know it is always finite. The witnesses gave us a note on that. I asked some parliamentary questions about this which the HSE replied to. Like most other Deputies, we look at people coming through the door in our constituency offices. We see the kinds of challenges that people face. It would give us some sort of insight about how services go and are provided. What is the average cost of an overnight acute hospital stay?

Mr. Liam Woods: An average is not a good indicator but if all the costs are averaged out, it would be approximately €850 to €900 per night.

Deputy Catherine Murphy: Are there averages for home care packages?

Mr. Liam Woods: Colleagues may know better but I think the hourly cost is approximately €23.

Deputy Catherine Murphy: There is not an average in the same way. The witnesses have not done that.

Mr. Stephen Mulvany: It would depend on the intensity of the home care package.

Deputy Catherine Murphy: I understand that.

Mr. Stephen Mulvany: We often talk about a package that costs approximately €300 to €500 per week. It can be more and many people are getting fewer home help hours.

Deputy Catherine Murphy: It would be fair to say that, on average, it is probably a better, cheaper option for people who can go home with regard to how money is spent.

Mr. Stephen Mulvany: No doubt.

Deputy Catherine Murphy: I asked these questions because I saw what was happening in my own area. In looking at an individual case, I wonder how it is playing out generally. I asked a question and got a reply in June about community healthcare organisation, CHO, area 7, Kildare and west Wicklow. There has been an increase in the budget between 2014 and 2018. When I asked a question about the availability of a home care package for an individual person, I was told that the money for this year had been spent earlier this year. There is no scope in my location for home care packages. The €6.9 million is essentially all accounted for at this stage. I understand there is a degree of scoping out for a year for a particular individual, and that may change if somebody goes into a nursing home. There is a bit of flexibility in that. Is that the same throughout the process or is it just in one particular area of the country? Is it the same profile?

Mr. Stephen Mulvany: The fundamentals are that there is a certain total level of resource and we must make the best with it. That is the same everywhere. Different areas will come under pressure because of capacity issues. In fairness, a significant amount of the tens of millions of euro invested over recent years has been invested additionally in home care. As the Deputy indicated, there is no argument that it is, for those for whom it is suitable, a far better option than the more expensive acute care. Fundamentally, there is a limit so we prioritise discharge from hospitals. That means we can end up with people in the community waiting and it is an area of constant focus between ourselves and colleagues in the Department about reprioritising the resource we have. Fundamentally, there will be a limit. It is a reality.

Deputy Catherine Murphy: There are queues of people on trolleys, and there are queues of people waiting to get into hospital for procedures or operations. We have queues of people who could benefit from home care as another means of care but there is no money to deal with it.

Mr. Stephen Mulvany: In fairness, every year in the Estimates we get additional resources for home care. During the year there is typically some level of a winter initiative that the Department generally prioritises. Further funding comes from that and we will see during the year if we can prioritise resources towards home care. It gets much focus but as has been mentioned, eventually the limit is reached.

Mr. John Connaghan: If it is helpful, would the Deputy like me to outline the budget? In 2016, the budget for the area was €349 million. In 2017 it was €377 million and in 2018 it was €417 million. There has been an increase of approximately €67 million in investment in the area, notwithstanding inflation over the past two years.

Deputy Catherine Murphy: That is perhaps very good investment. We should use the world "investment" as it is part of the health system. If people are occupying acute beds at a more expensive cost, is it not a no-brainer to reconfigure the spend?

Mr. John Connaghan: We have gone beyond the current level of home care packages. The 2018 national service plan has home support services for approximately 50,000 packages. As

of May this year, the HSE is providing funding for home support for 52,700 packages. That is 5% or so more than what is in the current national service plan. As the chief financial officer has outlined, at some point there is a limit in what we do in terms of prioritising what we can. Where the Deputy is going is absolutely appropriate.

Deputy Catherine Murphy: I want to ask about the Hannaway report relating to HSE estates. Are the witnesses familiar with it? HSE estates are responsible for maximising the value of the HSE properties and facilities. I have been trying to get the report but I have been told both that it exists and that it does not. Will the witnesses come back to me about that?

Mr. John Connaghan: What is it?

Deputy Catherine Murphy: It is the Hannaway report, which was drawn up relating to HSE properties and facilities. A person interviewed by Mr. Hannaway stated that the person was requested to carry out irregular transactions by a manager of the estates. That is the substance. It either exists or it does not exist. I would like to have a copy provided.

Mr. John Connaghan: We will try to source that. Looking at colleagues here, they do not seem to know about it. We will try to source the report and perhaps give the Deputy a commentary on it.

Deputy Catherine Murphy: I thank the witness. Going back to the section 38 and section 39 bodies and the weaknesses in the process, given the amount of money allocated was €4.1 billion, members will recall examining last October chapter 19 of the Comptroller and Auditor General's report for the public services for 2016. It reviewed the HSE's framework for monitoring grants for service providers. The final sentence indicates that the HSE acknowledges that the audit findings of the 2017 statement on internal control make it obvious that what occurred in 2016 reoccurred in 2017. I accept the point made that there is a systemic examination ongoing. What did the HSE do as a consequence of some of those weaknesses? Will the witnesses give a few examples of weaknesses identified and if there was a financial implication identified? Were there penalties applied to change behaviour? A few examples would be helpful.

Mr. John Connaghan: I will make a very brief comment and pass to Mr. Mulvany. During the course of 2017, and with regard to the work of the national compliance unit established, we wrote to all chief executives and chairs of section 38 and section 39 bodies, bringing to their attention the key findings of national and systemic importance that were uncovered through internal audit. It has always been a criticism from this committee that something in one organisation is sorted but downstream we might find some of the exact same issues reoccurring. We have taken that on board. One of our key actions has been to ensure that the learning from internal audits is not just compartmentalised to one organisation but is spread out. We made it an absolute requirement that chairmen and chief executives note these.

Mr. Stephen Mulvany: There are sanctions involved but it is about more than sanctions. To take one example, an issue in the past was late signing of the service level agreement, the key governance document between ourselves and the relevant voluntary body. We instituted a policy of withholding cash at a level of 20% from organisations, which has had a significant effect on improving the speed at which people will get their service level agreements signed. There are also a number of incidents based on internal audits where there may be a requirement to pursue a return of moneys and some of those are being progressed.

Deputy Catherine Murphy: Will Mr. Mulvany expand on that a bit? For example, St.

Raphael's Garda credit union was a case we dealt with some time ago in which salary increases were awarded outside what was allowed. A repayment of those was to be sought. Is that the kind of example to which the witness is referring?

Mr. Stephen Mulvany: An example is the Order of St. John of God, where the internal audit indicated there were payments in excess of public pay policy to a number of senior managers. One of the outputs of the external review ongoing currently is to determine the precise amount that we need to pursue with the organisation. My expectation is we must address that directly with the Order of St. John of God. It is not a sanction but it relates to reimbursement.

Deputy Catherine Murphy: The HSE indicated it would pursue that directly. Do I take it that a repayment will be pursued?

Mr. Stephen Mulvany: It is being pursued.

Deputy Catherine Murphy: Okay.

Mr. Stephen Mulvany: We will look for the resource to be provided to the community services being delivered by St. John of God in the intellectual disability services. The order is aware of that, although it may have a different view. It is being progressed.

Deputy Catherine Murphy: It should not have an impact on the quality of services being provided.

Mr. Stephen Mulvany: We see it as supporting or benefitting services.

Deputy Catherine Murphy: Are there particular section 38 or section 39 agencies that are standing out in terms of weaknesses? Are there good examples or bad examples of those agencies? What are the particular outliers?

Mr. Stephen Mulvany: We tend to see our focus on specific agencies as a result of internal audit reports. That may not be fair to the overall bulk of the agencies. A number of them, including the one I just mentioned, have had difficulties in the past and, as the director general said, the internal audit reports in many cases have indicated problems around certain financial control measures. That is why we have written to the chairpersons of all the section 38 and the larger section 39 organisations to highlight examples of those areas and to ask them to improve on those.

Deputy Catherine Murphy: Sometimes it is unfair to treat all organisations the same. There might well be organisations that are doing very well and there might be others that are dragging things down. Including them all does a disservice to good behaviour and it does not highlight the ones where there is a problem. Are there particular ones where there is a problem?

Mr. Stephen Mulvany: The ones I am aware of are the ones that are indicated in internal audit reports and have been reported to this committee. The Deputy mentioned a number of those. I agree with her point that we should not tar all the section 38 and 39 organisations with the same brush. Many of them have good governance arrangements but I do not have a specific list.

Deputy Catherine Murphy: Could we get that specific list at some point? Is there a list in existence?

Mr. Stephen Mulvany: The outcome of the external review being carried out by Deloitte

will provide us with a broader view. As the director general said, 30 of those are either complete or in factual accuracy checking with the organisations.

Mr. Jim Breslin: I can answer the question on parliamentary questions and I can also give the committee the detailed information on it. I thank the Deputy for the opportunity to recognise that the HSE contributes significantly to answering all of those questions. The number of oral questions, and they are all done within the Department, is 597 in 2017. The number of written questions answered by the Department is 3,205. A further 152 are answered by the Minister having been referred to the HSE. Some 7,900 are assigned within the Department, looked at, signed out to the HSE, there is liaison with the HSE and then the answer comes from the HSE. In a very significant number of them the final piece is done by the HSE. The HSE can comment on the daily work involved in responding to those. I also have a page which shows the responsiveness of the HSE to those referrals, that is, how many of the questions the HSE gets that are answered within ten working days. I have those statistics.

Chairman: I would love to see that.

Deputy Catherine Murphy: Yes.

Chairman: It is possibly a work of fiction from our perspective.

Mr. Jim Breslin: It will not say what the quality of the answer is, just the timeliness of the answer. We are always trying to work on the quality of the answers.

Chairman: Put simply, approximately 85% of the questions to the Minister for Health are specific to the HSE.

Mr. Jim Breslin: It is 7,900 out of 11,318.

Chairman: That is fine. You can send us that information.

Mr. Jim Breslin: I can give it to you now.

Chairman: Thank you. We will circulate it. I call Deputy Jonathan O'Brien.

Deputy Jonathan O'Brien: I wish to cover three issues and if I do not get through them in the first round I will return to them. What stands out for me with regard to speech and language therapy, CAMHS and the assessments of needs is that there appears to be a failing across all areas in one healthcare area, CHO 4, which covers Kerry, north Cork, north Lee, south Lee and west Cork. In terms of speech and language therapy, in March this year there were almost 11,000 assessments waiting to be carried out, which was a 5.5% increase from September last year. The good news is that 70% of them are being carried out within four months, which is positive. It is slightly down on last year when it was slightly higher. The bad news, however, is that 28% of children are waiting more than a year for speech and language therapy. Some 50% of all the assessments that are currently outstanding are in the CHO 4 area.

In terms of CAMHS, in March this year there were 2,691 people waiting for assessment, which was a 15% increase since September 2017. Some 14% of them, 386 people, are waiting more than a year. Of those, 55% are in the CHO 4 area. Regarding assessments of needs, in March this year there were 4,242 people waiting for assessments. Of those, 80% are waiting beyond the statutory timeframe of three months. Again, 50% of them are in the CHO 4 area. Clearly this area has issues which need to be addressed. Do the witnesses have any comments on this area within the organisation? It is falling far behind everywhere else across the board in

terms of speech and language, CAMHS and assessments of needs. Can the director general tell me the reason? That is my first question.

Mr. John Connaghan: For any child to wait longer than is necessary is a tragedy. Looking at some of the other services aside from the ones outlined by the Deputy today, clearly our position is not one we would want to readily accept. We should be doing better, particularly for children. It is important because of the stage of development they are at and the implications for later in life. We understand the gravity of the question the Deputy is asking.

There was some investment in this area in 2016 and 2017. I realise it is difficult to attract staff to certain locations. We need to do more in terms of providing cross-regional support, so if there is one CHO that is in trouble because it cannot attract and retain staff or where we do not have the right mix we must do more. Looking at the statistics here, it is 50% in CHO 4 but it is nothing in CHO 1 or CHO 2, for example. The question is what we can do to provide cross cover. That is the first issue. The Minister of State, Deputy Jim Daly, is due to meet officials soon and we will wait to see what action plan comes out of that. However, we accept that the numbers waiting for speech and language therapy services are high and that more must be done. We want to address the absolute resource in these areas as part of the Estimates process as we approach 2019.

With regard to the CHO 4 area, Cork and Kerry, an additional 13 posts were allocated in total. I do not have the up-to-date details regarding where we are in the recruitment cycle for those, but I can find out and forward that information to the Deputy.

Deputy Jonathan O'Brien: I acknowledge there are CHO areas where there are virtually no waiting lists. That must be recognised as well. However, there is definitely an issue across the board in the CHO 4 area. Perhaps a little more focus could be put on that. I do not know if it is due to recruitment or other other issues, but it must be examined.

Mr. John Connaghan: I should probably add the CHO 7 area.

Deputy Jonathan O'Brien: Yes.

Mr. John Connaghan: It is not quite as bad but there are issues in CHO 7. We need to be honest about the position.

Deputy Jonathan O'Brien: The second issue I wish to mention relates to mental health. Is there a figure for the number of CAMHS residential beds that are currently closed? If the witnesses do not have the figure, I am quite happy for them to revert to the committee with it. However, it would be useful to have it now.

Mr. Jim Breslin: The figure I have is 15 nationally.

Deputy Jonathan O'Brien: Are there any plans to reopen them?

Mr. Jim Breslin: Absolutely. They are not closed for anything other than operational reasons, usually around staffing. There can be an odd occasion where the infrastructure needs to be addressed. There has been a programme of expanding the number of CAMHS acute beds over the last number of years and significant expansion has taken place, but from time to time we are not at full capacity and we must continue to work on that.

Deputy Jonathan O'Brien: How many beds are there?

Mr. Jim Breslin: There are 76 inpatient beds in four acute units.

Deputy Jonathan O'Brien: Some 15 of them are currently closed.

Mr. Jim Breslin: Yes, and 51 are operational.

Deputy Jonathan O'Brien: Is there a target in the A Vision for Change document for inpatient beds?

Mr. Jim Breslin: Yes, and I understand we are not far off it. I have not got it precisely and it would relate to the movement in the population over time. However, we have reached it and we have done so with better facilities than were historically available. The new children's hospital, which is being built on a site at St. James's Hospital, will also provide more beds.

Deputy Jonathan O'Brien: On the same issue, A Vision for Change committed to a 24-7 service. What is the position regarding that commitment?

Mr. Jim Breslin: I have been informed by the HSE that it is in the final stages of recruiting staff to deliver 7/7 cover for areas which do not currently have it. It is expected to be late quarter 2 before those services become operational. Also of note is the roll out of telepsychiatry, which has been a priority of the Minister of State, Deputy Jim Daly, and offers remote access to an opinion when needed. It is of particular value out of hours.

Deputy Jonathan O'Brien: In terms of community mental health, a 24-hour seven-day service will be rolled out by the end of quarter 2-----

Mr. Jim Breslin: No, there will be 7/7 cover. That will not provide 24-hour services seven days a week in every situation. A full seven-day service in 2018 is a core priority of the national service plan.

Deputy Jonathan O'Brien: Will the service run from 9 a.m. to 5 p.m.?

Mr. Jim Breslin: No, its hours will differ in different areas.

Deputy Jonathan O'Brien: I ask Mr. Breslin to explain what the 7/7 cover involves.

Mr. Jim Breslin: There will be local differences in different situations.

Deputy Jonathan O'Brien: Based on demand and so on.

Mr. Jim Breslin: Yes, and the configuration of the local service. We can get more detail for the Deputy on that issue. The objective is to have a full seven-day a week service by the end of quarter 2.

Deputy Jonathan O'Brien: What level of investment is needed to get to a 24-hour seven-day-a-week service? I know Mr. Breslin does not have that information with him but I ask him to pass it on to the committee if it is available.

Do I have time to raise another issue?

Chairman: Deputy Jonathan O'Brien has two minutes remaining.

Deputy Jonathan O'Brien: Is there anything in the contracts of clerical staff working in hospitals that allows them to carry out work on behalf of consultants' private practices? For instance, may a person working for and paid by the HSE take up work during his or her working

hours on behalf of a consultant in a private capacity, such as managing the consultant's private diary or sending out appointment letters for the consultant's private practice and receive remuneration for such work from the consultant? Is double jobbing permitted under those contracts?

Mr. John Connaghan: I ask Mr. Woods to address the current practice in that regard. It seems obvious to me that those who hold a contract of employment with the HSE are expected to fulfil that contract with the State.

Mr. Liam Woods: On double jobbing and double pay, the contract of a public servant within the HSE is very clear that it is one salary and one job which is normally determined by a job description and agreement with the person's supervisor. A situation such as that described by Deputy Jonathan O'Brien would be very unusual and I am not aware of employees receiving payment other than their HSE salary. However, if the Deputy is aware of such practices, I would be very interested in knowing more about them. Some work relating to income collection is facilitated because the hospital must submit claims, including consultant claims, in order to receive payment. That is about getting income for the hospital. That is the only such practice of which I am aware.

Deputy Jonathan O'Brien: I received certain information on such practices. Mr. Woods is not aware of any complaints regarding people double jobbing and receiving a payment from the HSE and another from a private consultant for carrying out work.

Mr. Liam Woods: I am unaware of such complaints.

Deputy Jonathan O'Brien: If I provide him with that information, will he investigate it?

Mr. Liam Woods: I would be happy to receive it, yes.

Chairman: I call Deputy Aylward.

Deputy Bobby Aylward: I welcome the new director general, Mr. Connaghan, and wish him luck in the role. He has a hard job ahead of him and will be under constant scrutiny, which is of importance in regard to the spending of public money. The Comptroller and Auditor General stated that the overall spend was €15.2 billion for 2016 but €13.64 billion was referenced in Vote 38 health. Can the witnesses explain that difference of €1.6 billion?

Mr. Stephen Mulvany: The simplest explanation is that one figure relates to 2016 and the other to 2017.

Mr. Jim Breslin: It is very complicated. Two sets of accounts are involved. One is the appropriation account for 2016, the lion's share of which goes to the HSE, and the other is the HSE 2017 accounts. To make life even more complicated, the appropriation account contains the gross amount or total spend and the Exchequer amount or net spend because we get some income from sources other than the Exchequer such as the United Kingdom, which contributes money. The amounts can be reconciled but doing so is not very straightforward.

Deputy Bobby Aylward: Which is the cost to the taxpayer, €15.2 billion or €13.649 billion?

Mr. Stephen Mulvany: The approximate cost for the HSE in 2017, taking account of all pay and supplier costs, is €15.2 billion.

Deputy Bobby Aylward: The cost is €15.2 billion.

Mr. Stephen Mulvany: Yes. Income from patient charges, superannuation etc. offsets some of that cost. The net figure is approximately €14 billion. However, the larger figure indicates the total cost of running the HSE. It is not all funded directly by the Exchequer.

Deputy Bobby Aylward: The spend on health, which is one of the biggest costs on the taxpayer, is the subject of much discussion. Could the problems in the health service be resolved were the Government or Minister for Health to decide to allocate €16 billion to the HSE or does the answer lie in increasing efficiencies? I am regularly asked about that issue. It is frequently stated that the funding of the HSE is adequate to provide the service needed across all sectors but that we are not getting value for money and more efficiency is needed. I put that to the witnesses.

Mr. Jim Breslin: It is a case of all of the above. Nobody could say that every euro is used as effectively as it could be by the HSE. That is the experience of health services the world over. We have some distance to go to ensure that we are best in class in the delivery of services. The expanding and aging population is placing us under pressure to grow services and that pressure will continue. Waiting for additional money to fall through the letter box every year for investment in new services will not be sufficient to address the demand for those services. We must also consider how our services are organised and how productive they are. That is at the heart of the Sláintecare report to which Mr. Connaghan made reference. One often finds that individual parts of the service are working productively but that services are not properly joined up and the right services are not being offered in the right places. Taking the example made earlier, a person waiting for a year for speech and language therapy will experience developmental delay as a result and his or her requirements, when eventually seen, will be significantly more complex than would have been the case had earlier treatment been provided. Putting resources into a primary care community setting for far more accessible care can often help us avoid some of the more expensive approaches of highly specialist care such as acute hospital care and so on. That is key to the Sláintecare vision. Also of significant importance is working very smartly, using information and technology and doing things really well. I earlier mentioned telehealth in that regard. We need to move forward with a huge reform agenda. While that will not be delivered with a static budget, nor can it have an open-ended chequebook. No country in the world can afford that.

Deputy Bobby Aylward: If the Department finds efficiencies, whatever one calls it, which it tries to improve every year - everyone wants to get to the highest standard - are areas of waste being eliminated? Are we getting value for money? We are told we are spending as much per person as they are in other countries but we are not getting the same value for our buck.

Mr. John Connaghan: I will add some colour to Mr. Breslin's remark. I thank the Deputy for his kind opening remarks.

What examples do we have of the ability of the health service right now in Ireland to pursue good value for money? That was the first question. The second question is: how can we spread that best practice throughout Ireland? I will consider the three different types of value-for-money activity in terms of our pursuit of better value for the public purse. One is what I would call the usual suspects. They are the basic things that are non-clinical in essence. They are good procurement, conversion of agency posts into full-time and substantive posts, efficiencies in back office services such as print, energy and postage, and shared non-clinical front-line services. We do not need to have 29 or 56 of everything for Ireland. They are things that are being pursued right now by each CHO and each hospital group. That is the first category. One must understand that the first category only touches a certain element of the cost base. One needs to

look beyond it in terms of being able to look at the entire €15.2 billion.

The second category I will draw the committee's attention to is clinical efficiency. We need to do a lot more in that regard. Clinical efficiency does not mean we need to get our clinicians to work harder - although maybe in some cases we do - but to work smarter with better technology and more modern methods of delivery of services where we help clinicians to do that. An example is the pursuit of theatre efficiency. We know if we were to arrange things better and look at the best performing theatre system in Ireland we would probably get more throughput but to do that we would probably need some investment in things like theatre systems and new and innovative ways of working. That is an example of clinical efficiency.

The third and biggest area, which is where most of the €15 billion would lie, is in what I would call efficiencies associated with the model of care. I will boil that down into a couple of big things. Sláintecare gives us a hook here. One of the big hooks is the separation of elective and unscheduled care. I came from a system where we had developed that over a five-year period. What we found by separating elective and unscheduled care was much greater efficiency in terms of throughput because it was unrestricted and not stopped by the vagaries of winter. Where there was protected elective time we could plan efficiency and throughput through a system, which in that case was protected. The idea in Sláintecare to do something with investment in that would drive better clinical efficiency. Another example is we can do things differently. Mr. Breslin made reference to the fact we are doing too much in acute systems. If I take some of the examples such as the Sligo air care model or the Letterkenny urology model, which move activity out of the hospital system into the community, they mean faster delivery which is closer to home and also more efficient. It allows clinicians in the acute system to concentrate on the things they need to concentrate on. They are three buckets of things on which we can pursue value for money. We are only part of the way down that road.

Deputy Bobby Aylward: Can I ask a more personal question? As a result of the recent fallouts over the cervical cancer thing, it is generally thought by the public that no one in the HSE can be touched or moved aside. I am not picking on any individual but if a member of personnel is not up to scratch and not doing his or her job, are there sanctions in which the person can be moved aside or sacked if necessary? It is important because of the recent scandals, or whatever one wants to call them, that the public is assured that if someone is not up to scratch something will happen. If people in other Departments, particularly in other countries, are not up to scratch they are taken out or moved aside. In this country, the public's opinion is that no one in the HSE can be touched and that no matter what goes wrong no one takes responsibility, no one is moved aside, demoted or moved to some other Department and the person is left in his or her position and the thing just goes on. Can Mr. Connaghan answer that question? It is important with regard to the public having confidence in the HSE.

Mr. John Connaghan: It is a good question. I will address it in two parts. I gave the committee, in the session immediately before this, an answer about what we are doing and the conduct of the investigation. I have to be absolutely neutral on this. We have 116,000 staff in the HSE. Many of them are doing a fantastic job every day of the week, particularly when it comes to times when the provision of healthcare to the nation is threatened such as during storms and snowfall. Many of them are doing a fantastic job. That is reflected in patient satisfaction surveys. The Deputy raises a more fundamental point about the process in place to assess, in particular, senior managers and staff in responsible positions. How do we assess whether The objectives they are meant to pursue in a year on a personal basis have been delivered? We do not have such a system operating in the Irish healthcare system. It is something we need to

consider carefully as we go forward. It is one of the things on my radar.

Deputy Bobby Aylward: Will Mr. Connaghan bring in regulations, standards or a new code of conduct? Will it just be the same system we have had up to now?

Mr. John Connaghan: We have a code of practice and governance with regard to public bodies. It makes reference to ethics and conflicts of interest, etc., which is a good start. Whether it is entirely fit for purpose for the individual, because it is based at an organisational level, remains to be seen. It is something we need to consider.

Deputy Bobby Aylward: The reason I am dwelling on it is to give the public its confidence back in the HSE and its personnel. That is why I am dwelling on it. It is important we get that message out there to the public in general that this issue will be rectified and standards and procedures will be put in place to make sure everything is up to scratch.

Chairman: The Deputy will have a second opportunity later in the afternoon.

Deputy Bobby Aylward: Are my ten minutes up?

Chairman: Yes.

Deputy Bobby Aylward: Can I ask a more personal question?

Chairman: There must be a Kilkenny question coming.

Deputy Bobby Aylward: Yes. It is about the south east. There is a general election coming up.

Chairman: The Deputy will have a second opportunity to put questions after the divisions are taken in the Dáil.

Deputy Bobby Aylward: Deputy Cullinane mentioned psychiatric services in the south east. I will not go over the issue of juvenile services again. It is a disgrace that we do not have a juvenile psychiatrist. My constituency is in the south east and includes Kilkenny and Waterford. We do not have a juvenile psychiatry service in the south east. If a young person has a problem and it is addressed early there is less expense on the HSE, the country and the taxpayer but the five counties in the south east have no psychiatric service for under 18s. I will not dwell on it.

I want to ask about psychiatric services for adults in St. Luke's in Kilkenny. This week a strike was averted by management which was planned because of overcrowding of the psychiatric unit in St. Luke's where there are 44 beds in two units. I raised the issue in the Dáil. The strike has been called off. It is the second time a strike has been threatened by SIPTU workers as a result of the overcrowded conditions. They had to say they would not work in the system that was in place. I am told a bed management officer is needed for the south east, including Wexford, Waterford, Carlow, Kilkenny and Tipperary. That would be an officer to manage the beds. There is also a unit promised for Clonmel to relieve the pressure on Kilkenny. The same is required in Wexford and Waterford. Has the HSE a plan for psychiatric services in the south east, both juvenile and adult? I am speaking in particular about St. Luke's and the unit there that is overcrowded.

Mr. John Connaghan: I have been made aware of the issue in St. Luke's. I am appreciative that the staff have deferred industrial action. It is a wake-up call.

Deputy Bobby Aylward: It has been going on for a long time now.

Mr. John Connaghan: We should not have too many of those. The position and what the plan is will be resolved by 12 July. Part of it will include putting additional resources in to accelerate the discharge of a number of patients and to move them to a more appropriate setting to relieve some of the pressure. Local management is on the case. There is a deadline. There is a clock ticking on that. I would hope that we can resolve the issues to the satisfaction of local staff and patients by approximately the middle of this month.

Deputy Bobby Aylward: Would the HSE look at providing a bed management officer for the south east who would be able to divide up the beds and ensure there are enough beds available for those who need their services? Psychiatric services are very important to people.

Mr. John Connaghan: That would be considered as part of the plan.

Chairman: Would Mr. Connaghan send a more detailed note to the committee?

Mr. John Connaghan: We could.

Chairman: That would be helpful to the Deputy.

Mr. John Connaghan: I suggest I do that after 12 July.

Deputy Bobby Aylward: That is no problem. That is not too far away.

Chairman: That is fine. We are happy with that.

Deputy Alan Kelly: I have a number of questions across different topics. At the very beginning, I need to conclude some stuff on the previous topic. In the interval, while we had the break, I had a chance to speak to Mr. Stephen Teap and Ms Vicky Phelan. It is not good news. I also had the opportunity to listen to Ms Emma Mhic Mhathúna's interview, one of the most emotional interviews ever on RTÉ radio. Ms Phelan stated on "Today with Sean O'Rourke" that, after speaking to Scally, the HSE is not co-operating. This is Ms Vicky Phelan saying this, not me or anyone here. I asked Mr. Connaghan a question earlier. I asked would he be able, by the end of August, to ensure that the HSE had provided full co-operation. Ms Phelan stated on radio, and to me privately as well, that the information was not being provided. According to her conversation with Dr. Scally this morning, there was still information he was not getting, much information was being redacted, and there was much legal process before information was being provided and questions were not being answered. That is what she said. I am paraphrasing what Ms Phelan stated on radio, which is the same as what she said to me.

This is a live situation. This is Ms Vicky Phelan said this on national radio a little less than an hour ago. Ms Phelan is referencing her conversation with Dr. Scally. There is something significantly wrong and Mr. Connaghan is in charge.

Mr. John Connaghan: Let me comment on that. I will deal with the position of redaction first. I would advise the committee that we have sought and received permission from the Minister to apply section 40C in relation to all the information we hold. That information can now be released in an unredacted format. We took action last Friday when we received that.

Chairman: Would Mr. Connaghan clarify that? He made a reference to that this morning but he stated it was subject to some patient confidentiality.

Mr. John Connaghan: Subject to the odd bit of patient confidentiality, which Mr. Scally is comfortable with.

Chairman: In other words, the full documentation is not being submitted to Dr. Scally with the agreed redactions. Mr. Connaghan gave the impression it was unredacted but there is a qualification.

Mr. John Connaghan: Let me take the committee through the position on redaction. I met with Mr. Scally last week. We had previously sought, at the back end of last week, a section 40C direction from the Minister which would allow us to supply everything to Mr. Scally on an unredacted basis.

We had previously supplied redacted documents. We, therefore, worked over the weekend to re-provide all of those documents. My belief is - I have been told - that all of those have been supplied as of the close of play last night. I will just check again that that has been done.

Dr. Scally is comfortable in so far as he tells me that if there is something, particularly in relation to patient confidentiality - this will be very, very rare - we will take that out because we need to preserve some of the interests of the patients in this as well. All of that should be provided.

In relation to the provision and searchability of documents, one of the things that hampered the position between Dr. Scally and the HSE right at the very outset was the different platforms that we had in terms of their use and searchability. We have made recommendations - I think Dr. Scally has taken these board - that we invest in an appropriate eDiscovery platform which can search anything. For the very few instances where we do not have original documentation that can be searched through the normal Adobe Acrobat or Adobe Pro, we can use eDiscovery platforms with OCR to be able to identify everything. We are now on that. My position, just now, is that we have certainly turned the corner in the course of the development over the last week.

Deputy Alan Kelly: I thank Mr. Connaghan for that. There is a fundamental issue here. The lady who brought us to this stage is on national radio, on the most listened-to programme on radio in Ireland, stating that she heard in conversation with Dr. Scally this morning that the HSE is not co-operating fully. That is merely a fact. Everybody in Ireland who was listening heard it. I listened to it after speaking to Ms Phelan.

I accept what Mr. Connaghan is saying. Whatever is going on, it is not working. There is not a hope in hell of Dr. Scally having a comprehensive report by the end of August. I am saying it now - not a hope in hell. We already know it will not be comprehensive because the 3,000 cases will not have been reviewed and that will not tally. That means the report itself will not be comprehensive.

I am sorry but this is deeply unacceptable to the public watching the committee today. I was emotional listening to Ms Emma Mhic Mhathúna on the radio today. I will not get into what was said because Mr. Connaghan would not have had the chance to hear it but the whole country is talking about it.

It is time for a quick period of reflection and change course as regards how information is being provided to Scally and, immediately, although I accept Mr. Connaghan has not had time yet to get rid of this protocol that the HSE is undertaking with this firm. If this protocol exists tomorrow, my confidence in the HSE as an organisation will have collapsed. No legal protocol

can be put in place that will take this length of time. These women are entitled to their information. Just, bloody well, give it to them. If they go to the High Court, they will get it anyway because the HSE will be too embarrassed in front of a judge. Will the HSE just give these 80 to 90 women the information they are all looking for? Never mind about protocols, for dignity purposes give it to them. Many of these women do not have the time. Mr. Connaghan should just do that.

My third issue relating to the information provided is that the process for moving the HPV would be in place by October. According to the liaison committee which met, and I spoke to Mr. Teap, that committee was told that it would be at least the first quarter of next year. So which is it? That is a complete contradiction.

I will leave it at those three issues on CervicalCheck. Then I will come back to other matters.

Mr. John Connaghan: I have already provided some information on Scally.

I will just deal with HPV. I briefed the committee at the previous session on the four parts of the critical part that we need to put in place around HPV introduction. We need to get this absolutely right. It is so important for the women of Ireland that we do not want to rush on it.

One can understand our national caution about pitching something to the committee here that says we will promise to have this in by October, and that does not materialise. I would be back in front of the committee being asked about what went wrong.

It may well be that we are able to get something in sooner rather than later if our position on a negotiated contract with some of the laboratories that are interested in doing this are more fruitful in the short term rather than the long term, but we will take out the tendering process and tender evaluation part of that.

I hope we will have a clinical director next week who we can put into this full time to be able to take the service specification and make sure it is fine from a clinical point of view. That is one of the key steps we need to put in place. I am reluctant to give an answer at this stage until I have an appropriate critical path in front of me. The Deputy can understand that.

Deputy Alan Kelly: I do not but I will move on. There was a mood change and change of direction regarding co-operation with the Scally enquiry. The protocol has to be gone immediately and third, the HSE needs clarity on the HPV vaccine.

There are other issues, for example, the general practitioner, GP contract, negotiations have not kicked off. The witnesses should not try to pull the wool over our eyes. Mr. Breslin might give us the facts on that and an estimate of how long it will take.

The second issue is a matter for the HSE and the Chairman will be aware of this. I refer to a circular, dated 17 July 2015, about the appeals procedure in relation to circular 17/2013. This was issued to allow for any staff in position over a certain period to apply to regularise their positions. It was not communicated to staff. The HSE is facing a class action because of this.

Chairman: Is this the Haddington Road issue?

Deputy Alan Kelly: Yes. The HSE is facing a class action and the witnesses know full well what I am talking about. The staff covered by this circular were not informed as this letter states:

Dear Colleagues,

Please find attached procedure and associated appeal form to be used in the case of those who wish to put forward their case for adjudication by Mr. John Doherty.

I would ask that you ensure those who have made applications prior to the 30th June 2014 and have been refused the provisions of the Circular, or have had no decision given to them, are formally made aware of their option to utilise this process.

All applications under this appeal procedure must be submitted to Susan Keegan, 63-64 Adelaide Road, **before 5 pm on the 21st August 2015**.

It was very hard for members of staff or their unions to submit these seeing that they bloody well were not told about it. How will this be dealt with and how much will it cost the taxpayer? They will take a case and they will win it. How will the HSE fast forward this? How will it deal with this on behalf of the taxpayer?

There is a serious issue in respect of residential care. The next big scandal in the health service will be in residential care. We do not put enough money into it. Granted, it is expensive. It can cost up to €250,000 per person for people with serious disabilities, such as severe autism and various other conditions. I know of many cases, as do my colleagues, of people who are being left in limbo with their families left in difficult circumstances. The director general of the HSE knows of one case that I have raised with him. People with these issues are residing at home and endangering other family members. The State is allowing this to happen, whether there is potential for sexual or physical violence or whether these people are a danger to others or themselves. The provision of residential care needs to be dealt with from a budgetary and service point of view yesterday. It is the next big scandal. What provisions are being put in place to do that?

I represent Tipperary. There is not a single mental health bed in the county. A lobby group seeking mental health services in Tipperary is upstairs. I will meet with it after talking to the witnesses here. When and how will that be dealt with?

Mr. Jim Breslin: There was full discussion of the GP contract at Cabinet. A mandate was put in place for management to table not just the approach to the talks but what we want to get out of them. We have been given riding instructions on the type of money that is available to try to conclude a deal. I will not say what that is and we have not told the other side what it is. We have a substantial sum to get the type of reform to GP services and an enhancement of those services that everybody wants, including the recommendations in the Sláintecare report. We have engaged with the Irish Medical Organisation, IMO, and have put that position. It has gone away to consider it. Its preference is that we would unwind the financial emergency measures in the public interest, FEMPI, legislation and hand back all fee reductions that have taken place. Our preference is to address that but we also want to get an enhanced contract that delivers chronic disease management and a range of other objectives. The talks have initiated and they are-----

Deputy Alan Kelly: How have they initiated, for the sake of clarity, for the public because people are asking?

Mr. Jim Breslin: We have sat down across from them.

Deputy Alan Kelly: Who?

Mr. Jim Breslin: The senior officials in the Department of Health and in the HSE. They have sat down, based on the mandate they have. The Department of Public Expenditure and Reform is also-----

Deputy Alan Kelly: Has the Department met with the IMO and the doctors' representatives on it?

Mr. Jim Breslin: We have met with IMO officials and they have gone away to talk to its GP committee and to report on that. There is no timeline being placed on the Government negotiators. If negotiations are to be done by a particular date that weakens the hand of the management negotiators, as I have seen previously. The Ministers and I have told the leads on our side and in the HSE we would like them to do this as quickly as possible, to get the type of priorities we have identified for these negotiations but we are not putting them on the clock.

Mr. Stephen Mulvany: I do not have the specific details of the regularisation that the Deputy has but if he wants to share them we can certainly-----

Deputy Alan Kelly: What is Mr. Mulvany talking about?

Mr. Stephen Mulvany: The Deputy mentioned the staff who had not received the memo which I understand was-----

Deputy Alan Kelly: If the HSE does not know what I am talking about, I have to say, honestly lads, that is something severe.

Mr. Stephen Mulvany: I can only talk about what I do know about. The Deputy has asked me a question. The answer is we have regularised staff since 2015. I have seen some of the forms myself. We have issued the memos. If the Deputy wants to share the information with us, I am happy to check whether some group of staff was not regularised. I am not aware of, and have not been advised of, any court case. We will look into the matter and come back to the Deputy or to the committee but we have regularised staff.

Deputy Alan Kelly: Does Mr. Mulvany have no knowledge of what I am talking about?

Mr. Stephen Mulvany: No. I know about the issue of regularisation and I have a briefing on that but I do not have a briefing for-----

Deputy Alan Kelly: Does Mr. Mulvany know about the memo I referenced?

Mr. Stephen Mulvany: I do not know of a group that did not get the circular according to the Deputy's information. I am aware of regularisation and the process around that and the fact that people have gone through that process.

Deputy Alan Kelly: I suggest that the chief executive send out an email to all staff and ask were they all informed of this circular at the time. That will solve this problem fairly quickly.

Mr. John Connaghan: Does the Deputy know the group of staff that is affected?

Deputy Alan Kelly: We all do.

Chairman: We received the correspondence directly. We will send it to the witnesses.

Mr. John Connaghan: Yes, please give us the circular and the correspondence.

Chairman: It came to us. We will send it on to Mr. Connaghan after lunch.

Deputy Alan Kelly: Could the witnesses answer my other questions please?

Mr. John Connaghan: I will make a brief comment on residential care and mental health provision. I am aware of the case the Deputy mentioned in his remarks. The issue is how we do risk and needs assessments on an individual basis. The answer I sent back to the Deputy on that case applies generally. An assessment of the risk associated with each case is required to decide how we deploy that budget locally and individually, from what we have nationally. Whether that is right or wrong and whether we have the risk assessment right all the time remains to be seen and that is open to challenge and it should be challenged because if it is not right we need to fix it.

The second point to consider is what will demand be like in the future. How do we assess that demand and how can we make it much more responsive to the needs of the future? We do not want a hospital-based system; we want one that is based in the community. That is important for our future provision of care and the implementation of the Sláintecare plan.

I am keen that we give as much flexibility in decision-making within the budgets we have available not just to the staff involved in care but also their families.

Mr. Stephen Mulvany: Acute mental health and psychiatric beds are governed by A Vision for Change policy and strategy. From recollection it refers to acute mental health beds being at the level of a population of 350,000 or 400,000, not at individual county level. The issue is access to beds not whether beds are specifically located.

Chairman: A vote has been called. There is one item of business that we have to conduct as a committee. I am giving members a simple choice. We must finally sign off on our periodic Committee of Public Accounts report in order that it can be launched next week. It could take 20 or 30 minutes. Would members prefer to start with it and get it out of the way, or are they happy to continue with the witnesses from the HSE? If they choose the latter option, the report can be finalised by whoever is left at the end of that process.

Deputy Catherine Connolly: Everybody will be present at the end of that process.

Chairman: I will be.

Deputy Catherine Connolly: Great.

Deputy Bobby Aylward: How long more will we spend with the witnesses from the HSE?

Chairman: We will be with them for the afternoon.

Deputy Alan Kelly: Could we get it done with the correspondence and other stuff?

Chairman: The first priority is to clear the report for launch next week. If we have time later in the afternoon, after we have finished with the HSE, we will deal with correspondence in private session.

Deputy Alan Kelly: We will have to judge it.

Chairman: We may need to have a special meeting for an hour some evening next week.

Deputy Alan Kelly: I agree. I think one will be needed. The Chairman can come back to

us with the details.

Chairman: Are members happy to come back directly to the HSE?

Deputy Alan Kelly: Yes.

Chairman: We will finish the periodic report at the end of the public session. Will we say we will come back at 2.30 p.m?

Deputy Alan Kelly: Perhaps the witnesses might answer the final question asked. They were halfway through their reply.

Chairman: Okay. I will let them back in to finish their reply and then we will suspend the sitting until 2.30 p.m.

Mr. Jim Breslin: I would like to contribute to the reply. The Minister of State, Deputy Jim Daly, has met a local delegation of Deputies. It has been acknowledged that if we were to apply the bed norms for the entire south east, there would be a deficit of 18 acute psychiatric beds. I know that the chief officer is looking at the options for delivering those beds. Like the Minister of State, she has heard from the local group in County Tipperary about the proposal for them to be delivered in Clonmel. That is being looked at. Other sites are also being looked at. The four acute hospital sites are being looked at, with a view to trying to come up with a plan in that regard.

Deputy Bobby Aylward: A 16-bed unit has been proposed for Clonmel.

Mr. Jim Breslin: That is right.

Deputy Bobby Aylward: Is it on the cards?

Mr. Jim Breslin: It is on the table. I am not saying it has been decided on. It is an option that is being looked at.

Chairman: We will continue our interaction with the HSE when we resume at 2.30 p.m.

Sitting suspended at 1.05 p.m. and resumed at 2.30 p.m.

Chairman: We are now back in public session. We are resuming our discussion with the Department of Health and the HSE. Deputy Catherine Connolly is the next speaker.

Deputy Catherine Connolly: I welcome the witnesses and thank them for all of the documents. They have been very helpful. I want to come back later to the audit that has been stopped because I have still not gotten my head around it. First, I have practical questions on the accounts. In Mr. Connaghan's opening statement, on page 2, it says that the majority of the deficit, €73 million, is attributable to income shortfalls and associated bad debts, primarily related to hospital private maintenance charges. Could Mr. Connaghan elaborate on that?

Mr. John Connaghan: I will pass over to Mr. Mulvany.

Mr. Stephen Mulvany: The largest income source we have for acute hospitals is the private maintenance charge, namely the charge which is levied on patients and paid by their private insurers, the four large companies which the Deputy will be aware of. There are two issues. First, the insurers have taken a stance in the last two years around the timing of when we are entitled to charge in their view. Our understanding of the legislation is very clear in that once

the individual elects to be treated privately it is from the date of admission and the insurers are pursuing a line which says they will only pay from the date of a particular form being signed. We have an entirely different view from that. There is also what we would refer to as a campaign that the insurers are running, encouraging members not to use their insurance when admitted through the unscheduled care route into hospitals. Those two issues are matters which we are considering our options on and we are engaging with our colleagues in the Department. The reality is that it is having a financial impact and it had a significant financial impact in 2017. That is the €73 million.

Deputy Catherine Connolly: Are people being treated in public hospitals on their private insurance but the insurers are not paying up?

Mr. Stephen Mulvany: They are only paying for a portion of the stay in one case and also the amount of the charge that is being levied and raised is being suppressed by a campaign they are running to encourage their members not to utilise their private insurance when admitted through the emergency care route, as is their entitlement.

Deputy Catherine Connolly: In terms of the delay in signing the form, if someone is in hospital for a day or two and they do not sign the form, does the public purse pick up the cost for those days?

Mr. Stephen Mulvany: The insurers are not willing to pay and they have also gone back over a period and sought to retract and have retracted money that they had previously paid over to the health service on behalf of their clients.

Deputy Catherine Connolly: What is the HSE doing about that problem?

Mr. Stephen Mulvany: We are looking at what options we have and we are engaging with the Department to determine the appropriate way to deal with it.

Deputy Catherine Connolly: Is it down as a bad debt of €73 million?

Mr. Stephen Mulvany: They are not all bad debts.

Deputy Catherine Connolly: How much will not be recovered?

Mr. Stephen Mulvany: That will depend on the outcome of the process we need to engage in between ourselves, the Department and the insurers.

Deputy Catherine Connolly: Has the figure gone up or down since the previous year?

Mr. Stephen Mulvany: It is going up. It will not go down until there is some resolution to the issue.

Deputy Catherine Connolly: What has it gone up by?

Mr. Stephen Mulvany: I would have to check and come back with what the figure was in 2016.

Deputy Catherine Connolly: On governance issues and value for money which are the main reasons the witnesses are before us, many problems have emerged in how bodies under section 38 and 39 are run. We do not need to go back over them but they have been set out. As a result of that different things have happened and a series of external reviews has been set up. The last time we were here discussing chapter 19 of the Comptroller and Auditor General's re-

port, I understood that those external reviews on section 38s were being carried out by Deloitte, is that correct?

Mr. John Connaghan: Yes they are.

Deputy Catherine Connolly: They were to be completed by the end of 2017. Why were they not completed?

Mr. John Connaghan: We are in a situation where it was realised in late 2017 that there was a potential conflict of interest between Deloitte and some of the agencies on the business relationship Deloitte might have with the agency. If they were in essence the auditors of the agencies, once we gave them a list they could not do that, so we sought two other providers and we have to gear up with those two other providers-----

Deputy Catherine Connolly: Who were the two other providers?

Mr. John Connaghan: I can get those names to the Deputy if she wants. I am also right in saying that we have extended coverage of the audits to more than was originally envisaged.

Deputy Catherine Connolly: These are serious issues of governance and then we are reassured that external reviews are under way and that they will be completed. How many have been completed? How many remain to be completed? What is the cost and timeframe?

Mr. Stephen Mulvany: I do not know the cost but I am sure we can get it.

The other two companies are Prospectus and Treacy Consulting. Of the 40 audits or external reviews to be done among the section 38 organisations, 13 have been finalised, draft reports have been issued to the provider for facts and accuracy checking in 18 cases and nine are yet to commence.

Deputy Catherine Connolly: How many have to be done? What is the contract with these three firms?

Mr. Stephen Mulvany: It is 40 in total across the section 38 organisations.

Deputy Catherine Connolly: Is that it?

Mr. Stephen Mulvany: That is it.

Deputy Catherine Connolly: When will that be completed?

Mr. Stephen Mulvany: According to the dates I have, in the 18 cases where the reports have been issued to the provider, our expectation is the reports will be complete by October this year. That depends on the provider coming back and there being no further processes to be gone through around fact and accuracy checking. There is an element of back and forth when one does these reviews. I am not sure if the end of 2017 was the target date but we can check that.

Deputy Catherine Connolly: That is in the note we have. I checked it and it was expected to be completed by the end of 2017. In any case, Mr. Mulvany is saying all 40 will be done by October this year.

Mr. Stephen Mulvany: No, what I am saying is that 13 are done and in 18 cases the report has been drafted and sent back to the organisations, which is 31 in all, leaving nine to be started. I do not have a date for when those will be completed.

Deputy Catherine Connolly: Why not?

Mr. Stephen Mulvany: Because they have not yet started. I expect they will be started in the-----

Deputy Catherine Connolly: At the beginning of this process there were 40 section 38 bodies to be reviewed. I presume the HSE entered into a contract with Deloitte to carry out the 40 reviews and then a potential conflict of interest emerged. Is that correct or was the contract for a certain number of those 40 reviews?

Mr. Stephen Mulvany: As the director general said, my understanding is that the contract was to do all of them.

Deputy Catherine Connolly: What was the period of time to do the whole 40 reviews?

Mr. Stephen Mulvany: My recollection is that the original intention was that it would take about three years to complete all of these, starting some time in 2016.

Deputy Catherine Connolly: I ask Mr. Mulvany to send a note to the Chair outlining the exact cost and length of the contract that was initially entered into and how it changed. Will Mr. Mulvany confirm that in writing?

Mr. Stephen Mulvany: Absolutely.

Deputy Catherine Connolly: That is great.

The internal audit procedure has thrown up very serious issues and things have happened as a result. The audit compliance unit was established in 2014. I think Mr. Connaghan said it is now fully operational. Was it not fully operational-----

Mr. John Connaghan: Is this the national compliance unit?

Deputy Catherine Connolly: Yes. Was the unit fully operational from when it was set up in 2014? Did it have all its staff in place?

Mr. John Connaghan: It had to recruit staff. I know that it was set up in 2014. This precedes my time so I do not know precisely what the date was and I do not know what the mobilisation was. If necessary, we can tell the Deputy how many staff we have employed in that unit.

Deputy Catherine Connolly: That would be helpful. Will the HSE also indicate if the unit has its full staff complement?

Mr. John Connaghan: I suggest that I include an additional note. If the Deputy remembers, I also said at the end of that comment that we want to move this away from purely national and do something more-----

Deputy Catherine Connolly: I understand that. How many internal audits were carried out each year in 2016, 2017 and to date in 2018? What issues are emerging? I know we have been through this before in terms of planned and random audits. Will Mr. Mulvany give me a breakdown of the figures?

Mr. Stephen Mulvany: According to the information I have, in 2016, 23 audits of voluntary organisations were done. In 2017, there were 31 and to date in 2018, the number is 12.

Deputy Catherine Connolly: How many are planned for this year?

Mr. Stephen Mulvany: I will get that figure.

Deputy Catherine Connolly: On the 23 done in 2016 and 31 done in 2017, how many were planned and how many were random?

Mr. Stephen Mulvany: I have a list of them all. More and more of them are becoming planned. The random ones have tended to be larger single audits around specific issues. My sense is that the bulk of audits undertaken in the last two to three years are planned, but we can confirm which it is.

Deputy Catherine Connolly: That would be helpful. What issues have emerged this year as a result of those audits?

Mr. Stephen Mulvany: The typical issues, which the Comptroller and Auditor General had also noted previously, are around financial controls, governance issues, in some cases lack of internal audit, and things like bank accounts and credit cards. That is what prompted the HSE's compliance unit to write twice to the chairs of all the section 38 organisations and to the larger section 39 bodies around those issues, as the director general said at the start, and share those learnings so that the wider system had an opportunity to begin addressing those issues under their own governance.

Deputy Catherine Connolly: This is basic stuff. The issues include non-rotation of board members, expenditure on gifts and entertainment, poor audit trails over credit card expenditure, salary payments in excess of approved pay scales, board members not completing standards in public office returns and a high number of bank accounts. My time is limited. These are serious issues that should be dealt with very quickly. Why are still they ongoing year after year? When will this basic stuff be finally sorted out?

Mr. Stephen Mulvany: I do not have a particular timeline. There is a large number of organisations. The position is improving and our expectation is that it will continue to improve. Our compliance unit and our service teams have put a lot of effort into engaging with section 38 and 39 organisations, into the compliance annual statements which they must complete, and into circularising them about these control issues. It receives significant attention. At some point, we have to rely on these separate legal entities to organise their own governance arrangements. Our task is to support them significantly in that and to ensure the service they provide is up to scratch.

Deputy Catherine Connolly: I am afraid I was distracted as a vote has been called in the Dáil.

Chairman: A division has been called in the Chamber. I do not know what the procedure will be for the rest of the afternoon. Do some members wish to stay and allow others to go to the Chamber?

Deputy Marc MacSharry: I will stay.

Deputy David Cullinane: I will stay to enable us to get through this.

Deputy Catherine Connolly: Will the Chairman clarify on what the Dáil is voting?

Chairman: I believe it is on the intoxicating liquor legislation or Deputy Kelly's Bill on

microbreweries.

Deputy David Cullinane: Deputy Kelly will have to be present for the vote.

Chairman: Yes, he is in the Chamber. Those of us who want to stay will continue the meeting and we fully understand that others may wish to go to the House. Deputy Connolly's time has concluded. We will move to Deputy MacSharry.

Deputy Catherine Connolly: That is fine.

Deputy Marc MacSharry: I will pick up on one of the threads of the discussion, namely, deficits and insurance companies. I assume there is no process afoot to recover the loss. The witnesses stated they could not quantify the absolute loss or the amount that must be written off until such a time as they engage in a process. Has a process been commenced?

Mr. Stephen Mulvany: We have not finalised an action as to how to proceed on that.

Deputy Marc MacSharry: When will that be done?

Mr. Stephen Mulvany: I hope it will be in the coming weeks.

Deputy Marc MacSharry: What is the Department's view on the issue?

Mr. Jim Breslin: There is a question of the legislation and what is allowed for. Through the Office of the Attorney General, we have got a significant amount of legal advice which is being finalised and which will, I think, be released to us within a few days. At that point, we will look to secure the best option to secure as much money as we can.

As Mr. Mulvany said, there are two issues. There is the day from which something is chargeable. A quite separate issue is that all of us have an entitlement to go to a public hospital, whether one has health insurance or not. If one has health insurance in one's back pocket, one is entitled to go to a public hospital and be treated as a public patient. That is a person's primary entitlement as a resident of the State. The means by which one becomes a private patient is when one waives that public entitlement and decides one does not wish to be a public patient and ones wishes to be a private patient.

Deputy Marc MacSharry: I pay for voluntary health insurance. In the few times I have attended hospital, I have been asked whether I have health insurance before I see anybody. Is it not clear that somebody is in hospital in a-----

Mr. Jim Breslin: In the last year or so, the insurance companies have stated publicly and have written to their customers to make them aware of that when they attend an emergency department, the position is different from scheduled care where a patient has a relationship with someone who will be their consultant. The private insurance companies are telling people that they do not have to declare that they are private patients in an emergency department and why would they do so? It is kind of an odd thing for somebody who sold the product to say but the person is entitled to say that. People are entitled not to opt to go.

Deputy Marc MacSharry: Are people saying that? Is that what is happening? Are patients saying they are there as public patients and that their health insurance company should not be charged?

Mr. Jim Breslin: We are seeing a fall off in the numbers of people who are declaring them-

selves to be private patients.

Deputy Marc MacSharry: Is that directly linked to the loss?

Mr. Jim Breslin: I think it is. To wind it back another bit, a legislative change was made in 2014, which allows somebody to be charged as a private patient, regardless of where he or she is accommodated in the hospital. Up to that point, the insurance company was charged if the patient was in a private or semi-private room. Over an extended period, both the Comptroller and Auditor General and the Department looked at that and said that was a major hidden subsidy to private healthcare within public hospitals because insurance companies were having their members treated in the public hospitals but because they did not get a single room, which is one of the cheaper parts of the total cost of a person's stay in a hospital, the insurance company was not paying for it. I was not there at the time but in 2014, the Minister changed the law and said that one is chargeable at a somewhat different rate, regardless of what bed one is in.

Over a period we saw the yield from private insurance to public hospitals go up, and then - I am not quoting anybody but I am giving the committee my take on this - last year the insurers said, "Why do we not try to suppress that by saying to people that if they do not get a private room, if they come in as an emergency patient and if they are not under the care of a consultant with whom they have a relationship, why go private?". They started to publicise that and we have seen is a reduction-----

Deputy Marc MacSharry: In terms of the amount of money, can Mr. Breslin directly correlate the drop off to that amount of money?

Mr. Jim Breslin: We can correlate it to the two things.

Deputy Marc MacSharry: The likelihood is then that we are in a legal grey area and we will probably not get any money back.

Mr. Jim Breslin: We will do our best to get as much back as we can, and we will certainly be robust in trying to get as much back as we can.

Deputy Marc MacSharry: Are they acting *en bloc* or is insurance company A better than insurance company B, or is insurance company C more reasonable?

Mr. Jim Breslin: It kind of started with one and it has had a domino effect.

Deputy Marc MacSharry: Would Mr. Breslin suggest there is cartelism?

Mr. Jim Breslin: I am not suggesting that.

Deputy Marc MacSharry: We might consider having them in, if they were prepared to come in.

Chairman: Is the Deputy talking about the private insurance companies?

Deputy Marc MacSharry: For clarification, everybody who pays his or her tax is entitled to free treatment. What has private insurance got to do with the taxpayer arriving who has paid his or her tax?

Mr. Jim Breslin: Our business is public healthcare, and we are there to treat people on a public basis. If somebody says he or she has insurance and wants to be treated on a private or semi-private basis in a public hospital, the hospital is entitled to charge for that at a daily rate.

The public hospital has a responsibility to give public healthcare to anybody who is entitled to it.

Chairman: For clarification, when a person arrives into the accident and emergency departments that we all know are overcrowded, there is no private queue and public queue. There is one queue for everybody.

Mr. Jim Breslin: In emergency departments, there is no charge and there is no differentiation. The admission is made on the based on a clinical decision as to who should come in, and that is very important. Emergency department consultants are not remunerated by insurance companies but are paid out of the public purse.

Chairman: I am sorry, Deputy MacSharry, for cutting across you.

Deputy Marc MacSharry: That is no problem. I think it is something we could return to because I would suggest that there is a level of opportunism here by the insurance companies.

Deputy Catherine Murphy: Can I make a quick point because I raised this before? Someone contacted me who was chased around by someone with a clipboard, insisting that this person be a private patient even though the person did not want to become one. This happened when the person was sick and least able point to defend themselves. The person had paid taxes and was entitled to this care. There is definitely two sides to this.

Mr. Jim Breslin: There is.

Deputy Catherine Murphy: If we are going to have them in, let them come in with the witnesses so we can get the two sides to this issue. If people feel that they are being pressurised, it then drives up the cost of private health insurance and makes it unaffordable for other people.

Deputy Marc MacSharry: Maybe it is the HSE which is being opportunistic.

Mr. Jim Breslin: The way I have explained it is, factually, the legal position. It is important that people make an informed decision. We are not advocating for people to go private within public hospitals. It is important that they make that decision on an informed basis. The only bit that is somewhat unfortunate is that if the insurance companies adopt a position which is that there are no excuses for not having it signed off on as the person arrives in. There are other things to be done with people, particularly those who are sick, as they arrive into the hospital. It would not be a priority for the public hospital to throw a form in front of the patient while it has all these other things to do. As Mr. Mulvany pointed out, it is unfortunate that they are requiring the paperwork to be done at the start of someone's stay. It would be an administratively fair thing for both sides if there was some allowance for that.

Deputy Marc MacSharry: Mr. Breslin might give us an update when a decision is made on what to do and let us know how that is going.

I raised this question when we were dealing with the cervical issue but I do not recall getting an answer. The State Claims Agency told us that 50% of claims to do with the HSE are settled without an admission of liability. I asked what processes existed for retraining for, or supervision of those who may have been associated with an incident which was settled without the admission of liability. The State Claims Agency told us it was unaware of one. I suggested that it should recommend to the HSE that this should happen, that is, that without prejudice, consultant X, nurse Y or doctor whatever should be subjected to a mandatory period of supervi-

sion or retraining, relevant to the area where an issue has come to light. Has the HSE thought about that?

Mr. John Connaghan: I will ask Mr. Liam Woods to come in from the hospital side. The Deputy's question is probably wider than CervicalCheck and we should consider it in its widest sense as it would apply where care is substandard and it is down to someone's individual practice. With that thought, perhaps I might ask Mr. Woods to outline where we are there.

Mr. Liam Woods: We have quarterly meetings with the State Claims Agency in terms of picking up information on its interactions with the operating health system and to make sure that we are aligned - a point which was made previously - in our understanding. That happens and it is very useful. Claims settled are normally settled some time in arrears of three to five years. If the opportunity for learning arises, it should be visible at the time or soon after an incident and it should be built into professional training and development. There are situations where there may be support or retraining happening within an individual unit or-----

Deputy Marc MacSharry: That word was used the last time I asked the question. I was told "support" was available. Mr. Woods said this could happen, this might be identified and that this would be available and there would be support. Is it not prudent for us, as a State, to have a mandatory process? I accept one size does not fit all. Cases are often settled without an admission of liability and that may be due to fortuitous and creative legal work as opposed to supporting the absolute facts. Would it not be prudent for us to have mandatory processes of supervision or retraining in place to ensure we learn?

Mr. Liam Woods: Clearly there are regulatory bodies for healthcare professionals. I refer to a deficit of care issue. Presuming issues, which needed to be addressed, came out of a particular settlement which was made without going to court, I agree entirely that there should be a process that should picks up those issues and ensures that within both that unit and beyond-----

Deputy Marc MacSharry: But, there is not.

Mr. Liam Woods: I would not say that. If one looks at the women and infants programme at the moment, there has been huge learning from issue arising from obstetrics over the past number of years. There are very specific education processes going right across the 19 units. There is a real learning process there. There is dedicated training taking place in areas of high risk.

The Deputy's point was well made in terms of looking broadly at all claims and asking, "From that perspective, what are we seeing?".

Deputy Marc MacSharry: Without prejudice to the individuals, this should be the process that we go through. When an issue like this arises, everybody should go through this. No physician is going to be struck off by the regulatory body on the back of a settlement, without admission of liability. We cannot take refuge in regulatory organisations or whatever. The HSE needs to do this.

Mr. Liam Woods: Where it is relevant across the country, many standards have been adopted and training has been done on those standards of healthcare provision. Obstetrics is a significant example. There are others. They feed from and need to learn from incidents and claims. Processes are in place but the Deputy's point is well made.

Deputy Marc MacSharry: Will Mr. Woods look at and come back to us about the intro-

duction of a mandatory system of retraining or supervision to give peace of mind and to ensure that the mistakes of the past have been learned from? The State Claims Agency said it is not aware of any.

Mr. Seamus McCarthy: It is possibly something that the Deputy could take up with the State Claims Agency next week because part of its function is to provide a feedback mechanism.

Deputy Marc MacSharry: I did before and will again next week. As we are here with the health service-----

Mr. Seamus McCarthy: There needs to be provision of feedback. Spotting patterns in claims that might be indicative of something that could be addressed at hospital level is a important function.

Deputy Marc MacSharry: Moving on to another point, I ask the Chairman to give me time between his interventions. An article was published some time ago that got some coverage about how 650 of our 4,500 consultants were not qualified as consultants. Is this true?

Mr. John Connaghan: To put the figures in perspective, we have 2,950 consultants. I remember the article the Deputy is referring to which covers both public and private facilities. Mr. Woods is prepared to speak about where we are now.

Deputy Marc MacSharry: To refine the question, are we hiring people who do not have the specialist training and calling them consultants? Something I found really frightening was that the term "consultant" is not defined in the Medical Practitioners Act.

Mr. Liam Woods: The number of 650 was quoted in the article as being across public and private. The latest data I can share with the committee show that 134 consultants who are not on the specialist register are engaged in the public system in both hospitals and mental health services, which I can break down.

Deputy Marc MacSharry: What does not being on the specialist register mean? Have they studied?

Mr. Liam Woods: There are two categories. There are those who are not on a specialist register who were appointed pre-2008 and did not have a duty at that time to be on the specialist register, and continued since that time. There are also those who have come in since 2008. We would like all categories to be on the specialist register. There are 27 in mental health and the balance of that 134 are in acute hospitals. Many of those are psychiatry posts, which we discussed earlier today. These doctors are mostly, though not totally, located in smaller units outside major urban centres. With regard to human resources, HR, we have a national unit that works with doctors on doctors' training. We have written to all groups, group chiefs and clinical directors to support as many of those doctors as we can in registering on the register of specialists.

Deputy Marc MacSharry: Does registering mean more study or more exams?

Mr. Liam Woods: It depends on the individual. There is a support process involving the colleges, with both the Royal College of Surgeons in Ireland and the Royal College of Physicians of Ireland assisting. It may mean more study or it may mean summarising work already done. A process is under way right now to reduce that number through that process.

Deputy Marc MacSharry: Are they paid the same?

Mr. Liam Woods: Yes.

Deputy Marc MacSharry: There is the same salary regardless of whether one is on the specialist register.

Mr. Liam Woods: Yes. We have also looked at how many of those 134 would retire in the next two to three years. Approximately 15 of those will retire.

Deputy Marc MacSharry: Consequently, some have been around for a very long time and have not been qualified.

Mr. Liam Woods: They are pre-2008 and did not have a legal duty at that time.

Deputy Marc MacSharry: I am very much a layman when it comes to medicine. Are these guys just out of college who, having decided they are interested in ear, nose and throat, ENT, applied for an ENT post as a consultant and who then got it?

Mr. Liam Woods: Typically not. It depends on the time period, but for example, South Tipperary General Hospital has 11 such doctors. Hospitals may have difficulty recruiting over an extended period, have people who have some competence in the area, and appoint them because they needed to have somebody in place to fill a post.

Deputy Marc MacSharry: What would they been before, if, for example, an ENT post is given?

Mr. Liam Woods: Most likely a registrar or senior registrar working in that area. The first task for us is to reduce that number through bringing as many as possible onto the register.

Deputy Marc MacSharry: The President of the High Court, Mr. Justice Peter Kelly, has asked whether this is safe. Is it?

Mr. Liam Woods: That is a question for each hospital group and for clinical directors within groups to work on. The question that will arise is if a consultant not on the register is fit to practise and if we can be assured that the service is safe-----

Deputy Marc MacSharry: Who answers that?

Mr. Liam Woods: -----and how we understand that. That work and the review of it is being done by clinical directors in hospital groups.

Deputy Marc MacSharry: A clinical director in a hospital group probably plays golf with one of the 134 on Saturday because they are both consultants in the same hospital. Is that not correct?

Mr. Liam Woods: I would not necessarily take it like that. They take the duty to provide safe care very seriously. A hospital group may typically have between seven and 11 hospitals in it.

Deputy Marc MacSharry: They are reviewing and justifying their own position as opposed to somebody else.

Mr. Liam Woods: That would be an unfair-----

Deputy Marc MacSharry: Is it the clinical director of the hospital group or of the hospital

itself?

Mr. Liam Woods: It is the group. Groups are made up of between seven and 11 hospitals. I am not suggesting in any way that safety is compromised because consultants know one another but the underlying point I want to make is that the clinical director in Ireland East hospital group, for example, has 11 hospitals across an extensive area to work with. The larger numbers here are in a relatively small number of units. Going to the heart of the matter, there is a balance between providing a safe service and having clinical personnel to do that and assuring ourselves that that is safe. That assessment and support to get people on the register is what we are doing right now.

Deputy Marc MacSharry: Apart from support and encouragement, like before, would we not issue a direction as the governing body of health in the country and say this must be done by a certain date? Since it is medicine, I do not think grandfathering such as with auctioneers is the right way to take people along.

Mr. Liam Woods: There was a different legal circumstance pre-2008. Post 2008, we have set a timeline and are working to it.

Deputy Marc MacSharry: What was the timeline? Ten years?

Mr. Liam Woods: It is a three-month period, which we are in. We are looking to support as many doctors as we can to get on the register.

Deputy Marc MacSharry: I will come in again later.

Deputy David Cullinane: With regard to hospital consultants, some of the issues were raised by Teachta MacSharry. There was a court challenge by consultants relating to pay. Will the witnesses remind us what that was about, what the outcome was and what the liability is for the State as a consequence of that action by consultants? Will Mr. Breslin or Mr. Connaghan take that?

Mr. Jim Breslin: The issue went back to 2008, when a new contract was put in place with consultants. The first phases of that contract were paid, so they saw increases. A phase in the contract was not paid because of the financial crisis. That was a time when many people were either not getting increases or, in many cases, having their pay reduced. The Government of the day took the decision not to implement that increase. That persisted up to last month, when a number of cases were taken.

Deputy David Cullinane: How many consultants took cases?

Mr. Jim Breslin: Ten lead cases were taken but their colleagues were standing behind them, waiting to see how that went on. They were seeking the back pay for that non-payment of salary and the implementation of the increase with a current effect.

Deputy David Cullinane: What was the outcome of that?

Mr. Jim Breslin: Settlement has been reached. The consultant bodies have gone away to recommend that settlement and the State has entered into an agreement that it will implement the settlement. In broad terms, the implementation of the settlement would see a total of 55% of the back money paid to those consultants. That would commence next year, not in the current year-----

Deputy David Cullinane: How much would that cost?

Mr. Jim Breslin: -----and it would be staggered over 2019 and 2020. That 55% would be a 45% discount on the retrospective pay, with the implementation of the corrected pay rate with effect from January.

Deputy David Cullinane: How much would that cost?

Mr. Jim Breslin: I am about to get to the figures, which I have here. The total quantums in the settlement, which will be staggered now over 2019 and 2020, will be €73 million payable next year in retrospection. Then, on an ongoing basis, the cost will be €62 million per year. As we will implement the corrected salary with current effect, there will be a payment back to June of this year but we will not pay it until next year. That will cost €31 million. Next year, a combined total payment of about €160 million will be made. Consultants will also be due a further element of the retrospection in 2020, and that will comprise €109 million.

This was a multimillion claim, involving hundreds of millions of euro. The initial figures put forward by the HSE were a cost of €700 million. The clock was ticking on it, or better described, the taxi meter was running on it. It was continuing to escalate.

Deputy David Cullinane: Mr. Breslin will admit that was an extraordinary amount of money, both in the retrospective payments and the year-on-year costs. It is a huge amount of money for the cohort of people involved.

Mr. Jim Breslin: It is an absolutely huge sum of money. It was robustly defended over a period of years. There was a great reluctance on the part of the State to pay this. The consultants felt particularly strongly as we moved out of the emergency that this was a contractual commitment and that it needed to be paid. Ultimately, they took the case all of the way to the High Court to enforce it. The settlement is not a comfortable place to be in terms of the amount of money being paid out. This was on the risk register of the Departments of Health, Finance and Public Expenditure and Reform. We saw this as a very significant financial implication and ultimately the reason for reaching the settlement was the discount that was involved.

Deputy David Cullinane: Reading between the lines, the settlement was made reluctantly.

Mr. Jim Breslin: Yes, the reason for settling was the possibility of saving money that might be awarded in a court case.

Deputy David Cullinane: I understand that. The State robustly defended its position right up to the settlement. Mr. Breslin indicated there were ten consultants involved.

Mr. Jim Breslin: There were ten lead cases.

Deputy David Cullinane: Private investigators were hired to examine the movements of some consultants in the public service. Who would they have been?

Mr. Jim Breslin: There were three consultants where private investigators, for a relatively short period, formed part of the State's defence. The reason for that was because the consultants were suing the State for not complying with the terms of the contract, and the State wanted to establish the extent to which the consultants were complying with the terms of the contract. There is one part of the contract which is particularly difficult. Some consultants have an entitlement to off-site - not in the public hospital - private practice. That is not something that is observable to the public hospital. We cannot see that as it is not happening within our institu-

tions.

Deputy David Cullinane: Did the three cases in which private investigators were used involve three of the ten people who brought lead cases?

Mr. Jim Breslin: Yes.

Deputy David Cullinane: In terms of robustly defending its position and reluctantly agreeing to a settlement, the State seems to have gone to extraordinary lengths. Unusually in this instance, it hired private investigators to examine the movements of these particular consultants. In Mr. Breslin's view, was that justified?

Mr. Jim Breslin: I have thought about this because we have been criticised for doing it. In my view, if any one of us was facing, with our own money, the type of cost implications that were being faced here around a contract compliance issue, we would want to establish the other party's compliance with the contract. While it might be unusual in our experience, it is not unusual in court cases that that would be used part of a defence.

Deputy David Cullinane: How much did the private investigators cost?

Mr. Jim Breslin: I think the cost was quite modest because it was not for a protracted period and it was only in respect of three consultants. I do not have a figure on the exact amount of money.

Deputy David Cullinane: Were the private investigators given terms of reference as to when they would track the movements of the individuals in question? Did privacy issues arise in relation to the rights of these individuals? How was their privacy protected when the private investigators were hired?

Mr. Jim Breslin: The issue was about contract compliance. It was not about prurience or anything like that.

Deputy David Cullinane: I understand that. I ask Mr. Breslin to bear with me. There was obviously a contract of some description with individual private investigators or a firm to track the movements of three individuals. I am making a judgment on the rights and wrongs of that but trying to establish what the process was. In the first instance, which arm of the State was responsible for employing the private investigators? How did it go about doing it? What type of contract was in place? What were the terms of reference for the contract? How were the rights of the individuals in question protected? At the same time, the witness would argue this was justified to ensure the huge claim being made was properly defended by the State and, as such, any information the State could obtain from the work of the private investigators would help in that regard. Will Mr. Breslin help me with those questions?

Mr. Jim Breslin: My understanding is that the private investigators were contracted by the legal firm that was involved in the defence of the cases. It related to specific questions that would have arisen around the pattern of somebody's commitment outside of the public hospital and the extent of that. I did not go in to trying to establish personal details of what was established here, but my-----

Deputy David Cullinane: Mr. Breslin will imagine that the consultants involved will have felt uncomfortable and will have questions. I have not been lobbied by any of them, nor have I met any of them. I have seen the media coverage of the matter and I am aware of the criti-

cism made for using private investigators and the defence made by the State. I imagine if I was one of the individuals involved, I would want to know what safeguards were put in place by the State. If the State is to employ private investigators to track the movements of individuals who work for the State, what protections do I have, as an individual, that whatever the private investigator is tracking, it will not encroach on my right to privacy?

Mr. Jim Breslin: The media coverage perhaps led people to believe that this was a widespread practice and that it was not tied to specific cases that we were facing within the courts. That was the basis for this perception, and I do not believe that there is an infringement there. I believe that one is entitled to do that in defending a case. It may not be something that one would like to do, but when one faces those kinds of catastrophic costs, it is an option to take on.

Deputy David Cullinane: Was any wrongdoing discovered?

Mr. Jim Breslin: What was found formed part of the negotiations around the settlement. I do not think there was anything widespread or egregious, but we were trying to establish the bona fides of the compliance with the contract.

Deputy David Cullinane: That is the point I am trying to address. The State went to what I consider to be extraordinary lengths in hiring private investigators to track the movements of these individuals. Incidentally, I am conscious that this practice is sometimes used in cases involving people receiving social welfare payments and, as such, is used in a number of different contexts. In this case, the way in which this was done seemed to be somewhat unusual. Perhaps it has been done before and it would be interesting to find out how many times the HSE and the Department have used private investigators. Mr. Breslin stated the results of the private investigators' work informed the settlement agreement and their work did not find anything of substance. In terms of the good names of the three individuals in question, who may be easily identifiable within their world, is it safe to say that nothing was found in that work to suggest any substantial wrongdoing on the part of those individuals?

Mr. Jim Breslin: I am not seeking to identify anybody and neither am I aware of the detail. What I am trying to present here is that we were heading into a court case where the plaintiffs would have argued that the State was in breach of its contract. There would have been a discovery process attaching to that, to the extent to which the plaintiffs were going to introduce evidence into the court. The same would have applied to the other side. The other side would have been told what the State knew and would have had to defend its obligations under the contract. It was not as if it was an entirely secretive process in which it was not obvious to people that both sides of that argument were going to be played out across the court. I acknowledge this is unusual and I want people to understand, including people who are employed in the health service, that I recognise it to be unusual. The circumstances that we found ourselves in, where we were starting off with a €700 million exposure, were highly unusual as well. In the context of some of the other coverage that was done over the period, including, for example, the "Prime Time" programme, it was not unprecedented either.

Deputy David Cullinane: I have one final question, which is for Mr. Connaghan. I gave prior notice of this. My final question is a very local one. Mr. Connaghan will have to forgive me for that but I did give him a heads up on it. The Minister for Health announced last week that he would deploy a modular catheterisation laboratory for University Hospital Waterford. Mr. Connaghan knows that this has been a long-running issue. An independent report carried out following the formation of the Government headed up by Dr. Niall Herity did not recommend a permanent second catheterisation laboratory at the hospital. In any event, a modular

laboratory will be deployed for a time period. The Minister has stated the money will be made available in this year's budget but that there would be significant tendering, project design work, planning, construction and commissioning work. Does Mr. Connaghan have the updated information because in his letter to Members of the Oireachtas, the Minister stated he had asked the HSE to commence the work of making this happen now? Has that been done? Has that direction from the Minister been communicated to the HSE? What work is being done and can be done now? Can Mr. Connaghan give us an indication of timeframes in delivering that project?

Mr. John Connaghan: I thank Deputy Cullinane for the advance notice of the question, which allowed us to prepare. Mr. Woods has got most of the detail of that in his mind so I will ask him to start.

Mr. Liam Woods: I saw the announcement. It is very fresh. I have not yet seen a written instruction from the Minister but that could be in our own system or on the way to us. As the Deputy rightly said, there would be a piece of work around things like planning, site clearance and connectivity to the main hospital. I will come back to the Deputy about precise timelines but I think we are probably looking at something up to a 12-month time period. I will confirm that.

Deputy David Cullinane: Twelve months?

Mr. Liam Woods: I will confirm that because I do not have it in front of me.

Deputy David Cullinane: As I can tell Mr. Woods that 12 months would be completely unacceptable, the HSE needs to come back with a detailed breakdown of what the process would involve. This includes the tendering process, the project design work process, planning, construction and all the rest of it. All of the Members from the south east have met the Minister on this issue several times. This is a hugely important issue for me. I would not accept 12 months. There is not a chance that we will accept that we must wait for 12 months for this. I have no doubt but that it could be done far more quickly. I am a bit disappointed that Mr. Woods has not yet received the letter from the Minister but has just seen it in the media or wherever he saw it. This needs to be done quickly and 12 months is not acceptable.

Mr. Liam Woods: I would be very happy to come back-----

Chairman: The HSE must come back with a detailed report month by month.

Mr. Liam Woods: I am very happy to come back with it.

Deputy Bobby Aylward: I have it here. The Minister said January or February.

Chairman: We have to address the Minister's comments and his commitment.

Mr. Jim Breslin: I am happy to record the Minister's decision on this. I think people may have letters. The Minister has issued an instruction on it and we are in the process of engaging with the HSE. We have done so informally but I would expect the formal letter to have gone today while I have been here.

Chairman: In light of what we are hearing, the committee wants an agreed timetable month by month.

Mr. Jim Breslin: I saw the business case referred to by Mr. Woods. The Minister approved it while acknowledging that the timeline in the business case was not sufficiently worked out.

Some of the detailed tasks to be done to introduce that were not delineated fully within that. The Minister was happy to approve it in principle but wanted us to engage with the HSE on making that happen as quickly as possible.

Chairman: Does Mr. Mulvany want to make a final comment?

Mr. Stephen Mulvany: With regard to Deputy Cullinane's earlier questions about surveillance, the investigator was required to agree to comply with a written data processing agreement that set out the parameters within which the surveillance could be carried out.

Deputy David Cullinane: Could Mr. Mulvany send us a note on that? People who work for the State were disconcerted on seeing a small group of workers who were under surveillance in this way. While I do not pass any judgment on the rights and wrongs of it, people would be entitled to know exactly what was the process and what safeguards were put in place by the Department. I accept what Mr. Mulvany has said but if he could put it in writing and send it to us, I would be happy.

Chairman: We will ask for a more detailed note.

Deputy Catherine Murphy: Have we received any replies regarding the commitments made this morning on the protocol and the national screening service? Do we have replies?

Mr. John Connaghan: I have asked and I have with me the protocol, although it is just in electronic form at this stage. I have had a look at the protocol. It refers to the provision of slides from the laboratory that currently holds them to a third party laboratory. Having looked at the protocol, I can say that it is as much set up for the protection of the patient because it deals with the request from the patients, the identification of the patients and a safety issue, which is taking a high-resolution digital image of a slide before it is then sent out. I am quite happy to give the Deputy a copy of the protocol. As regards the patients waiting for those slides, I am advised that we have had 120 requests, 50 of which have been fulfilled within the relative timescale. I checked today on the remaining number, which is 70. I think the Deputy referred to something like 80 or 90. From my records, I believe the figure is 70. I am advised that they will also be fulfilled within the appropriate timescale. I am happy to give the Deputy a copy of the protocol if she wants to look at it.

Deputy Catherine Murphy: I would appreciate it if Mr. Connaghan could do that. We could do with having that today.

Mr. John Connaghan: It might be useful if I put in something on the timeline we have achieved so far in terms of turnaround.

Deputy Catherine Murphy: Does the figure of 70 relate to paper-based requests? I specifically asked about the slides that are held by the laboratories and what the contract says. The HSE created two different scenarios - where it was complying with the paper records or records in digital format that are held by the HSE and the ones that are held by the laboratories. I specifically asked about the laboratories as they relate to the contracts. Are they being requested or have they been delivered?

Mr. John Connaghan: They are included in the list of 120, which is a mix of slides, as well as paper requirements.

Deputy Catherine Murphy: Is there any delay in providing them?

Mr. John Connaghan: I am not aware of any delay. All of the ones that have been submitted so far, 50 of which we have fulfilled, have been made within the appropriate timescales. I am happy to send the Deputy the details about that together with the protocol.

Deputy Catherine Murphy: We are hearing one thing in here and the polar opposite through the media from those who are directly impacted or their representatives. We must be able to reconcile those. I would appreciate any information Mr. Connaghan can give us today, including that protocol. Can he give us an assurance that this is not an impediment or is not causing a delay to the people concerned?

Mr. John Connaghan: There is some degree of prioritisation within that. Those involving people who are coming up for a court case and require the information in a relatively short space of time, for example, within two days, are prioritised but all of those requests are fulfilled within that timescale.

Deputy Catherine Murphy: I would appreciate it if Mr. Connaghan could send us that information.

Mr. John Connaghan: I am happy to take any views on the protocol but having read it, it seems to be a sensible one because it protects the patients, allows them some degree of flexibility in nominating where she or he - if it is the next of kin - wants the slides sent to. It also deals with the courier method used and it allows for tracking. The disaster would be if we lost some of those slides in transit.

Deputy Catherine Murphy: I will move on to the €73 million in bad debts and the private hospital maintenance charge. Is this included as a bad debt when in fact, there can be something legally dubious about the demands if people are put under pressure? Is there any issue relating to this because it seems that this amount is growing every year? I believe this is what the former Minister for Health, Senator Reilly, intended it to be. Nobody has a dispute if it is about a private room. Of course, there should not be a separation when a person attends at an accident and emergency department in terms of queues or the kind of treatment people receive. Are the witnesses certain that the private hospital maintenance charge is legally robust?

Mr. Jim Breslin: It is not legally dubious to levy a charge on a private patient in a public hospital who does not have a single room. All of the advice we have received, which is based on the 2014 Act, upholds that the Act made that change and we can follow it through. The rationale for that is that although some cost attaches to the room in which a private patient is treated in a public hospital, the majority of the cost is accounted for by treatment, staff input and technology. That is the philosophy behind that policy.

Deputy Catherine Murphy: This mainly regards accident and emergency departments.

Mr. Jim Breslin: In the main, yes.

Deputy Catherine Murphy: There is no differentiation when a person arrives in an ambulance. What happens after that is the issue. I gave an example on a previous occasion when the HSE was before the committee of a female patient who was pestered for 24 hours to the point where a medic had to be called for a blood pressure issue because of the pressure put on her to sign a form she did not wish to sign. Is Mr. Breslin assuring the committee that such practices no longer occur?

Mr. Jim Breslin: The Deputy asked me a legal question in regard to the legislation. I will

not address the specific case to which she referred. The insurance company of a patient who attends a public hospital through the accident and emergency department or as a booked admission and wishes to be treated as a private patient will be charged even if the person is placed on an ordinary ward rather than in a single room. The single rooms may be occupied by persons with MRSA or other clinical issues. The State may legally recover the fee from the insurance company.

Deputy Catherine Murphy: I have very limited time and wish to close out this issue and ask other questions. The experience relayed to me by several people is that they were very aggressively pursued in regard to the fee while in hospital. I have given an example of that. Do such situations still occur?

Mr. Jim Breslin: That is a question for the HSE.

Mr. Stephen Mulvany: The HSE does not condone any practice that involves aggression between our staff and patients and we do not expect such incidents to occur. The vast majority of our staff are very hard-working and do a decent job under difficult circumstances. Accident and emergency department can be very difficult places in which to work. If the Deputy shares any details or evidence she has of specific incidents, we will be happy to have that looked into.

Deputy Catherine Murphy: I have already done so but I may provide more examples.

The issue of delays in speech and language and occupational therapy has been raised. One must plan services and hire staff based on existing needs. A child must undergo an assessment of needs to determine what supports he or she requires. I am aware that it is increasingly the case that people are told there is a three month waiting time for assessments of needs. I assume other members are aware of people in such situations. After three months, the person is told the waiting list is six months but after six months he or she is told it is nine months, and then 12 months. Is that occurring across the country or is it limited to one location? How does the HSE plan its services when there is a waiting list of that length for assessments of needs? Is there a problem with that process and what are the guarantees in that regard?

Mr. John Connaghan: We need to take account of local situations when assessing the provision of healthcare services throughout the country. We heard this morning that the service is fine in some parts of the country but not in others and we fully acknowledge and were aware of that. As part of the annual planning of the budget and service plan for the following year we consider what investment or change is needed in each local area. Those requirements are addressed in the national service plan in terms of targets for the activity we want to see and the expenditure to be provided to that end, as referred to by Deputy Catherine Murphy. The national service plan is clear on what we wish to achieve. The reality is that those plans are sometimes not realised because of issues such as staffing, additional demand or a significant historical backlog. We fully recognise the variability in services across the land and that we need to do something about that.

Deputy Catherine Murphy: A person does not get a second chance at childhood.

Mr. John Connaghan: That is correct.

Deputy Catherine Murphy: A child awaiting an assessment of needs may miss windows of opportunity and learning that would affect his or her life chances and so on.

Mr. John Connaghan: If I may, I will give the Deputy an example involving an area of

interest to me. She mentioned speech and language therapy and other services. I am also interested in the number of children awaiting a basic eye assessment. There are many ways of approaching that issue in light of the fact that we may encounter barriers or constraints in terms of the available workforce who can deal with the assessments. For instance, I am interested in exploring whether the optometry community in Ireland can, with the appropriate supervision, take some of that burden from the hospital and community-based system. We do not wish to give up should we run into obstacles but, rather, think about how else we can supply that service such that we can have a-----

Deputy Catherine Murphy: Some of these issues are the remit of the Joint Oireachtas Committee on Health rather than the Committee of Public Accounts. As regards waiting lists and the projection of needs, some people are unable to even get onto waiting lists, which is a further impediment. I ask Mr. Connaghan to arrange for the committee to be sent a note detailing where the problems are in that regard. He stated that assessment of needs provision is satisfactory in some parts of the country but not in others. I wish to know which areas are performing well and where there are gaps because the issue is increasingly being raised in my area and I wish to compare services in different areas. What steps does Mr. Connaghan intend to take to address the issue and in what timeframe will that be done?

On procurement, in a sampling exercise the Comptroller and Auditor General found evidence of a lack of competitive procurement. Some €700 million or €800 million could be saved through a competitive procurement process. I note that in his opening statement Mr. Connaghan referred to successful tender outcomes, particularly in the utilities category. That is very welcome because it shows that savings are possible. Is the lack of competitive procurement included on the HSE risk register? What measures are being taken to address it?

Mr. John Connaghan: I will offer the Deputy some high-level thoughts in that regard and then ask Mr. Mulvany to offer his views. The previous director general intimated almost a year ago at the meeting of the committee in regard to the HSE financial statements for 2016 that it would take some time to bring all of the €2.2 billion of expenditure inside our appropriate procurement framework. We can see from the figures now available that significant progress has been made over the course of the past two years. Some €1.1 billion of contracts are inside the framework and provision has been made to increase that to €1.5 billion, which shows that work is continuing in that regard. We will confirm those figures shortly. Mr. Mulvany might have the figures for 2016 and be able to offer further information in that regard. I ask him to outline from where we have come and what we have done.

Mr. Stephen Mulvany: As Deputy Catherine Murphy rightly pointed out, non-compliance is a serious issue and will take a number of years to resolve. As regards the HSE spend, our target is to bring the total procurement spend of in excess of €2.2 billion inside the framework. As Mr. Connaghan stated, at the end of 2015 approximately €488 million of contracts were in place between the HSE and the Office of Government Procurement, OGP. That figure has now risen to €1.1 billion.

Deputy Catherine Murphy: When will the €2.2 billion be inside the framework?

Mr. Stephen Mulvany: Our aim is to get to €2.2 billion by the end of next year or early 2020.

Deputy Catherine Murphy: Is Mr. Mulvany aware of the value of savings made by bringing the contracts within the framework? What potential savings could be made by bringing the

total spend of €2.2. billion within the framework?

Mr. Stephen Mulvany: The Deputy mentioned a very large figure in that regard. I do not want to give the expectation that that amount of money would be saved but there are savings to be made. There is also an issue of procurement compliance. There are contracts which are not any more compliant but are still delivering value. Let me give members more information. In terms of frameworks, which go alongside the contracts between the Department of Health and the Office of Government Procurement, OGP, we have 202 frameworks in place compared with having 97 at the end of 2015. We are showing year on year progress. Between those contracts and the frameworks, we have €1.56 billion in procurement spend covered by either contracts or frameworks. In 2017, we estimated that we had saved about €21.6 million purely from price savings on our contracts. There is a significant process of work on the way to assist our locations to become more compliant, to look at local contracts and some of them can actually be registered as national contracts.

I will now deal with the sample and as we said this time last year, it is a sample so whether the results are good or bad we cannot say it applies to the whole HSE. Last year's sample had a 48% non-compliance rate whereas this year, the non-compliance rate is 36%. While we would not argue with the Comptroller and Auditor General, there is one contract of a particular type for medical services which we are very satisfied is delivering value and it is about another 5%. We would not rely on the samples year to year to say it is definitely improving but it provides some evidence of improvement and the figures I gave earlier provide more evidence.

Mr. Seamus McCarthy: May I comment? I think comparing the figures of 48% and 36% is not indicative of a trend. The difficulty is that there are 11 systems and there are many ways in which procurement is happening and getting a complete overview is very difficult in the HSE. There may be progress being made but we may not be able to identify it until we see regularly, where we do samples in four or five locations, that the figure is coming down and staying down from year to year.

Deputy Catherine Murphy: May I ask one last question on the parliamentary questions? In 2017, some 11,000 parliamentary questions were tabled. In the years from 2012 onwards it ranged between 7,000 and 8,000, but there was a major spike in 2017. Members do not table parliamentary questions for fun but because they see failures or people come through the door with an issue. It strikes me that there was something going on. Does the Department use the process of parliamentary questions to analyse the trends where the failures are happening? What does the Department do to address the issue in order that the system is fixed rather than that the individual problem is fixed?

Mr. Jim Breslin: Obviously the first priority is to answer the parliamentary question. What we do periodically is that the research until drills down into the data to identify the policies that the clusters of questions relate to. For example, we have talked a great deal today about home care. We are pretty confident that if we move home care towards a statutory basis that the public clearly understands and can see the rule set, the number of questions would diminish. We see from the fair deal scheme that the number of questions diminished once we did that compared with previously. That would help us prioritise policy development. In addition, when individual cases are aggregated it could indicate a performance issue. As people ask questions around therapies and waiting times for them, not only do we rely on the HSE's performance information telling us how things are going but as the Department looks periodically at the parliamentary questions, we also would be able to say we are seeing a pattern. To the absolute credit of Deputies, there are always nuggets of parliamentary questions that shed a light on

something, which is a cause of surprise to us. Not that there is an aggregate, but one question will tell us that there is something that we did not know. The civil servants in the Department are encouraged not just to do the parliamentary questions in order that we get an answer for the Member but to use it as part of their own understanding of the services they are interacting with and to challenge people using the information they are getting from the parliamentary question process.

Deputy Catherine Murphy: I thank Mr. Mulvany.

Chairman: I now call Deputy O'Brien.

Deputy Jonathan O'Brien: I have a number of questions on the Supplementary Estimates. Between 2008 and 2016, the total savings through efficiencies within the HSE amount to €1.223 billion. Will the witnesses confirm whether that is correct?

Mr. Stephen Mulvany: Where did the Deputy get that figure?

Chairman: It is in a briefing document, a separate document that was sent to the secretariat.

Deputy Jonathan O'Brien: It is in a briefing document. It is the figure of €1.223 billion saved between 2008 and 2016.

Mr. Stephen Mulvany: They were savings targets applied to the primary care reimbursement service. Then the next paragraph talks about how much of that was delivered, which is the figure of €432 million and the balance was effectively returned via Supplementary Estimates in those years.

Deputy Jonathan O'Brien: Nearly every single year a Supplementary Estimate is required for the health budget. I raised this yesterday with the Minister for Finance and for Public Expenditure and Reform in respect of the reasons for it and Mr. Connaghan has outlined some of them. The answer I received is that he is currently assessing with the Minister for Health and the Department the reasons for such underfunding of the service. It seems to be a continual process when it comes to health. We give a budget but it is never enough. We always come back for a Supplementary Estimate. We keep making the same mistakes over and over again. Will Mr. Breslin or Mr. Connaghan talk me through the process of negotiation with the Department? How does the planning process work in terms of next year's budget?

Mr. Jim Breslin: A Supplementary Estimate *per se* is not evidence that the figures are wrong. To take the example of 2017, the Supplementary Estimate was €195 million and some €75 million of that figure was to do with the national pay deal, where the pay increases were brought forward. In fairness, I have robust debate with the HSE on their finances, that is something that was imposed on them. The Government met that cost. There was a €40 million Government initiative to try to improve winter responsiveness and try to open extra beds in acute hospitals and try to get home care levels increased. Again that was a Government initiative. Consequently, €115 million from a total of €195 million arose as a result of two Government decisions.

There was €50 million for the State Claims Agency, with which members of this committee will be familiar and this reflects settlements and court settlements, which can be very significant. One can have a €10 million settlement and these figures can be both significant and unpredictable. That is not say that we do not try to estimate them and try to provide funding for them but it is hard to get it exactly right. The other area foe which the Supplementary Estimate was

made available in 2017 was the area to which we have given some time, namely, the income area. We provided €30 million for that. Above and beyond that Supplementary Estimate, last year there was a figure of €140 million for the deficit that the HSE had generated at the end of the year. I would see issues within that where again, although we made €50 million available to the State Claims Agency, we got it wrong by €10 million. By the end of the year, during November and December, it was €10 million above the figure we expected. There are certainly other areas, where the Department would consider that it gets a budget that is set by the Government and which is based on the fiscal rules. We are told that is the total amount of funding that is available for the health service and then we work with the HSE, outlining that it must come up with a service plan that can deliver the greatest value within a budget of €15 billion. There must be some areas of the health service, even though they are complex and difficult to manage, where people seek to manage their budget in such a way that by the end of the year, they do not have a deficit. If there is not, the difficulty becomes that the people who have the deficit get that dealt with and the people who seek to manage without having a deficit have to bear it. Although it is hard in the health service and there is demand that is hard to manage, we are seeking with the HSE to improve upon the budgetary discipline in the health service.

To bring it back to the Estimates process, we would look at each element of the HSE's budget with them. As part of that we would engage with the Department of Public Expenditure and Reform and then we would conclude a service plan. I do know, in terms of Supplementary Estimates for example, that in previous years there were areas, perhaps pensions and retirements costs, demand-led schemes and fair deal schemes. Where people seek to retire they must be paid their lump sum and these cases have been difficult to predict in advance. Last year, no costs arose excess to what our predictions were in respect of areas like the primary care reimbursement service, PCRS, pensions, demand-led schemes and fair deal schemes. Last year, we did a better job in those areas and we continue to refine our methodologies. Ultimately, it is the Oireachtas, on the recommendation of the Government, that decides the health budget but we and the HSE must come up with a service plan to deliver upon that.

Deputy Jonathan O'Brien: I would say that it is the Government that decides, based on what the Government says the health budget is, rather than the Oireachtas but that is a moot point.

I want to ask about next year's budget, which we do not know. I presume, Mr. Connaghan, that the HSE is already considering areas for further efficiencies-----

Mr. John Connaghan: Yes.

Deputy Jonathan O'Brien: -----or savings. That is one area. We have a demand-led service and an aging demographic. Costs will arise in one area and the HSE may find savings in another area. How often does the HSE hold discussions prior to the budget in terms of trying to figure out the budget? Does the HSE approach the Department and tell it what is needed to run the service the following year? Does the HSE say that if the Department does not provide money that a service will be reduced? Does the Department just tell the HSE what funding it can give within the fiscal rules and ask the HSE to cut its cloth to measure?

Mr. John Connaghan: Can I give the Deputy two sets of comments?

Deputy Jonathan O'Brien: Yes.

Mr. John Connaghan: The first one is on efficiencies and the second one is on the process

for how we engage with the Department. I ask Mr. Mulvany to say a little bit about it, from the HSE's perspective.

Deputy Jonathan O'Brien: That is okay.

Mr. John Connaghan: Most western, developed, modern health economies pursue something called the triple M which takes account of increases in the health of the population; the delivery of high-quality services; and, the pursuit of value in the public spend. I think I have previously described the three tentative value elements to what the HSE is currently about. One is what I would call the usual suspects, and I have gone over those, like print, postage, back office services, etc. Right now the HSE is well engaged on that, with every CHO and every hospital group at national level, through what we are doing in terms of our procurement strategy. The next bit is one where we are only partially engaged and we can do an awful lot more. I would recall it is the clinical efficiency bit that I have previously explained. That is doing things like increasing the level of day care surgery that we have. That in itself leads me back to one of the drivers that we have in the national service plan. We have always had, in the national service plan, a desire to do more for the amount of money that we have. That is a good thing but the question is whether we are doing the right things. Maybe it is not always right that we drive more activity through our hospitals. Maybe it is a sign of success to be driving less activity through our hospitals and doing more in the community, doing the right kind of things. We should optimise inside hospitals what should only be done inside hospitals. Is the Deputy with me?

Deputy Jonathan O'Brien: Yes.

Mr. John Connaghan: There is lots more to be done around clinical efficiency.

The third element that I need to bring to the Deputy's attention is the model of care, and that has got to be long-term. That is the structural way in which we deliver healthcare services in Ireland. Sláintecare addresses that over a ten year period.

Mr. Stephen Mulvany: As has been indicated, it is an iterative process. Across the public service with all of the Departments, and the large agencies below the Departments of which we are one, there is a process whereby the annual Estimates round commences around now. We are starting to look at what are our likely levels of running what we call the existing level of service for next year and then there is a separate process to look at what may be developments. That involves a lot of engagement, back and forth, between ourselves and the Department, and ultimately the Department of Public Expenditure and Reform. Ultimately, the Oireachtas does decide what the final figure is and we have to get it-----

Deputy Jonathan O'Brien: In terms of the process, does the HSE first calculate how much it needs to maintain the level of service that it had the previous year?

Mr. Stephen Mulvany: Yes.

Deputy Jonathan O'Brien: Next, the HSE calculates the additional moneys it needs to meet demographic changes or rising demand. Does the HSE discuss how it will tackle backlogs, waiting lists and all of that stuff? Does the HSE say: "Look, we need X amount to reduce waiting lists by a certain percentage every year?" Is there such a plan in place?

Mr. Stephen Mulvany: Yes, Deputy. Again, let us remember that only a certain amount of money is available.

Deputy Jonathan O'Brien: Yes.

Mr. Stephen Mulvany: We would look at what we are currently running, what is the demographic impact for an individual patient and, if there are more patients, whether what we are currently running gives the same level of access. We also look at what we call unmet critical need or developments, and we look at savings. All of those go through an iterative process. Obviously we will have our view and the Department will have its view. There is engagement and evidence must be provided. The issue is demonstrating, with more and more evidence, what the actual requirements are. Ultimately, though, there is a certain amount of money available.

Deputy Jonathan O'Brien: I perused some of the accounts for the community health organisation, CHOs, and focused on the mental health area. I would like a couple of things to be further explained. To be fair, we received very detailed accounts and some of the accounts ran to more than 300 pages. The accounts were broken down into categories such as catering, cleaning, washing and medical but really everything.

Chairman: What report is the Deputy referring to?

Deputy Jonathan O'Brien: It was a report that was given to the Joint Committee on the Future of Mental Health Care.

Chairman: I thank the Deputy.

Deputy Jonathan O'Brien: I was struck by one item in the report and I ask the delegation for an explanation. I refer to the transport heading where costs were entitled "staff transport" and "patient transport" costs. I understand what the staff transport costs might be. For example, the cost may refer to visits by public health nurses and so on. I ask the witnesses to explain what is meant by the term "patient transport". I ask because the figure almost reached €300,000 in one year for patient transport.

Mr. Stephen Mulvany: Is that entirely within the mental health service?

Deputy Jonathan O'Brien: This is just within the mental heath service.

Mr. Stephen Mulvany: Patient transport, in that context, Deputy, would be where any of the services is providing supports to patients, either directly or through funding, to enable them to go to and from services. Given that we do not have a single financial system, some of the code and classification of those figures may be slightly different in areas so we would have to look at the specifics. Typically, staff transport, in terms of mental health, would be staff travelling, as the Deputy has said, to and from locations.

The patient transport is some form of assistance to patients, either directly or through providing financial assistance to travel.

Chairman: Clearly, the witnesses will have to supply the committee with a detailed explanation. We all understand that the term "patient transport" refers to transport between hospitals or something like that.

Mr. Jim Breslin: I can give an example. Somebody could be in a mental health hostel, for example, and he or she would be doing vocational training during the day. Transport would be arranged for him or her to get there.

Chairman: We understand. We can all work out-----

Mr. Jim Breslin: In principle.

Chairman: -----or envisage some of the cases. I ask the witnesses to give us a bit of information on the matter.

Deputy Catherine Murphy: Particularly in response to the specific query on that.

Deputy Jonathan O'Brien: Yes. I understand, from the information that I have been told, that the vast majority of that budget involves the transfer of files rather than individuals. If somebody moves from one service to another or from one unit to another unit, the file is not given to the patient but is transported separately, and we use a taxi service to transfer the files. Is that correct?

Mr. Stephen Mulvany: It could be in certain circumstances. Absolutely.

Deputy Jonathan O'Brien: Is it possible to get a better breakdown of the heading entitled "patient transport"?

Mr. Stephen Mulvany: Patient transport, yes.

Deputy Jonathan O'Brien: I want to know the following. How much of the money is spent on transporting patients? How much of the money is used to transport files?

A taxi service is used. My questions are based on certain information in my possession. Let us say a hospital wishes to transfer nine files. In that case, the hospital must ring nine different taxi services. Is there no scope within the system for having a contract with a local taxi service so they might get discounts?

Mr. Stephen Mulvany: We do have contracts with taxi service firms.

Deputy Jonathan O'Brien: Is that reviewed annually? Does it go out on a tender basis?

Mr. Stephen Mulvany: Absolutely. I am sure there are areas of non-compliance but we do have some fairly decent taxi contracts where we get very good value.

Deputy Jonathan O'Brien: If there are areas that do not do this, it is not because of a protocol or a rule but because they are not complying with best practice.

Mr. Stephen Mulvany: I am not sure I have picked the Deputy up correctly.

Deputy Jonathan O'Brien: We have a system where we use taxi services and we engage with them to try to get best value for money. It should not be a case that a person has to call nine taxis to transport nine files in one morning. If that is happening, it is down to bad practice in that particular area.

Mr. Stephen Mulvany: Unless there is some urgent reason, I cannot think why one would want to transport nine files in one morning.

Deputy Jonathan O'Brien: If possible, perhaps Mr. Mulvany could come back to the committee in the next few days or weeks on the figures for each of the community healthcare organisations, CHOs.

Mr. Seamus McCarthy: I draw the Deputy's attention to a figure in the financial statements

on page 167 for patient transport and ambulance services. The patient transport figure is €50 million per year. A comprehensive note breaking this figure down would have transport of ambulance patients and so on. That certainly does arise, but it is a very substantial expenditure.

Deputy Jonathan O'Brien: It is and I thank the Comptroller and Auditor General for clarifying that because I have not seen that figure. I have only been looking at the mental health figures which have broken it down by ambulance and by taxi. In some areas we are spending nothing on transferring patients by ambulance but in CHO 7, for example, €270,000 was spent last year. These are significant figures and I definitely believe it is worth getting a breakdown of the bigger figure with regard to health.

Mr. Stephen Mulvany: We can look at the bigger figure, or we can look at the mental health figure-----

Deputy Jonathan O'Brien: I would prefer if the bigger figure was broken down. I was just working off the mental health figures because that is the only information I had. A figure of €50 million is a significant amount of money.

Mr. Seamus McCarthy: Certainly we found that the procurement of taxi services was not competitive. A taxi contract or service use contract would have rolled over from year to year with the same people being used and so on. In more recent years that has not come up. The procurement space in the context of value for money may have been dealt with but then there is the question of efficiency of use of an expensive resource. This is the area where one would look for additional value for money.

Deputy Jonathan O'Brien: Perhaps the committee could get a note on that figure because €50 million is a significant amount of money.

Deputy Catherine Connolly: I cannot help a wry smile when my colleague has left asking about consultants. I sat through many cases where consultants, especially for defence companies, were asked to comment on plaintiffs having been followed by a private investigator. I had a wry smile about this. I did not hear any objections from the consultants at the time or any questions on privacy or the invasion of privacy for the plaintiffs as the consultants sought to reduce the costs for the insurance companies.

Deputy Catherine Murphy asked a question on procurement, a recurring issue that is commented upon by the Comptroller and Auditor General every week at this committee. I believe that Deputy Catherine Murphy asked if this issue was put onto a risk register, but her question was not answered.

Mr. Stephen Mulvany: Yes, I am fairly sure that it is-----

Deputy Catherine Connolly: Mr. Mulvany is fairly sure, or it is?

Mr. Stephen Mulvany: I can check for the Deputy. The key part of the risk register is to have a list of controls and actions. I will take the Deputy through these if she wishes. There are very significant controls-----

Deputy Catherine Connolly: No. I accept that and I hear what the witness is telling me, but I see procurement and non-compliance as a recurring issue. It is one of three major aspects highlighted by the Comptroller and Auditor General each week. Is it on the risk register?

Mr. Stephen Mulvany: I will confirm that. For clarity, we have said that this is a multi-year

process to resolve.

Deputy Catherine Connolly: I understand that but besides providing services, proper procurement is the one aspect that leads to confidence in a public body. We have made this point practically every week with all the organisations that come before the committee. It is simply unacceptable that there is non-compliance, except for emergency cases.

On page 21 of the appropriation accounts for 2016, note 6.2 illustrates legal costs. The note says, "The Department has not disclosed a breakdown of the total costs as required by DPER circular 29/2016 [the Department is not in compliance with the circular] as the Department believes that such a disclosure may prejudice the outcome of ongoing cases." Will Mr. Mulvany explain this to me? I have never seen that before from any public body that has come before the committee. They give us a breakdown.

Mr. Seamus McCarthy: In the template of the appropriation accounts there is a specific disaggregation of the figures called for as between different headings. The Department did not provide that level of detail. We asked the Department to include a note to explain the reason.

Deputy Catherine Connolly: Is that note acceptable to the Comptroller and Auditor General?

Mr. Seamus McCarthy: We would have preferred to see the compliance with the analysis that was called for in the template. We would not let it pass without an explanation being provided.

Mr. Jim Breslin: I am happy to look into that. It is obviously an aspect we would have looked at. It would have been looked at in finalising the 2016 accounts and taking on board the view of the Office of the Comptroller and Auditor General. The 2017 accounts have been done since and I would be happy to come back to the committee with a considered position on that. I would like to be as transparent as possible to identify if there was a specific anxiety around that.

Deputy Catherine Connolly: It does not make sense. I would understand if there is a worry around one or two ongoing cases, but even then I would look for an explanation. Some of the cases had to settle. The Department should be able to give a breakdown on the number of cases, the types of cases, the compensation given and the legal costs.

Mr. Jim Breslin: I am not answering the Deputy with the level of detail she requires, but I will answer with that.

Deputy Catherine Connolly: It is not a case that I require the detail. It should be given.

Mr. Jim Breslin: I could envisage a situation where one might not want to declare the actual settlement because it might be a signal to others perhaps to go the same route. The information could cause prejudice in certain situations, but that would be the exception rather than the rule.

Deputy Catherine Connolly: Will Mr. Breslin come back to us on that point?

Mr. Jim Breslin: I will come back to the Deputy on that.

Deputy Catherine Connolly: On page 169 of the HSE 2017 financial statement note 11 refers to the State Claims Agency. There is an estimated €2 billion figure for contingency. What was the figure that was paid over?

Mr. Seamus McCarthy: It was €283 million.

Deputy Catherine Connolly: Was this up on 2016?

Mr. Stephen Mulvany: That is correct.

Deputy Catherine Connolly: That is a significant increase on the previous year 2015.

Mr. Stephen Mulvany: The increase in cost is for clinical and non-clinical claims managed by the State Claims Agency on behalf of the HSE. The liability is the future estimated costs of cases going back over the past 15 or 20 years that have not yet been settled or closed.

Deputy Catherine Connolly: That is the liability for the future, which is some €2 billion. We can come back to that with the Comptroller and Auditor General next week with the State Claims Agency. What is the explanation for the significant increase in money that was handed over? Was this due to extra cases or were legal costs higher?

Mr. Stephen Mulvany: The State Claims Agency manages those cases on behalf of the State The agency is not our lawyer, it is our insurer. The cases relate to the HSE and our role is to lower the risk as much as possible by providing safe services. Every time we check this with the State Claims Agency, the reasons for the increase are not related to the health service provision. The increases are related to the cost of addressing legal cases. This is because legal costs are rising or because the internal rate of return around compensation is increasing and so on. The growth in overall costs is due to the operation of the legal and claims process. Consider the area of catastrophic births, which is about half of the overall clinical figure. Ireland's incidence of this is within international norms. This does not mean we are not trying to reduce it, but it is not the incidence of such cases that are driving the increase in claims year on year.

Deputy Catherine Connolly: I understood the legal costs were to decrease through a new procedure for considering a range of solicitor firms in order that the organisation would not be confined to just a small number. It was not anticipated that costs would increase.

Mr. Jim Breslin: Is the Deputy asking about the legal costs element of State Claims Agency payouts?

Deputy Catherine Connolly: Yes.

Mr. Jim Breslin: One aspect is the management of legal costs in an individual case. Another is the clinical indemnity scheme which was only set up in 2003. There is a long tail when it comes to insurance and everything before it was being picked up by insurance arrangements. The State now picks it up by way of self-insurance. That means that the cost to the State Claims Agency will build until it reaches a plateau which I believe is still three or four years away. Even with better management of individual cases, the aggregate cost might still grow. The State Claims Agency has put a great deal of effort into the management of individual cases, but the Deputy is correct. The Department of Justice and Equality has undertaken reforms to try to improve how the system works. The Deputy may be aware that last week the Minister established an expert group on medical negligence. It will examine this issue further to try to find a better solution for everyone when medical negligence cases are taken.

Deputy Catherine Connolly: In respect of the cervical smear cases, BreastCheck and so on, are the witnesses in a position to clarify how much has been allocated to meet future contingencies? Is there a breakdown of the figure for those cases?

Mr. Stephen Mulvany: I do not have that figure.

Deputy Catherine Connolly: Who would have it? Who makes the decision on what should be set aside?

Mr. Stephen Mulvany: It is not a contingency figure but an estimate of future costs. We will have to ask the State Claims Agency.

Chairman: These are the 2017 accounts and the figure was not known before 31 December, but it will definitely be an issue in this calendar year.

Mr. Seamus McCarthy: Correct.

Chairman: That is how I see it.

Mr. Seamus McCarthy: As I understand it, there is a very small amount of approximately €1 million provided for. The best body at which to address this question is the State Claims Agency.

Chairman: Next week.

Mr. Seamus McCarthy: As I mentioned when representatives of the agency last attended, there had been a change in the assumptions made. Arising from a court case, there was a determination that the discount rate needed to change. That had a very significant effect, in the order of €300 million, on projected liabilities into the future. It will be reflected in higher settlements with individuals without there being any change in the volume or severity of cases.

Deputy Catherine Connolly: I wish to address section 38 and section 39 organisations. At lunch time I read back over our documentation. When representatives of the HSE were before us previously, there was a note from the Comptroller and Auditor General on the cases he had considered. Just under one quarter of the section 38 and section 39 organisations had not provided audited accounts. Has the position improved or deteriorated?

Mr. Stephen Mulvany: Did the Deputy say "had provided audited accounts"?

Deputy Catherine Connolly: I said, "had not provided audited accounts." Just under one quarter of the section 38 and section 39 organisations had not provided audited accounts.

Mr. Stephen Mulvany: I have some figures. Of the organisations required to provide us with audited accounts, we have somewhere in the order of 90% plus. We have reviewed 94% of the audited accounts for 2016. I will dig out the figures.

Deputy Catherine Connolly: My final question is for Mr. Connaghan. I am trying desperately to get my head around this issue. Has what happened at CervicalCheck been included in a risk register?

Mr. John Connaghan: Yes.

Deputy Catherine Connolly: Since when?

Mr. John Connaghan: Since not long after April this year.

Deputy Catherine Connolly: It was not included in a risk register before that.

Mr. John Connaghan: It depends on the level of risk attached to it. I cannot say with hon-

esty what the level was. I am looking at the position in the HSE's risk register. It is at the very top. It was certainly elevated and I knew that it had been after April this year. I am not aware of what happened in previous years.

Deputy Catherine Connolly: Will Mr. Connaghan, please, check?

Mr. John Connaghan: I will.

Chairman: For members' benefit, the HSE submitted to us its risk register for the past six or eight quarters. We received substantial documentation from it a couple of weeks ago. The register is prepared every quarter. I suspect that it was not included in the March register, but we certainly expect it to be included in the June register. The issue might have been discussed, but I am not sure if it was included in the previous quarter. It has to be included in the next one. I am speaking from recollection. I recently saw a large volume of risk register documents going back over the past two years that had been submitted to us.

Mr. John Connaghan: I will check the history to see when it was included in the register.

Chairman: And the current status.

Mr. John Connaghan: I will also do that.

Deputy Catherine Connolly: Is the stage at which the HSE recognised it as a major risk not a key issue?

Mr. John Connaghan: Indeed. The whole point in having a risk register is that it should be anticipatory.

Deputy Catherine Connolly: And to learn. If it was not included in the risk register until April this year-----

Mr. John Connaghan: Why not?

Deputy Catherine Connolly: Absolutely.

Mr. John Connaghan: I am sorry. I should not be asking the Deputy questions.

Chairman: It was rhetorical.

Deputy Catherine Connolly: I assume Mr. Connaghan did not make the decision on the audit.

Mr. John Connaghan: Which decision?

Deputy Catherine Connolly: To suspend it.

Mr. John Connaghan: No.

Deputy Catherine Connolly: Who made that decision?

Mr. John Connaghan: I need to check. Unfortunately, Mr. McCallion is not present. He will have the information in his mind. Given the Deputy's interest in the matter, it might be useful to lay out the rationale for why it was paused. I will probably need to say something about when we hope to reinstate it. I will lay out the decision-making process and the rationale for suspending it.

Deputy Catherine Connolly: Mr. Connaghan will do that in due course, rather than doing so now.

Mr. John Connaghan: I will.

Chairman: He will send us the details.

Mr. John Connaghan: We will send them through.

Chairman: Will Mr. Conaghan take us back to the beginning and set out when the audit started? How many of the 209 people were covered? Did it start with people who had already been diagnosed and were the 209 then included. I do not know which came first.

Mr. John Connaghan: The committee wants the entire history.

Chairman: Yes.

Deputy Catherine Connolly: That would be helpful, but I read in detail everything in the terrible memos. My understanding is patients were diagnosed with cancer and that as a result, an audit was carried out. It discovered that the result of the sample taken had either been misread or that it was a false negative. The process of the audit resulted in the women concerned finding out eventually. Now that there is no audit, how will women find out?

Mr. John Connaghan: When Dr. McKenna was before the committee, he explained that it had been paused and that we were waiting for the Scally review to be completed.

Deputy Catherine Connolly: But-----

Mr. John Connaghan: We also want to have the view of the Royal College of Obstetricians and Gynaecologists on this issue. It depends on the timescale. Dr. McKenna's answer was that it would be paused until we had the results of the Scally review.

Deputy Catherine Connolly: Perhaps I am missing something. I do not understand what women are to do in the meantime. The mistakes were picked up in the audit, even though, as I read it, it was for educational purposes. If there are no audits, how will mistakes be picked up?

Mr. Jim Breslin: I am not involved in the decision-making process, but I will offer the Deputy a view. I do not believe an audit has ever worked in real time, if I may use that expression. When it kicked off in 2013 or 2014, it went all the way back to 2008. The Deputy is right - a range of women were informed some significant time after they had been treated for cervical cancer that this was what was known about their previous smear test history. Having got it up to date, there would still have been a time lag in the audit. It is not that someone would be diagnosed today and told within a couple of weeks that we had looked at her smear test and that here was the result. Dr. McKenna reflected that, rather than carrying out an audit that could be criticised and seen as inadequate, including by Dr. Scally who might say there was a problem with it, there would be a pause period of a couple of months. The relevant individuals would be new diagnoses during that period. They would be caught up with as soon as the audit recommenced with a clean bill of health. Those results would be communicated in line with the best practice that would be applied from there on. The Deputy is correct, but it only stands up to scrutiny if the pause period is limited and a backlog does not build up.

Deputy Catherine Connolly: It appears that somebody has made a decision to abandon the audit process, not because that process was defective but because the decisions in communicat-

ing the results of the audit process were highly defective.

Mr. Jim Breslin: There is definitely not an abandonment of the audit.

Deputy Catherine Connolly: It has been stopped.

Mr. Jim Breslin: There is a pause on the audit. We all feel a responsibility to continue with the audit, but there are aspects of it that can be improved, including information about the audit so people know about it. When they are diagnosed they should be told there is an audit, how it works and if we find something within a certain time period, we will be back to them. There are improvements that can be made to it.

Deputy Catherine Connolly: On the recruitment of nurses, the annual report gives an extraordinary figure on page 13 for the ratio of nursing jobs in Ireland to the number of nurses looking for them, which is four to one. Are there four jobs for every nurse or am I reading that backwards? The report says it is particularly difficult to fill specialist nursing roles.

Mr. John Connaghan: What is the reference again?

Deputy Catherine Connolly: It is page 13 of the health service annual report, nursing recruitment. Will the witness comment on that? The report goes on to refer to a staffing pilot project in six hospital wards. I will finish on that question. Is the ratio of nursing jobs in Ireland to the number of nurses looking for them four to one?

Mr. John Connaghan: This means that if we have a job available for a nurse in Ireland, we have up to four applicants for the job. The ratio of nursing jobs in Ireland to nurses looking for them is four to one. Am I reading it wrong?

Mr. Stephen Mulvany: If the English is correct, it is the other way round, that there are four jobs for every applicant and that is why we are having difficulty filling them. Mr. Woods might be able to give more context.

Mr. Liam Woods: The report probably means that there are more jobs to be filled than there are nurses available to fill them, which is what the Deputy is taking from it.

Deputy Catherine Connolly: It is a huge deficit.

Mr. Liam Woods: I will develop the point a little, and it was a point raised in the health committee yesterday. We have been successful coming out of last year to quite a high degree in terms of retaining graduates from last year, and that is a key focus for us again this year. That is helping us fill some of those roles and to reduce agency staff, which was discussed earlier. It is hoped in time it will help us staff the capacity to come. The nursing numbers in 2018 to date are up 1,300, but if I eliminate students we are up about 400 in total nurse numbers. We are recruiting additional nurses now. We still face challenges. The reference in the note may be specifically to challenges in areas such as theatre and intensive care where specialist skills are required.

Deputy Catherine Connolly: It is a crisis. I live in Galway and when two operating theatres closed in Merlin Park, we found out that St. Finbar's ward in the centre of excellence is closed. I have mentioned that we find out things by accident. A ward is closed in the hospital in Galway where there are huge waiting lists. When I ask why it is closed, I find it is an absence of staff. If there is an absence of nurses at that level, we have an emergency. We need proper packages, and the package that was provided to attract nurses home has not worked. Is it cor-

rect that there has been little uptake of it?

Mr. Liam Woods: The Deputy is correct that there is a serious gap. Some of the work taking place at present in intensive care units, for example, is training. There is training under way within our system to grow the number of nurses available for that, but both that and the theatre have been two areas of critical deficiency that we have had to address. It remains a challenge.

Deputy Catherine Connolly: It is a crisis.

Mr. Liam Woods: Yes.

Chairman: I call Deputy MacSharry.

Deputy Marc MacSharry: To follow up on Deputy Connolly's question, did the Minister approve the cessation or pause of the audit? Does he know about it?

Mr. Jim Breslin: He was aware that there were still some people whose audit was being finalised and that the HSE was looking at where the audit was going next over this period. I was not involved in any briefing of him where he was told it was paused.

Deputy Marc MacSharry: Have no lessons been learned from this crisis about escalating key facts to the Minister? It would appear to be quite big news that we have ceased the audit that could lead to other revelations, as Deputy Connolly said.

Mr. Jim Breslin: There is a huge level of engagement around this. We have a steering group which sits every week that has departmental, HSE and patient representatives on it. There is a weekly report to the Minister. The Minister's engagement on this and all its facets is a huge part of his working week at this stage.

Deputy Marc MacSharry: However, he does not know that it has ceased or paused.

Mr. Jim Breslin: He knew that there was a clinical question around it. The clinicians involved have reached a determination and-----

Deputy Marc MacSharry: That did not emerge when Deputy Connolly asked her questions. Was there a clinical issue with the audit?

Mr. Jim Breslin: No. It is a clinical audit, not an administrative audit. It is a clinical audit within CervicalCheck. The discussion which Dr. McKenna was a party to about how that should be dealt with appropriately over that period is not simply an administrative matter, it is a clinical matter. Dr. McKenna outlined both the decision on the audit and how the clinical management of cases continues over that period. That is the nature of decision-making in the health service. Clinical decisions will be made.

Deputy Marc MacSharry: We know there are 3,000 to be looked at but we have stopped looking at them.

Mr. Jim Breslin: No. I am sorry but we are at cross purposes. I will bring it back to the beginning. The trigger for an audit of a case is a diagnosis of cervical cancer and the CervicalCheck programme being informed that somebody has been diagnosed with cervical cancer. That is an individual notification. CervicalCheck asks then if the person has a screening history. On occasion the person will not have a screening history. Where the person has a screening history the audit looks at the engagement with that person to see when CervicalCheck last engaged

with the woman. It is a case of whether they called her and whether she did not come, which is a possibility, or whether they called her and she came and she had a difficulty with the quality of the smear test, and it goes all the way through the chain. The most important issue, however, is around the reading of the smear test and, after that has been looked at through a process to try to determine if there is a discordance, to communicate - this is where it fell down - that discordance to the woman's consultant who is treating her for cervical cancer, and for him or her to inform the woman that a previous smear had missed a screening potential to send her in for further review.

To bring that forward, as I understand it as a non-clinician, and it would be helpful if Dr. McKenna were here, the pause is for a period. If somebody is diagnosed with cervical cancer, and there will be a lag in that information getting to CervicalCheck so there is always a lag in any event, that information would come to CervicalCheck and the pause is that the look-back or review is not done and communicated over that period. It is to be a very short period, as I understand it. In all likelihood it will be much shorter than the period that would normally arise from the woman being diagnosed and the result becoming available. I will use some very rough figures but it is not 3,000. If there are 300 diagnoses in a year on average and, for example, half of them have a screening history - I am using very rough figures now - we are talking about 150, and if that is spread over the course of a full year, we are talking about ten or so in any single month. That means over two months or so approximately 20 cases have to be done.

Deputy Marc MacSharry: Like Deputy Connolly, I simply do not understand the psychology of pausing something that was working.

Mr. Jim Breslin: It was working but not as effectively as we believed it could be. Certainly, the communications around when someone is diagnosed, what the audit is, how it is geared up, what kind of timelines attach to it and how all of that will be disclosed is something Dr. Scally will comment on.

Deputy Marc MacSharry: Internally, the Department believed it was not good enough and paused it. Is that correct?

Mr. Jim Breslin: I have reflected to the Deputy that I have tried to help people's understanding. I have not been party to making the call on it. I am trying to put it into proportionate terms rather than to have it misunderstood.

Deputy Marc MacSharry: Anyhow, Mr. Connaghan is going to give us a blow-by-blow account in writing on that issue.

I welcome Mr. Connaghan back. This question is for him. Earlier in the morning we discussed the cervical cancer issue. I asked about disciplinary processes and procedures and so on. Mr. Connaghan said that after the Scally process there is an intention for a conduct investigation – I believe they were his exact words. What is that?

Mr. John Connaghan: A conduct investigation is an investigation that comes under disciplinary procedures. We have a national procedure agreed with staff representatives about how that would work. It is a standard procedure that has been in existence in our human resources framework. That is what I mean by a conduct investigation.

Deputy Marc MacSharry: It sounds a bit bureaucratic to me. It was not a term I had heard before.

Mr. John Connaghan: It is a term I am used to from the UK. I will try to use Irish terminology in future.

Deputy Marc MacSharry: The intention is for a conduct investigation to be commenced by the HSE following the Scally report. Is it Mr. Connaghan's intention to do that?

Mr. John Connaghan: Earlier, the MacSharry asked for a copy of the procedures that we might use. If he did so, we can make them available. It is a standard national document.

Deputy Marc MacSharry: Mr. Connaghan's choice of words was based on his UK experience. It is a disciplinary process. Theoretically, depending on the findings, it could lead to tangible sanction, whether suspension, dismissal or whatever.

Mr. John Connaghan: Yes.

Deputy Marc MacSharry: I thank Mr. Connaghan for clarifying that.

Earlier, the HSE representatives mentioned that exit interviews are held with some exiting staff. Is that only at consultant level or does it apply at nursing level and to junior doctors and so on?

Mr. Stephen Mulvany: It is generally carried out for all levels.

Deputy Marc MacSharry: Does it apply at all levels?

Mr. Stephen Mulvany: It is a norm for all departures.

Deputy Marc MacSharry: What is the problem? Is it money, morale, treatment or facilities?

Mr. John Connaghan: I have had a look at this. It relates to a particular instance around Wexford and Waterford psychiatric services.

Deputy Marc MacSharry: I am more interested in the north west. We have the same problem there.

Deputy Bobby Aylward: We are interested in the south east.

Mr. John Connaghan: I am interested in the north west as well but I must remain nationally neutral.

Deputy Marc MacSharry: What is the problem? What are the exit interviews telling us? Is it a matter of money, hours or the weather?

Mr. John Connaghan: I do not have any information at this stage on what the exit interviews might be. I can speculate that people might leave based on a range of issues. It could be pay, conditions or advancement elsewhere.

Let us consider the three psychiatrist positions in Wexford and Waterford. One was a locum who is going to another job somewhere else – I do not know where that job is. One is leaving to pursue additional studies as part of a pre-determined study plan. One is leaving to move elsewhere in the healthcare system. I am told one of the major reasons one of the consultants is leaving relates to the premises, the conditions of buildings and various other things. The latest information I have on that is that we are pursuing arrangements to move the service into new

premises. This should happen soon – by soon, I mean this autumn.

Deputy Marc MacSharry: We are just talking about the specific Wexford case. On the basis of these exit interviews it would be useful for the committee and the State generally if the HSE could correlate some of this information. The executive could tell us X% are leaving because of money and Y% are leaving because of facilities and so on. In that way, the committee could prevail upon the Department of Public Expenditure and Reform to get more money for the HSE, if that is what is needed, or to change conditions or whatever it is.

Mr. John Connaghan: There is something I may need to look relating to the staff survey. It might be useful in these circumstances. We could point the Deputy towards that. I understand Mr. Woods wishes to come in.

Deputy Marc MacSharry: As Deputy Connolly said earlier, it is a crisis. If we have four jobs for every one applicant, then that is a problem. Certainly, there are examples in the north west. I imagine there are examples in every community healthcare organisation.

Mr. Liam Woods: I will make a brief observation on that, which may be helpful. Specific research was done on doctors through our human resources unit with the support of the Royal College of Surgeons in Ireland. The research looked at doctors in Ireland and Irish doctors who have gone overseas. It looked at the drivers that caused them to leave, their views when they were away and what they thought about coming back. Another question was whether they thought about coming back before going away and whether that changed while they were away. There is good analysis. I suggest we made a copy available to the committee.

Chairman: Was that done by the HR department?

Deputy Marc MacSharry: That would be useful.

Mr. Liam Woods: It is interesting research.

Mr. Jim Breslin: One point is worth noting. I am not suggesting there are no shortages or that, based on growing demand, we do not have difficulties. Anyway, let us consider three areas. Last year, the number in nursing increased by 942. Over the past 12 months, the number of consultants increased by 113. A total of 479-----

Chairman: Are they net increases?

Mr. Jim Breslin: There has been an increase of 479 over the past five years. The number of non-consultant hospital doctors increased by 1,345 over the past five years. These numbers are all up on the previous period. They represent aggregate increases. There are shortages and areas of particular difficulty, whether certain locations in the country or specialist skills that we need. However, overall we are growing the numbers in our health service.

Deputy Marc MacSharry: Does that compare favourably to the number of people completing their internships? What percentage of people who complete their internship are heading for Canada, Australia and elsewhere?

Mr. Jim Breslin: In the case of nursing, the HSE has put in place an arrangement whereby it offers to everyone who is graduating from the degree programme a placement or job. The latest information is that more people are taking that up. There was a time during the crisis when jobs could not be offered and people went abroad. Now what happens is that people take the job and do it for several years. However, they would still like to see a country and experience travel and

so they go abroad. At the Joint Committee on Health yesterday, Ms Collette Cowan, who is the chief executive officer of the University of Limerick hospital group, explained the approach. She said the important thing is that when the hospital staff get someone in from college, they get the graduate accustomed to the work. Then they get the recruit to make a connection with the hospital. Crucially, they offer a career break. If they do not make a career break available then, when the recruit goes it is a break and she does not come back. We will always see people leaving. The important thing is that when they have experience, they come home to give us the benefit of it.

Deputy Marc MacSharry: The previous speaker had 24 minutes. I have about four more questions and they will be quick.

Chairman: I want to let in some Deputies who have not contributed yet. That is the only reason I want to hurry the Deputy.

Deputy Marc MacSharry: I apologise. Are there any protected disclosures from doctors or consultants before the HSE at the moment?

Mr. John Connaghan: We would need to check that out. I do not have the figures before me.

Deputy Marc MacSharry: Can Mr. Connaghan come back to us on that?

Mr. John Connaghan: The Deputy is looking for the figures for the HSE. Is that correct?

Deputy Marc MacSharry: Yes. Will the HSE ask the Department of Health, perhaps through the Minister, to define "consultant" in the Medical Practitioners Act. Clearly, this is a problem because it is not provided for.

My final question is regional. It is a point similar to the representatives from the south east. A cardiac catheterisation laboratory was going to be based in the north west. It was announced by almost ten Ministers and 30 Deputies in recent years.

Deputy Bobby Aylward: They were all from one region.

Deputy Marc MacSharry: What is the outlook on that proposal? I understand a letter is going from Mr. Breslin's office today to Waterford. That is good news. Did any such letter leave his office relating to Sligo?

Mr. Jim Breslin: There is not one leaving today, anyway.

Deputy Marc MacSharry: What is the state of play? It has been announced many times in the media by various political interests. I am interested to know whether it is political spin or waffle and whether is it coming.

Mr. John Connaghan: We can search Mr. Woods's mind on that point.

Mr. Liam Woods: There is a proposal from cardiology in Saolta to put a facility in Sligo. We are in dialogue with Saolta on that. It is not at the stage of getting a letter from Mr. Breslin but it is subject to dialogue between us and them.

Deputy Marc MacSharry: What does dialogue mean?

Mr. Liam Woods: It means we are talking about it.

Deputy Marc MacSharry: It means it is on the never-never.

Mr. Liam Woods: No.

Deputy Marc MacSharry: The Minister would have been wrong to say he was putting a cardiac catheterisation laboratory facility there. Is that the case?

Mr. Liam Woods: That is not the case at all. It simply means that we are at the moment in the process of discussing it.

Deputy Marc MacSharry: Is Mr. Woods saying that, theoretically, it is possible or that it is definitely going to happen?

Mr. Liam Woods: I would only go so far as to say we are in dialogue about it. We would need to conclude that before I can give a definitive answer.

Chairman: I ask Mr. Woods to provide the committee with a detailed note on the matter.

Mr. Liam Woods: I am happy to come back to the committee on it.

Deputy Marc MacSharry: Is it accurate to say that a decision has not yet been made?

Mr. Liam Woods: Correct.

Deputy Marc MacSharry: That is different to what is stated in the newspapers. I thank Mr. Woods for clarifying the position.

Deputy Kate O'Connell: Earlier, Mr. Woods referred to charges, private sector fees and non-payment of clinical costs. Will he elaborate on how this sort of thing emerges because I am genuinely unsure what he was talking about? For example, is it about people not paying the €100 fee at the hospital desk or non-payment by the health insurers?

Mr. Liam Woods: I think the Deputy is referring to a dialogue we had about receiving income from health insurers-----

Deputy Kate O'Connell: Yes.

Mr. Liam Woods: -----for patients who choose to be treated privately in public hospitals.

Deputy Kate O'Connell: Yes.

Mr. Liam Woods: We are having difficulties with that. It is a significant financial issue in the hospital environment. Some €73 million of our deficit in the acute system last year related to that issue.

Deputy Kate O'Connell: Is this a new issue that has emerged in recent times or has it been a constant problem for the health service?

Mr. Liam Woods: It is relatively new. It probably dates back two years at most. Mr. Mulvany, the chief financial officer, can confirm that.

Deputy Kate O'Connell: In Mr. Woods view, does this have anything to do with the disentanglement of the private hospital system from the public hospital system as proposed under Sláintecare? It seems coincidental that this happened around the same time.

Mr. Liam Woods: It would seem to relate more to insurance companies actively managing the cost of claims from their point of view. There is no indication that it involves any particular policy shift.

Deputy Kate O'Connell: Perhaps it is just a coincidence. Essentially, the guts of €73 million is outstanding, which we could do with, I am sure. How is it proposed to recoup it? Is there a plan or is it a litigious situation?

Mr. Liam Woods: We had indicated that we are looking at all the options we can take, including potential legal options with a view to recovering the income that is due to the hospitals.

Deputy Kate O'Connell: Is it €73 million annually or is that a cumulative figure?

Mr. Liam Woods: It is likely in 2018, on current trend, to disimprove.

Deputy Kate O'Connell: For us or them?

Mr. Liam Woods: For the public health system.

Deputy Kate O'Connell: I thank Mr. Woods. Will he provide the committee with the data on outstanding moneys and the trend over the last number of years?

Mr. Stephen Mulvany: There are two issues arising. The €73 million is the deficit for 2017 in accruals relating to income. The private charges issue in total is all of that. It is important to say that there are two issues in terms of the actions of the insurers, one of which is what could be referred to as retraction, where they are disputing from when we cant start charging and this is giving rise to what is called bad debts or us providing for bad debts. The second issue-----

Chairman: Is Mr. Mulvany saying that even though the HSE knows there is an issue, it has taken into income and is now considering what it might have to be provided against? Was it prudent to take it into income in the first instance?

Mr. Stephen Mulvany: These would already have been in income.

Chairman: It was in income already.

Mr. Stephen Mulvany: What the insurers have done - my recollection is that this started in mid to late 2016 and it started with one insurer - is they have started saying that we can only charge from a certain date of a form being signed not from admission and-----

Deputy Kate O'Connell: They are saying this?

Mr. Stephen Mulvany: The insurers are saying this. They have retrospectively withdrawn money from us. The second issue, which is bigger in terms of its impact, particularly in the context of the 2017 figures, is what we would refer to as the insurers' campaign to encourage their members not to use their private insurance when they are admitted through the emergency route, which people are quite entitled to do. From memory, this has caused the bigger difference between income in 2016 and 2017. The first issue is that relating to retraction, in respect of which we are identifying all of other options and will then pursue one of them. We are engaging with the Department of Health in this regard. In regard to the campaign, we are also engaging on it, but that is a different issue and it is people's entitlement, albeit, as indicated, it is-----

Deputy Kate O'Connell: What recourse does the State have in this matter? It appears that

the insurers are playing hardball. Are they in the driving seat? Private sector insurers, which are sector profit-making organisations, are steering the ship.

Mr. Stephen Mulvany: There is a complex set of issues. We will not know the answer to that until we bottom out our actions and then pick one on the retraction issue. The campaign around encouraging members not to use their insurance is a related by slightly different matter. It is the first issue that is most important.

Deputy Kate O'Connell: The retraction issue is serious.

Mr. Stephen Mulvany: Yes.

Deputy Kate O'Connell: The tail is wagging dog and so on. As a committee, we need to look into this matter.

The issue of agency staff was discussed yesterday at the meeting of the Joint Committee on Health. Mr. Woods said earlier that 20% would be the differential in the context of agency staff but that would depend on the job involved. Are we taking into account the considerations, such as pensions, sick pay and so on, that come with the public sector job? I imagine that agency staff do not have the benefit of the public sector pension and I am not sure what their sick pay entitlements are, although I imagine that the latter come via the social welfare system. In regard to the average of 20%, does that take into account the terms and conditions of the staff member? Is it a net figure?

Mr. Stephen Mulvany: As the Deputy rightly indicated, it is a complicated calculation. It varies by staff category. The overall premium is much higher for medical staff and it is at its lowest for what we call support staff such as care assistants.

Deputy Kate O'Connell: Does it include the pension?

Mr. Stephen Mulvany: Typically, the comparison does not. Obviously if one does include the pension that makes a difference. More and more agency employed staff are becoming entitled to similar conditions as directly employed staff, and rightly so I am sure but not the pension yet.

Deputy Kate O'Connell: The average 20% variation does not take into account pensions so one could argue that the differential would be less if those benefits were taken into consideration. Is that correct?

Mr. Stephen Mulvany: Yes. What we might do, perhaps, because it is a complex issue, is set out for the committee on a page the elements for the different categories and so on.

Chairman: And the different categories, such as home help versus nursing versus locum doctors and so on.

Mr. Stephen Mulvany: Yes.

Deputy Kate O'Connell: When locums are long term employed by the HSE, does that involve extra benefits? Is that the point that was being made or have I, perhaps, misinterpreted it?

Mr. Stephen Mulvany: No. What I mean is that, over time, employment legislation has required that the basic pay of a person employed through an agency versus an individual who is directly employed has to be the same. As I understand, they are not also eligible for annual

leave entitlements but I am not sure of the situation in regard to sick leave. Progressively, the difference between agency employed staff and directly employed staff is being narrowed but it has not been narrowed completely.

Deputy Kate O'Connell: Continuity of care was mentioned. When we talk about qualitative analysis in this area, what variable is brought in because if staff are changing all the time there is a lack of continuity of care and a lack of morale usually in departments. What variable is used to take that into account in compiling these figures?

Mr. Stephen Mulvany: There are concerns that a continually changing series of agency staff coming to a ward or a clinical area is not as good as having the same people. If one is luck enough to have an agency-----

Deputy Kate O'Connell: My question is has this been factored into the analysis? I know it is not as quantifiable as money but is there an actuarial sum that is taken into account such that we can compare apples with apples?

Mr. Stephen Mulvany: There is no actuarial sum. What we often do is say that even if the financial difference was very small we would prefer to have continuity of staffing. This can be achieved with certain usage of agency staff but in a lot of cases, it cannot. One rings the agency when a single shift needs to be covered but one cannot be sure who will turn up.

Deputy Kate O'Connell: When it comes to discipline, does the HSE have the same jurisdiction over agency staff as it does over directly employed staff? In other words, are agency staff and directly employed staff subject to the same HR rules and are they answerable to the agency or the HSE?

Mr. Stephen Mulvany: We are probably straying into an area where I am out of my comfort zone, but I understand that if we are unhappy with an agency member of staff - in general terms - we can request the agency to not provide that staff member.

Deputy Kate O'Connell: If they are becoming entitled to long-term rights, surely they would be due redundancy.

Mr. Stephen Mulvany: I was not indicating that they were becoming entitled to rights. I was indicating that the pay differential between the basic pay received by the agency person and that received by a directly employed member of staff is being narrowed because the agency has to provide them with annual leave and the same salary as the directly employed staff. They would not be establishing rights with the HSE, as far as I understand. They are separately employed by an agency company.

Deputy Kate O'Connell: I will now move on to the deficit of child psychiatrists. Mr. Connaghan said that this came to the fore in 2017 but I have been aware of issues in Wexford and in the south of Ireland for many years. I argue that 2017 is not the right year. I have been told, anecdotally, that it is not just about the consultants, it is about the team that is under the consultants. In situations where the HSE tries to attract people into the State by teleconference, is it not a big issue for consultants who their senior registrar is, who their senior house officer is, whether the team comprises agency staff and whether they are there for a long time? I have heard that many consultants leave because they do not have control over the team. How is this being addressed when trying to recruit from abroad or are those consultants not bothered about that issue?

Mr. John Connaghan: We would always want to see people on a face to face basis. We would never do this purely by telephone.

Deputy Kate O'Connell: That is not what I am getting at.

Mr. John Connaghan: I know that, but I wanted to reassure the Deputy on that. Deputy O'Connell has raised an important point about where we want to go, which is also dear to my heart. Mr. Breslin has previously described a system we eventually want, with much greater delegation and responsibility at local level. From my perspective, this means empowering local clinical directors, at local level not just at group level, to have as much delegated responsibility and authority as possible. That includes budgetary authority as much as possible and responsibility for the team. We do not have this on a universal basis, but it is in some places in Ireland. To my mind, this is a good direction to aim for. I say this because the kinds of decisions that are made at local level cannot really be made 15 or 20 miles away. One needs to be able to make decisions as they happen on the ground with regard to staff, team deployment, team working, analysing the workload ahead and sorting out the resources appropriately. To answer the Deputy's question, if we can get interest for that type of delegation, and if we can put in the appropriate training to make it happen, then this will be a good thing to look forward to in the future. I have spoken to a group of clinical directors on this very subject and I know that clinical staff would really warm to that idea.

Deputy Kate O'Connell: To be parochial, the former Mount Carmel Hospital is now a step-down unit run by a private operator. I live very near to the unit and walk by it a lot. I understand there is very poor occupancy there. Does the provider get paid regardless of how many beds are filled? Perhaps the witnesses cannot answer this today as it has just arisen recently. There are abandoned operating theatres there. The car park has grass growing through the pavements. I believe that sometimes there are only 20 or 30 people in the place. Does the cheque get paid no matter what the work is? Perhaps I am being parochial, but could I get an answer to this? Could we have sight of the contract that was awarded to that company? When is it due for review? What are the terms and conditions of that company taking on the contract?

Mr. Stephen Mulvany: We will follow it up.

Chairman: Will the witnesses please send in a detailed note on this to the committee?

Deputy Kate O'Connell: It is important. I am not against the practice, but we want to make sure we are getting value for taxpayers' money.

With regard to cervical cancer screening, Mr. Breslin explained very well about the trigger and so on, which I totally understand, but we are still not randomly auditing. Obviously, there are the women who have the diagnosis of cervical cancer, but are there proposals to do random checks? I have asked this before at other committees. Are there plans to check random slides of those who do not have a cervical cancer diagnosis? Have we to wait until there is a diagnosis? Will we do a random audit of the slides that have been taken over the last few years?

Mr. Jim Breslin: Dr. Scally is looking at the quality assurance mechanisms that currently operate. There are significant quality assurance mechanisms in place. In either his interim or final report Dr. Scally will identify if further checks could be introduced. We will certainly act on any recommendations he makes.

Mr. John Connaghan: I believe the Deputy was not in the room earlier when we advised that we hoped to be able to announce that a clinical director for the CervicalCheck programme

will be announced next week. That person - whoever it is - will have a key interest in and a decision-making role around that.

Deputy Kate O'Connell: I thank the witnesses.

Chairman: Before I call Deputy Aylward, I remind those present that this session started at 2.30 p.m. If someone needs to step out for a break, I will not stop the meeting because we will lose our momentum. I hope that we will conclude by 5.30 p.m., but do not hold me to that.

Deputy Bobby Aylward: I am going to be brief.

Chairman: We will aim to finish at 5.30 p.m. but if someone needs to step out, please do.

Deputy Kate O'Connell: Can I ask one more question? It is not really a question, but it is relevant. I spent yesterday morning at the Joint Oireachtas Committee on Health. Mr. Woods, who holds a senior position in the HSE, was there. I am aware that Mr. Breslin also has a lot to be doing, as I am sure all the witnesses do. When do the witnesses actually get to do their day jobs if they are at committees all the time? I am being deadly serious. I almost feel that I should be sending the witnesses Christmas cards because I know them so well. This is serious. If a witness such as Mr. Woods is the chief of operations of acute hospital services, surely he has better things to be doing than sitting here since 9 a.m. I am delighted to see the witnesses, but when is the work done and when are operations directed?

Chairman: I just want to concur with everything Deputy O'Connell has said. It is not that the witnesses have better work to do; it is other work to do.

Deputy Kate O'Connell: Other work, yes. Who is directing operations?

Chairman: I asked the same question. There was a time when the top six or eight senior gardaí were before the committee on a regular basis. I asked, "Who is out catching criminals if you are in here every week?" I sympathise and I appreciate exactly what is being said.

Deputy Bobby Aylward: There is accountability to be considered also.

Deputy Kate O'Connell: Yes, I know there is accountability.

Mr. John Connaghan: It is a fine balance. Today, there are no acute or primary care colleagues here. We have done our best to get answers to those questions that perhaps are not directly within our immediate remit. It is a fine balance.

Mr. Jim Breslin: The balance is between doing and explaining. I have spoken with people who are in the private sector about this and the one aspect of the position I do not get to do is reflect.

Deputy Kate O'Connell: Reflection is very important. Without it we do not learn.

Mr. Jim Breslin: The higher up a person goes in the private sector the more free time he or she has to consider strategic decisions and for refection. We are doing and explaining, and there is no time left for reflection.

Chairman: In a backhanded way, it is a compliment to all of the witnesses here.

Deputy Bobby Aylward: My only comment on that is to do with the accountability aspect of the committee. This is why we are here and that is more important. If there is not account-

ability then the whole system would break down. That is why the committee was set up.

Many of my points have already been covered so I just have two or three questions. On agency staff, why is there a need for agency staff at all if the HSE is doing its job and able to recruit qualified nurses directly? I understand some nurses want to go abroad, to travel and so on but why is the HSE not employing nurses directly? The agency is only there to make money. Instead of the HSE losing its money to agencies, which are there to make a profit, why not get rid of agencies and just have the HSE as the employer? A figure of €2.2 billion was referred to as costs for agencies, please correct me if I am wrong-----

Mr. John Connaghan: I believe that Mr. Woods gave the figure earlier.

Mr. Liam Woods: There was a quote of €293 million in total for agencies. In the acute system it is nearly €200 million.

Deputy Bobby Aylward: If the HSE was to recruit directly, there would be no need for agencies. There is a profit to be made by the agencies. They are not there for nothing.

Mr. Liam Woods: There are some reasons we will have some agencies some of the time that are just endemic in the business. Some maternity leave and other forms of leave may make sense. On the Deputy's core point, we have more agency than we want to have and we have agency in places where we do not want to have it. The challenge is to recruit to replace that. We will have some natural movement of staff that gives to agency just for short periods.

Deputy Bobby Aylward: I asked another question. How come the agencies are able to get the personnel and yet the HSE cannot do so? We have a deficit of 4:1. Do the agencies pay more than the HSE? Is it that people who have retired return as agency staff because the hours or whatever suit them better? I am puzzled by the fact that agencies can hire personnel yet the HSE cannot do so where there is a 4:1 deficit.

Mr. Liam Woods: The Deputy has made an interesting reflection. Some of that is about individual choice. A person may choose to work with an agency because he or she plans to move on or is there only for a short time.

Some of our hospitals do what they call bank, which has been the subject of discussion. They look to provide, from within their own staff, extra hours rather than bringing in agents. To go back to address the issue made about the consistency of care, maybe that is a more tenable way to attract additional staff.

Deputy Bobby Aylward: In general, do the agency staff comprise more of people who have retired from the HSE? Do older people who have retired from the HSE on a pension resume work as agency staff? Do young people work for the agencies, for example, newly graduated nurses?

Mr. Liam Woods: No. They are typically not retired people from within the HSE.

Deputy Bobby Aylward: I am not going to-----

Mr. John Connaghan: ---

Mr. John Connaghan: May I add one comment? The biggest slice of cost in agency and locum is on the medical side. It should be remembered that we are in an international recruitment market in many ways so we are not fishing just in the pool of Ireland. There is inevitably

going to be some delay in terms of our ability to recruit into certain specialist posts. That drives some locums and additional agency posts.

Deputy Bobby Aylward: Has research been done on how much money could be saved if agency staff were dispensed with? Does the HSE know how much money could be saved in that instance?

Mr. Jim Breslin: I will give the Deputy the example of nursing. What we are doing in nursing is being led by the chief nurse's office in the Department but, along with the HSE and all of the stakeholders, including the nursing unions, they have produced the research on nursing under the task force on staffing and skill mix. That has been able to identify, and they have gone into a number of wards at this stage, that even if the staff nurses, the agency and the overtime are identified on a ward and it is changed to a more stable workforce, it will not totally eliminate agency or overtime. There will be somebody, unpredictably, who gets ill and is gone for a period and somebody has to be called in. If annual leave, training courses, all of the natural things that happen in a year and so on are built into the roster and there are sufficient staff to cover that, it saves money, the quality of care indicators go up on that ward, the actual care that people receive improves and staff satisfaction goes up as well. We are successfully rolling out that model to wards across different sites and hope to do that across the whole hospital system.

Deputy Bobby Aylward: I want to discuss the capital surplus of €8 million in 2016 that was carried into 2017. Why? Every country is crying out for capital spend and new projects. Why was there a capital surplus of €8 million? We could have spent that sum.

Earlier the Comptroller of Auditor General asked why the HSE had not complied with its statutory responsibility to obtain the required ministerial sanction at the time of the Comptroller and Auditor General's audit. Has sanction been subsequently obtained? Why was there a surplus? Why did the HSE not get the permission of the Minister?

Mr. Stephen Mulvany: The €8 million is the surplus at the end of 2017. It is on a capital sum of more than €400 million. It is generally down to timing differences, in terms of when we order something and when we pay for it. Fundamentally, all of the underlying capital budget will be utilised as soon as we get the necessary approvals to carry it forward.

On the €14 million, we have sought the necessary formal sanction from the Department, and I understand that the Department is engaging with colleagues in the Department of Public Expenditure and Reform. That is a thing which goes through a process and the process is-----

Deputy Bobby Aylward: Is there a danger, when the sum of €14 million is not spent, that the Department or the Minister says that the money was not spent this year so the sum of €14 million is cut for next year?

Mr. Stephen Mulvany: The €14 million was the surplus at the end of 2016. The purpose of the sanction is to get approval, or not, to keep that surplus and use it for capital purposes. The outcome of the Deputy's question will depend on whether the sanction is granted.

Deputy Bobby Aylward: Why did the HSE not get the Minister's approval or seek same? I refer to what was said by the Comptroller and Auditor General.

Mr. Stephen Mulvany: We did seek it. The Comptroller and Auditor General has confirmed that we did not get it. We have sought it from the Department. I understand that the Department has-----

Deputy Bobby Aylward: Has sanction been granted since?

Mr. Stephen Mulvany: Not yet.

Deputy Bobby Aylward: Is it still not sanctioned?

Mr. Stephen Mulvany: It is still not sanctioned.

Deputy Bobby Aylward: Is there a question mark over it?

Mr. Stephen Mulvany: I could not comment.

Mr. Jim Breslin: A couple of question marks.

Deputy Bobby Aylward: I ask the Comptroller and Auditor General for his opinion.

Mr. Seamus McCarthy: I do not know why it has not been sanctioned.

Chairman: The Secretary General of the Department of Health to answer.

Mr. Jim Breslin: There are a couple of things. We certainly would not cut somebody's future budget because they did not spend money. That is a real recipe for having people just throwing money up against the wall, as it were. The capital budget for next year and the year after remains the same. It is a question of both our having to do some work with our colleagues in the Department of Public Expenditure and Reform from a legal point of view on how it interacts with the Health Act, and us then having to make a judgment call. Do we roll that over so the capital spend in the subsequent year is available or, in a situation where there is a revenue overspend, do we say that one has to be set off against the other? If there is an overspend in one area and underspend in the other, is it possible to come forward looking for the underspend to be carried over if one has not come within one's budget?

Deputy Bobby Aylward: It does not affect the money overall.

Mr. Jim Breslin: No.

Deputy Bobby Aylward: I want to ask about clinical expenditure on primary and medical care schemes and rebates in terms of pharmaceuticals and manufacturers. The figure has increased by nearly 45% from €76 million to €110 million. Why was there a significant increase in just one year? The sum increased by €34 million in one year, which is major money.

Mr. Stephen Mulvany: I will check. What is the number of the page?

Deputy Bobby Aylward: It is pages 167 and 168. Note 8 refers to the receipts under clinical expenditure in primary care. It shows that there has been a 45% increase in one year, from a figure of €76 million in 2016 to €110 million in 2017.

Mr. Stephen Mulvany: There are a couple of things. We can check the actual specific details while we are here. There is an agreement with the organisation called IPHA, which is the representative body of some pharmaceutical companies, which allows us attract an additional amount of a rebate. Also, as I understand it, we settled a particular contract with a number of suppliers. There are three or four elements to it, on which I can come back to the Deputy before the meeting is over.

Deputy Bobby Aylward: There is not €34 million of extra medical card assistance in the

system. That is what I am asking.

Mr. Stephen Mulvany: No, this is about a drugs rebate.

Deputy Bobby Aylward: Is it a drugs rebate?

Ms Mairéad Dolan: It is drugs.

Deputy Bobby Aylward: The item is recorded as medical card schemes. Is it a drugs rebate? There is reference to primary and medical care.

Ms Mairéad Dolan: That is a general title for the entire section. For the pharmaceutical services, the rebate is from the pharmaceutical manufacturers and then there is a further €5 million below in our corporate area. There is a combination of an improved agreement with the IPHA and additional drugs coming on stream. In 2016, the new contract with improved terms came in halfway through the year so there would be the impact of increased IPHA rebates in 2017 as well.

Deputy Bobby Aylward: Will the drug rebate increase year on year? Is the increase a one-off?

Mr. Stephen Mulvany: It is a saving. It is a rebate.

Ms Mairéad Dolan: This is an income, if one likes.

Mr. Stephen Mulvany: We are saving money. We did a deal with the-----

Deputy Bobby Aylward: Were savings made last year?

Mr. Stephen Mulvany: Yes. It is unusual.

Deputy Bobby Aylward: The figure has increased from €76 million to €110 million but Mr. Mulvany has told me that it is a saving.

Mr. Stephen Mulvany: What is seldom is-----

Ms Mairéad Dolan: It is not a cost but an income. It is a rebate, received by us.

Chairman: It is a refund from the company for overpaying in the first place.

Mr. Jim Breslin: We concluded an agreement with the industry and that agreement increase in 2016. When product was ordered at the end of the year, the manufacturer, before the agreement, would have given us a rebate of 5.25% and we negotiated an uplift of 5.5%. We estimated that that would deliver us €50 million per year in winning that concession. That is a saving overall on that agreement that we estimate to be about €600 million. That was an agreement done by the HSE, the Department of Health and the Department of Public Expenditure and Reform.

Deputy Bobby Aylward: Is this a good news story?

Mr. Jim Breslin: That is the one good news story of the day.

Deputy Bobby Aylward: Did I read the figures wrong?

Mr. Jim Breslin: The Deputy was right to raise the question because it is a significant varia-

tion.

Chairman: Deputy Aylward was right to highlight the matter.

Mr. Jim Breslin: I thank Deputy Aylward for the opportunity.

Deputy Bobby Aylward: That is the bonus for the day. I want discuss primary care. The Sláintecare report is a ten-year programme that has been rolled out. We all hear about primary care. We, as politicians and Ministers, refer to primary care and the Departments keep promoting primary care as the way forward and as a means to keep people out of hospitals and accident and emergency units. How far has the Sláintecare report on primary care advanced? How much will it advance over the next couple of years? We all want primary care. We all want to provide assistance that keeps people in their homes and out of hospital. Will the HSE comment on the matter and on the Sláintecare report in general?

Mr. Jim Breslin: Certainly at the health committee the Department was very anxious to try to support the all-party consensus that was produced by the committee and the Minister has been very supportive of it. Work is under way to try to bring that into an implementation plan. If I were to pick one element of the overall Sláintecare vision, it is that piece around primary care and moving some of the work that happens in hospitals back into the community, but also intervening earlier in more accessible care such as home care and self care so that people, increasingly, manage their good health. We are very strongly supportive of that.

We are doing some things in advance of the finalisation of the implementation plan. As we discussed earlier, we have opened negotiations with the Irish Medical Organisation on a new GP contract. A key priority for us in that would be chronic disease management, so that somebody with diabetes or chronic obstructive pulmonary disease, COPD, would not have to wait for an exacerbation of their condition and end up in hospital but would have it managed in primary care. We are also rolling out community nursing and in particular advanced nursing in the community. Somebody with asthma or another respiratory problem such as COPD would have an advanced nurse that would be trained in respiratory illnesses and, under a protocol, either in the primary care centre or in somebody's home they would be able to visit them over the course of a year and prevent their admission into hospital.

When we look at the type of money that we spend as a country, we have now reached a point where we are spending at least the average if not above the average. In total terms we spend the eight highest of OECD countries. In terms of public expenditure we spend the 12th highest of OECD countries but we do not manage as well as some others because we have people who are not accessing services in the right way and we need to develop primary care and make sure it is more accessible. We have done the research on this, and if we do not do that, when we look at the capacity we will need to put in place to respond to an ageing population, we just could not afford the type of numbers of acute hospital beds that we would have to put in place to continue with the model we have got. It is not even a case of affordability. We could not staff them or find space on the hospital sites that we have got, so we have to put the emphasis on primary care and also to put a statutory scheme in place for home care. There is a clear consensus now across all areas of the House in relation to that and it is one that we would be very anxious to deliver on with colleagues in the HSE over the next ten years to try to realise that vision.

Deputy Bobby Aylward: This will be rolled out with the help of GPs who will provide the primary care. Some GPs have tried to start up primary care centres but they have had to get out of the business because they could not afford it. Is money the problem in terms of getting GPs

to work together? Usually what happens is that three or four GPs come together and they build a primary care centre with the grants that are available but some have failed. Is that the model going forward? We have to make this work on the ground and convince GPs that it is worth their while to come together and give the service that has been outlined, whether it is dentistry or whatever else. We have a couple of examples in my county of Kilkenny which are very successful but other places are starved of such a service. What is the problem?

Mr. Jim Breslin: One of the things that happened relates to the crash and the effect of that on property at a time when GPs were seeking to develop group practices. They had invested in properties and the centres did not fail for healthcare reasons, but in some cases they were caught by the property bubble and the financing. We have now got a very significant programme of primary care centre roll-out. We are rolling them out as direct builds by the HSE. Where the HSE owns centres we are rolling them out as leases, where the HSE leases the primary care centres.

Deputy Bobby Aylward: Does that mean the HSE puts a building in place and rents it out?

Mr. Jim Breslin: The HSE gets a builder to build the primary care centres and it puts its own staff in it. It can also put other staff in it. Alternatively, the HSE leases the centre and often when it leases it, it will lease it from a developer and the developer will also lease part of the facility to GPs.

The third option is PPPs. We now have a public private partnership programme under way with funding in place from the European Investment Bank to put in place a programme of primary care centres. Right across this year we have openings of primary care centres. We will have to keep going at that for the next couple of years but we have a significant upgrade in the infrastructure of primary care. It has to be modernised if we are to say to people that healthcare is not all about hospitals, it is also about primary care facilities.

Deputy Bobby Aylward: That is good news. This is my last question. I accept it is not under the remit of the Department but I wish to ask about the National Treatment Purchase Fund, NTPF. What is the role of the Department? Does the Department play a part in the management of the scheme and getting operations and reducing waiting lists? Does the Department negotiate with the NTPF, assist it and try to co-ordinate its work?

Mr. Jim Breslin: The National Treatment Purchase Fund is another body under the aegis of the Department of Health, just like the HSE, but obviously it is a smaller body with smaller funding. We do put a programme of work in place with the NTPF. The one that is most familiar to people is tackling waiting lists. We have a significant programme of work under way this year and we are already seeing a reduction in inpatient and day case waiting lists as a result of that. There are two components to it; there are treatments in private hospitals on the island and also in one hospital in Northern Ireland, and then it also has funding available to the HSE where it can come up with a discrete proposal to do extra activity within HSE facilities.

I know the committee had the NTPF in last week. The Department has given the NTPF, under the nursing home subvention scheme, responsibility for negotiating pricing with private nursing homes. It has done that since the initiation of that scheme. It negotiates the prices; it does not pay the money. The payment is made by the HSE to the private nursing homes. The reason for that is that if the HSE were to do it, one could perceive a conflict because it also has its own facilities, so we separated that function out.

Deputy Bobby Aylward: One can also go to Europe for treatment. Could Mr. Breslin explain the system to me? People have asked me about it and I want to be able to explain it to them.

Mr. Jim Breslin: There are a couple of European schemes. The one the Deputy is probably asking about is the cross-border directive. That entitles one to go to another European country for a large number of treatments, but not for every type of treatment. One can get the cost of the treatment that would be borne in one's own country. One has to pay one's own way. One has to pay for flights and one has to pay upfront to the facility elsewhere but when one comes back, one can apply to the HSE for the cost of that treatment. If one went for a hip replacement or an eye procedure, one would get the price of the hip or the eye procedure in Ireland.

Deputy Bobby Aylward: Is it still paid for by the taxpayer?

Mr. Jim Breslin: It is paid by the taxpayer. The schedule of those prices is published. The other thing for people to be aware of is that very specialist treatment that is not available in Ireland but is available in another European country can be accessed through a European scheme. One's consultant here would refer one to another facility elsewhere in Europe and one could get treated there and that would be as part of public healthcare which means one would not be charged. They are two good schemes.

Deputy Bobby Aylward: Does the HSE pay for that as well?

Mr. Jim Breslin: As a country we would reimburse people. If one went to England for that, which is possible until Brexit happens, or France, we would pay the other country on a knock-for-knock basis.

The final scheme, with which people are more familiar, is the European health insurance card, EHIC, and one has an accident in a European country, we would pay for that as well.

Deputy Bobby Aylward: Could we get a bit of information on that? I would like a written explanation.

Chairman: We will conclude on that particular topic. Mr. Breslin can send us a note on the three schemes and how they work. I have some questions to put myself. The good news for Deputy Aylward on the cross-border initiative is that it is managed and run in Kilkenny.

Deputy Bobby Aylward: That is better news altogether.

Chairman: Any query I ever had I had to get approval from Kilkenny.

Deputy Bobby Aylward: They are always efficient down there.

Chairman: Absolutely, the system is working well. I have a series of questions to put to the Department. Some of these issues relate to process and some relate specifically to the financial statements. I hope Mr. Mulvany is listening.

I would like an update on an issue that has crossed our desk recently. I do not want the response now. It relates to the Harold's Cross hospice. There was a HSE internal audit report about a property being disposed of, allegedly, at a serious loss. We have discussed the issue. I know it has been reported to the Garda by some individuals. We want the witnesses to send us a detailed note, insofar as they can. We do not want to cut across any other investigation.

The second item corresponds to something we mentioned in the information that was sent about what we would raise, namely, dental treatment for high-risk patients. I refer in particular to Irish people with an intellectual disability or sensory deficit who can be either blind, deaf or dumb. Some dental surgeons are now getting letters in regard to them. They had a routine system for these high-risk patients for the service to be approved. They have now received letters from the HSE asking for documentary evidence of a person's medical condition to justify the high risk. They took that up. I have a letter here from the HSE Mid West Community Healthcare which states it has always been the case that there needs to be a record of the high-risk patients. Henceforth, it says, the HSE will audit a sample of approvals.

Is the approach in that region consistent across the country or is that region on its own? It seems to be a severe issue that if somebody is deaf and dumb, and it is well known and they are in the service year after year, he or she is all of a sudden subject to medical audit of his or her condition. Does Mr. Connaghan understand the query?

Mr. John Connaghan: Yes, I understand the query. We sent the committee some briefing but I do not know if it covers that query.

Chairman: Mr. Connaghan gets the point. We want a bit of clarity on that.

Deputy Cullinane mentioned the consultants' contract and the enforcement issue which led to the private security people's actions. This came up at the committee in February. I subsequently asked the Minister for Health a parliamentary question about whose job it was to ensure the consultants comply with their contract. The reply I received from the Minister on 14 February said it was the responsibility of management to make sure these contracts are enforced. Mr. Connaghan gave us some details about the percentage of inpatient discharges that are private versus public. If the HSE's managers had been doing their job, there would have been no need to hire private security firms. It looks as if when the HSE went to court, it could not prove its case around the mix of public and private because its hospital managers were not doing their job to start with. It could not verify or stand over them, which is why it had to go to an external source.

What robust measures are in place to ensure hospital managers make sure the consultants comply with the contracts in their area? The HSE sent a detailed note about the role of the clinical director, the responsibility of the hospital CEO, the responsibility of the group CEO and the responsibility of the national director. Much of it seems to have fallen on the hospital CEO. Formal arrangements should be in place with the clinical directors to review and report on individual contract performance across compliance with contracted hours as set out in the practice plan. Is that happening in each hospital? We have been here before and were told circulars had been sent out so we all assumed they were being implemented. We cannot assume anything.

Mr. John Connaghan: In the briefing, there is a 2018 response to that question, which is different from where we were in previous years. I will ask Mr. Woods to put a little colour on that briefly.

Mr. Liam Woods: On the issue of compliance, the process was documented, as the Chair said. Yes, that is actively managed. It is part of the dialogue between me and a hospital group as we meet monthly. It is also subject to return to me by way of assurance from a hospital group that they are complying, and if they are not they flag the issues. There is a process and a strong management practice around it. The process is basically as outlined in the consultant contract itself. The clear focus needs to be on managing exceptions. Overall, compliance is quite high

and the public work is approximately 83% of the total.

Chairman: How many consultants are covered by these arrangements? What are the ball-park numbers?

Mr. Liam Woods: In the acute system there are approximately 2,700 to 2,800.

Chairman: Would 50 of those be a cause of concern? I would like to get a feel of the scale of the problem.

Mr. Liam Woods: If one looks at the changes in recent times, there has been significant improvement in some sites in the past number of months. In my monthly reporting, I do not get individual levels. What I look for is assurance from groups they are exercising the process. We will also make returns to the Department. September is our deadline for that in terms of overall compliance with national process.

Chairman: On a hospital by hospital basis or a regional group basis?

Mr. Liam Woods: From my point of view, it will be group, but it will be available from group to hospital.

Chairman: Okay. Has any action been taken on any of these yet?

Mr. Liam Woods: Yes, there is action in reality on the ground between clinical directors and a small number of consultants in practice.

Chairman: What does "in practice" mean?

Mr. Liam Woods: It means if their practice is going over the limits set in their contract, which may be 20% or 30% depending on the contract, that is part of a discussion. Their work plan, which the Secretary General referenced, and their public commitment are also to be set out and reviewed, and that is happening.

Chairman: Okay. Will Mr. Woods tell us the list of vacant posts in the HSE at the moment? We are told in some cases there are more vacancies than people applying across the different categories. How many unfilled positions are out there? It is not specifically what is filled by agency. People would like to know, where there is approval for X number of consultants, X number of non-consultant hospital doctors, NCHD, right down to nursing and theatre staff and so on, how many unfilled posts are out there. I suspect the witnesses do not have that information here now, but HR must have a summary of unfilled posts.

Mr. Liam Woods: There is a list of consultants - we do not have it with us as the Chairman says - which we could make available of posts that are vacant or temporarily filled for which we want to recruit.

Chairman: Is that available across the board?

Mr. John Connaghan: It is available in the back of the mind. I cannot quote the exact-----

Chairman: I do not need it. Send us the information.

Mr. John Connaghan: Roughly 10% of our consultant posts are vacant. We have approval for approximately 3,300 posts, and I will check the figure to make sure it is accurate, as against 2,971 posts as of the end of December.

Chairman: Nurses were mentioned earlier. Will Mr. Connaghan give us the figure across the different headings?

Mr. John Connaghan: I am not sure where we are in terms of surveillance at a national level on nurses but I can check that out.

Chairman: On the CervicalCheck issue, I do not understand why everyone is using the word "audit" all day. I would have thought it was very simple. If somebody is diagnosed with cervical cancer, the obvious thing to do would be to look at whatever information is on file in the system about that person. That should include any screening that was done. An audit is not needed. If somebody is diagnosed, the first thing should be to look at his or her medical history. We should not call that "audit", it is basic patient management. I do not see why checking a person's medical records has to be called an audit process.

Mr. Jim Breslin: That makes a lot of common sense. We will see how Dr. Scally describes it. One of the causal factors is that it is not a singular relationship with that woman. She had a smear test taken by a GP that was sent to CervicalCheck, which dealt with it, and that is in the past. Through some other process, however, she may have symptoms, and she finds herself in a hospital with a consultant who was not engaged on that prior history at all.

Chairman: I understand that. The files can be in four or five different locations.

Mr. Jim Breslin: It is about bringing it together, which is where we fell down.

Chairman: Yes. I would not call that an audit, from a layman's point of view. I would simply call it getting the person's full medical information that is in the system. We have put a mystique around this by needing to do an audit.

Mr. Seamus McCarthy: There is a re-reading of the test, that is the element that would bring it into this area. It is a repeat reading of the screening.

Mr. Jim Breslin: It was mentioned earlier the origins of this were in CervicalCheck itself saying "let us have a system audit", asking if it had a check on how its systems work or if it had any system problems. It then moved to it having information that was relevant to women and to feeding it back, but in its genesis it was for educational, training and quality improvement purposes.

Chairman: In the chart given to the committee which was referred to this morning, the process starts with a national screening programme letter inviting women to participate in free cervical screening. At the bottom, it says a letter advising women of the availability of results and recommendation has also been sent to the GP. Are we saying that in all these cases the GP has something in his or her file in the surgery relating to all these cases?

Mr. John Connaghan: The GP has it both electronically and by post. There is a double-----

Chairman: Why did we have this debate about who should inform the patient - the consultant, CervicalCheck or the GP if I am now being told that at all times the information was in the GPs' surgeries?

Mr. Jim Breslin: The pathway here is different. If a smear test was done with one's GP and it was a normal result, the GP will be informed of that. The GP will talk to the person about it the next time the person is in. If it is not a normal result, the person will be sent for a colposcopy clinic for further investigation. If one stays with that GP, one will continue to have a conversa-

tion with the GP if the colposcopy finds something. However, it is not the GP who guides the person through the next stage when an abnormality is detected. It is the specialist service.

Chairman: I get the point. Mr. Breslin will be happy about the following. The last day he was here we asked about the introduction of the regulation for the Civil Liability (Amendment) Act, and during the course of the meeting, he gave me a timetable for the end of June-----

Mr. Jim Breslin: Done.

Chairman: He just about got there. I saw in this morning's newspaper that it was signed. When did Mr. Breslin get the Minister to sign it?

Mr. Jim Breslin: He signed it last night, I believe.

Chairman: The Committee of Public Accounts, I suspect, will take some credit for getting-----

Mr. Jim Breslin: It can take some credit. I would note that the same people who were doing it were doing the Patient Safety Bill, which was before Government today, so we want to get those two things done. That was our objective.

Chairman: It would be unreal talking about mandatory disclosure, if one had not already put the regulations in place.

Mr. Jim Breslin: The mandatory disclosures are in the Patient Safety Bill and the regulations the Minister signed last night are-----

Chairman: Separate.

Mr. Jim Breslin: -----for the voluntary process.

Chairman: Yes, under the Civil Liability (Amendment) Act. The presence of Mr. Breslin today is good and timely and it has helped. It was not the only reason but it helped to get it over the line.

We will now have questions on the financial statements which is the reason the witnesses are here. I refer to Mr. Connaghan's opening statement. There was a deficit of €139 million being carried forward from the end of 2017 into 2018. I understand that is called the first charge on the 2018 financial statements. There is a paragraph in the accounts which states that section 33(3) of the Health Act 2004, as amended, requires the HSE to manage and deliver services in a manner that is in accordance with an approved service plan, and within the determination notified by the Minister and that the Act provides for any deficits to be charged to income and expenditure in the next financial year, meaning 2018, subject to the approval of the Minister and consent of the Department of Public Expenditure and Reform. Has this first charge, which amounts to €139 million, gone against the 2018 accounts?

Mr. Stephen Mulvany: In effect-----

Chairman: Do not say "in effect". I am looking for a black and white answer. The reason I ask is that somebody told me when the Estimate was being discussed in the Dáil that this issue came up and there was a reference to not having the audited accounts for 2017 to finalise that figure. Is there discretion on this as to whether it is the first charge? The legislation seems to be quite clear. I have read the HSE's report. There has been an assumption in recent years that

the deficit from last year is the first charge and that is the phrase used in the HSE's financial statement. Has there been the first charge?

Mr. Stephen Mulvany: There is no option. We will have to do this. By the time we do the 2018 annual financial statements, that amount of money will have to be charged in it. The issue is how we deal with in 2018, which is a separate question.

Chairman: In other words, the service plan for 2018 would not have taken the first charge into account because the HSE did not have its audited accounts done when it was doing its service plan for 2018.

Mr. Stephen Mulvany: Exactly. The service plan referenced the first charge. The fact that it, along with a number of other issues, would have to be dealt within the course of the year-----

Chairman: What is the figure for the first charge in the service plan agreed for 2018?

Mr. Stephen Mulvany: In the service plan arithmetic, there is no figure. We have not accounted for it. We have referenced an estimate of €164 million, which the service plan states will have to be addressed during 2018, once the figure is actually crystallised. Addressed means subject to discussion between ourselves and the Department of Health.

Chairman: Mr. Mulvany is starting to wobble. On the one hand, it is a first charge but now it is subject to discussion, seven months into the year. Is the first charge not negotiable? Why is that figure not in the HSE's service plan? Mr. Mulvany said there was no figure in the service plan for the first charge. I thought this was meant to be a clear issue.

Mr. Seamus McCarthy: If one looks at the revenue, income and expenditure account,-----

Chairman: Yes, I can see it.

Mr. Seamus McCarthy: -----one can see the Department of Health revenue grant of €14.156 billion, the deficit on revenue, income and expenditure brought forward is €10 million.

Chairman: This is from the previous year.

Mr. Seamus McCarthy: Yes, from the previous year. For 2018, one would be looking at the grant figure, minus the €140 million.

Chairman: In other words, the HSE is down €140 million before it starts-----

Mr. Seamus McCarthy: It is a first charge on the grant.

Chairman: It is for this year. Am I right? That figure is not in the service plan.

Mr. Jim Breslin: No. The service plan was done in November, prospectively. We now have to take account of that, as we have the retrospective information on 2017.

Chairman: We are now saying, potentially, that before we got to 1 January, we were €140 million short in our service plan.

Mr. Jim Breslin: The annual financial statement, AFS, was available in March or April, so it now forms part of the management of the 2018 finances, and it will be recorded in the AFS for 2018.

Chairman: I know but it has to be found now out of the Department grant for 2018, which

the witness did not have a figure for when the service plan was agreed.

Mr. Jim Breslin: That is right.

Chairman: A plan was agreed in the knowledge that there was a big figure there which the HSE did not know but which would be worked out during the course of the year. We are at this stage in the year and the HSE is down €140 million from the first charge that was not specifically mentioned in the service plan. The HSE is down €200 million for the first two months of the year, which was reported last week. The figure will be higher figure as the year goes on. The payments for the cervical check issue must not come out of the patient care budget. The HSE will have to provide additional resources for that otherwise it will be taken from the health services, which people would find unconscionable.

The HSE is already down several €100 million at this point of the year. It has not quantified the first charge and has already indicated that it is in an over-run situation. There is going to be another serious charge as a result of the cervical cancer issue which will have to be met upfront and the figure will be quite large before the year is out. As Chairman of the Committee of Public Accounts, I am concerned that it will not be long before we face the same issue that the health service is down hundreds of millions again.

Mr. Jim Breslin: It is a significant-----

Chairman: Give me some assurance this is being run properly. The service is receiving €15 billion. It was said this is one of the highest OECD countries in terms of total spending on health, between public and private sectors, and the eighth highest on public spend. That would leave most people saying it is a management issue as much as a finance issue.

Mr. Jim Breslin: It is the 12th highest. The Supplementary Estimate I mentioned earlier for 2017 was €195 million. It was not the type of figures that we were talking about there. At least half of it was for Government initiatives. It is not that we have repetition. We now have a figure for a first charge that is larger than the Department would have considered was likely to materialise and as a priority we are engaging to try to address that along with the other items the Chairman mentioned. That is the very detailed and intensive discussions that are going on with the HSE and the Department of Public Expenditure and Reform.

The important thing is we do that within the context of the service plan, so that the services - just as the Chairman said - are not affected. Some of the slippage in the current year relates to savings initiatives that have not yet borne fruit, that are not patient care related and we have to redouble efforts to achieve those. The Chairman is right in saying that there are significant financial challenges in 2018. There is a commitment in 2018 on behalf of the two Ministers to seek to address those and to do so without affecting patient care. However, it is going to require serious effort on behalf of the Department and the HSE to achieve that objective.

Chairman: I know it is late in the day but that is probably the most significant statement we have heard, that is, there are already significant issues facing the current budget. I know Mr. Breslin mentioned Supplementary Estimates, which is a phrase we do not use any more. I do not believe there can be Supplementary Estimates, unless savings can be found somewhere else. No, the Oireachtas still has that ability. It is within the EU rules.

Chairman: According to one of the opening statements, the Department had a surplus of €2 million and did not have a Supplementary Estimate in the year.

Mr. Jim Breslin: That was in the Department's accounts for 2016.

Chairman: That is fine. I will flag an issue related to the current position. Page 122 shows that mental health accounts for 5.5% of the total budget of the Health Service Executive. The HSE cannot be happy with that. Of a total budget of €15.229 billion, mental health accounts for €841 million or 5.5%. Is Mr. Connaghan satisfied that only 5.5% of the budget should be spent on mental health? It seems to be a very small proportion.

Mr. John Connaghan: I do not have anything in my mind that gives me a ready comparator in terms of mental health spend in Ireland compared to other jurisdictions. Clearly, we need to live within that budget. We understand the service issues that give rise to budget pressures. I do not have anything I can relate to that outside Ireland which indicates that is a good or bad figure. It is clearly historical. I point to the significant increase in the mental health budget between 2016 and 2017. I have not worked out the percentage increase but it has been more than €60 million-----

Chairman: It is maybe 8%.

Mr. John Connaghan: -----which is greater than in most of the other areas in terms of relative spend.

Mr. Jim Breslin: The increase in the budget for mental health since 2012 has been €200 million. There has been an effort to try to address this but I do not say that we have the mental health services that are required. Historically, it was an area that was not invested in.

Chairman: I have a simple question on the Department of Health grant €14.156 billion for 2017, which is shown in chart 6 on page 123. I want Mr. Breslin to send the committee a note tying that figure to the Department's appropriation account because it is not possible for us to do so. I doubt the Comptroller and Auditor General could drag that figure back to the appropriation account. Perhaps I am doing Mr. Breslin an injustice in this regard but it is not transparent from the appropriation account as to how that €14 billion arises.

Mr. Jim Breslin: In fairness to the Comptroller and Auditor General, if the Chairman had the 2017 appropriation account before the committee today, we could do that now. We will do it for the committee.

Chairman: That is what I am asking. We have the 2016 appropriation accounts and 2017 financial statement. I am asking Mr. Breslin to do this for the-----

Mr. Seamus McCarthy: As part of the audit, we would do a reconciliation and we would need an explanation for any anomalies that would turn up.

Chairman: It would be useful for the committee to see the document.

According to the second last paragraph on page 149 of the report of the Comptroller and Auditor General, the Health Service Executive is not in a position to quantify the value of its expenditure on goods and services where the procedures employed do not comply with procurement guidelines. We have had a discussion on this. What percentage of HSE procurement is compliant? Some procurement is probably non-compliant and there will be uncertainty in some cases. Can the HSE tell me what percentage of procurement is compliant?

Mr. Stephen Mulvany: What we can tell the Chairman is the amount of spend under management. We have €1.56 billion either under contracts or frameworks that can be procured out

of approximately €2.2 billion or €2.3 billion of procurable spend. We do not have a system that tells us how much of that is being complied with.

Chairman: Will Mr. Mulvany explain that? The HSE has a framework but does not know if it is being complied with. Is that what he is saying?

Mr. Stephen Mulvany: We know that we have over €2.2 billion of our non-pay spend which is procurable, in other words, it should be going through a procurement process. We know we have contracts with a nominal value of €1.1 billion, which is much higher than we had two years ago. We know we have done €460 million in framework agreements, which are not the same as contracts but similar. We know that we have €1.56 billion coverage in terms of contracts being sourced. The issue then is compliance with those contracts. What percentage of the actual expenditure, now that the contracts are in place, is being used against those contracts? We do not have a single system that allows us to have one report on that. What we are doing is that we have a compliance approval programme and we are going around, area by area, determining or estimating a level of non-compliance, and then digging into that and assessing what contracts are there locally that we can make compliant and register nationally, what contracts we need to move away from, and what items we need to put on the sourcing plan to put contracts in place. Typically, that is showing good progress. That is the second of our three-year plans. That one finishes in 2020. It is a significant volume of work. If we had a single financial system - again we are working on this - we would be much more easily able to simply run off a report. Given the scale of our operations, we simply cannot do that. That is the reality.

Chairman: In two years, committee members, whoever they are at that stage, will be able to check out the veracity of that and to whether it all happens. On page 157, it is unusual that the letter of determination from the Minister on how much could be spent in 2017 was received on 29 December 2017. Did I read that correctly? I do not know how any other organisation could wait until the last working day of the year to be told how much it could spend.

Mr. Stephen Mulvany: In fairness, that is a formal letter of net non-capital determination. That would have been notifying us of that Supplementary Estimate. We would have known for some week, if not months in fact-----

Mr. Jim Breslin: The first letter of determination would have issued in October or November of 2016. As we finalised the year, including in the Department's Vote, if there were some savings in the Department's Vote, we might fire them to the HSE. The last thing we would do before closing the books for the year would be to issue the letter of determination.

Chairman: If everybody could open page 167, please. There has already been public comment on this matter. Without identifying the person who received €980,000 in 2017, will the witnesses talk me through this? The person is on pay of €220,000, which means some €760,000 was for back pay and arrears. This covers a period since 2010, which means the person was owed approximately €100,000 per annum for each of the last seven years. Explain to the committee how this could arise?

Mr. Stephen Mulvany: In as simple terms as I can, that individual held a role which would effectively be a non-consultant hospital doctor. It was a lecturer or assistant lecturer post, as I understand. The person was asked and agreed to take on a role to provide locum for a consultant. For a lot of reasons it took over seven or eight years to fully regularise that and then make all the back payments. There was no element of settlement in it. It was simply the difference between a junior doctor's salary and a consultant's salary over seven or more years.

Chairman: Did the matter go before the Labour Relations Commission? Who adjudicated on it?

Mr. Stephen Mulvany: I am not sure what the adjudication process was. There was a long series of negotiations so it may well have gone to a third party. It did not go to the court, as I understand it. In the eventuality, the matter was agreed, there was no additional settlement costs and the back payment was made in two chunks. It is a highly unusual situation.

Chairman: That individual is a very mild person to have waited for so long.

Mr. Stephen Mulvany: A good saver perhaps.

Chairman: Mr. Mulvany is saying the HSE did not have to pay the person any interest or compensation for the late payment. More power to the person, although the figure does appear to be extraordinary.

Page 168 refers to the treatment abroad scheme, which Deputy Aylward raised. Where is the cross-border initiative in these figures? I do not see it. How much did that initiative cost in the year? Perhaps the figure is in there somewhere? What does the HSE call the scheme?

Mr. Stephen Mulvany: On treatment abroad and related expenditure, I will have to double-check the-----

Chairman: Treatment abroad is a different scheme.

Mr. Stephen Mulvany: It refers to treatment abroad schemes and related expenditure.

Chairman: The Secretary General mentioned three schemes, namely, the treatment abroad scheme, the cross-border initiative and the E111. I ask Mr. Mulvany to send the committee a note providing a breakdown of expenditure on the three schemes.

Mr. Stephen Mulvany: I will do that.

Chairman: On the same page, the cost of prompt payment interest and compensation is €869,000. What went wrong in that year that gave rise to this level of payment, which did not occur the previous year? Why did the HSE not pay its bills on time?

Mr. Stephen Mulvany: I will have to check with my colleague, Ms. Dolan, who may be able to assist me on this. The prompt payment interest itself accounts for between €400,000 and €500,000 of that figure. There is obviously some accounting adjustment between the years. That makes up the difference.

Ms Mairéad Dolan: In 2016, we had a cumulative accrual for prompt payment interest and compensation, of which we reversed a substantial amount on the basis that we had no specific evidence the compensation would be paid. We had a derogation granted to us to allow us to put better systems in place for the payment of bills to reverse that compensation element. The element that is in there this year is the prompt payment only. We do not pay any compensation.

Chairman: Would that mean that, because the HSE had the derogation from the previous year, it effectively has a payment in there covering the previous year as well?

Ms Mairéad Dolan: No, to my understanding that is pure cost paid in the year on invoices that were paid late.

Chairman: What happened? It is inexcusable that €1 million in taxpayers' money was lost because people did not process payments. That sum would go a long way in the various areas mentioned, for example, the home help service. One cannot throw €1 million out the door just for not paying invoices in time. Do the witnesses take my point?

Mr. Stephen Mulvany: We take the point. My recollection, and I will double-check the figures, was that the figure is closer to €450,000 or €500,000, but I am open to correction on that. That is still far too much. The Chairman should not get me wrong on that. I will not go into how many billions we actually spent and what percentage of the total the figure is. We know from some of the work we do around processes that the reporting and, therefore, the payment of prompt payment interest, has improved. We accept it is a figure we would like to reduce to as close to zero as possible.

Chairman: I ask Mr. Mulvany to send the committee a detailed note as to how this arose. I can only go on the figure provided, which is €869,000. I do not know what figure Mr. Mulvany is referring to.

On page 175, the report states the HSE carried out significant self-review of tax compliance in respect of 2016 with external tax assistance, which was completed in 2017. This, it adds, resulted in an underpayment of tax identified in the course of the self-review. No figure is given for the underpayment. Was it so small that it should not have been mentioned or does the reference to it indicate it is significant? How much was it and in what category is it?

Mr. Stephen Mulvany: In respect of 2016, the overall tax settlement was €2.194 million.

Chairman: Please speak slowly because I have not heard this before.

Mr. Stephen Mulvany: The total voluntary disclosure made by the HSE under the Revenue's appropriate scheme, and made in time under that scheme, is €2.194 million. This is where I will give the big figure. That is out of an overall HSE tax-----

Chairman: Do not tell me it is a tiny percentage. It is big money.

Mr. Stephen Mulvany: It is big money but it is 0.14%.

Chairman: Tax settlements are published. Is it correct that this settlement was not published because it was self-declared?

Mr. Stephen Mulvany: Yes.

Chairman: A settlement of €2.194 million would be big news. This is a big settlement, even if Mr. Mulvany considers it small relative to the HSE budget. Why did the HSE underpay tax by such a large amount? That figure relates to 2016. What was the position in 2017?

Mr. Stephen Mulvany: The issue has to be looked at in the context of the HSE being the largest employer in the State.

Chairman: Yes.

Mr. Stephen Mulvany: Most employers, including the Houses we are sitting in, will end up making settlements larger than ours proportionately. It has to be looked at in that context. If we go back to 2017, when we started this, the figure was a multiple of that, and it has reduced progressively every year since. The largest single figure in that is €1.274 million in employment

taxes, and then construction taxes, as I would describe them, at €400,000. The interest figure, and there is no penalty, has dropped from being as high as €2.2 million five or six years ago to being €104,000. Again, we would like the figure to be zero, but if we were compared with most public bodies, including this House, the HSE would emerge rather favourably.

Chairman: What were the 2017 figures?

Mr. Stephen Mulvany: I do not have figures for 2017. This year, we will do the work to make a voluntary disclosure before the end of September or October.

Ms Mairéad Dolan: We are currently doing that work.

Chairman: I ask Mr. Mulvany to send us a breakdown of the 2016 figure.

Mr. Stephen Mulvany: I can leave it with the Chair before I go.

Chairman: We will circulate it. At the end of page 176, retained interest earned on patients' private property is mentioned. I know a major programme of work is ongoing on that and a steering group is actively managing a resolution of this issue. When will it complete its work?

Mr. Stephen Mulvany: The Chairman may recall that we advised the committee that there were three phases of the work. The first phase was data gathering and the second was calculation. Those two phases are now complete. We will be ready in the next couple of weeks to pay out into the 10% of active accounts, which, unfortunately, means clients who are still alive. The balance will take us approximately nine to ten months to identify where best to repay the moneys.

Chairman: If the patient has died and there is no next of kin, to whom is the money sent?

Mr. Stephen Mulvany: That would be subject to discussions with the relevant office. Eventually it may end up in dormant accounts but our aim-----

Chairman: Who does the HSE send it to? Is it the Chief State Solicitor's office?

Mr. Stephen Mulvany: The intestate estates. I am not sure if it is part of the Chief State Solicitor's office.

Chairman: Does Mr. McCarthy know to which office it is sent?

Mr. Seamus McCarthy: The intestate estates is run by the Department of Public Expenditure and Reform.

Chairman: I ask Mr. Mulvany to send us a note on where the money goes. We want it to be transferred into the dormant accounts fund or useful elsewhere for a beneficial purpose.

I do not see any reference to the national children's hospital. Is expenditure on the new hospital provided through the HSE Vote?

Mr. Jim Breslin: At the Government today we were busy on multiple fronts. The national children's hospital Bill was going through, which will establish the national children's hospital as a statutory body. At the moment, it sits within the HSE. That is the ongoing cost of the children's hospital service. The other piece to this is the capital development, which is the national paediatric hospital development board, NPHDR, a body underneath the Department.

Chairman: Expenditure in 2017 on the national children's hospital, even though the board is not a legislative-----

Mr. Jim Breslin: Capital expenditure.

Chairman: It is under the Department. From which Vote is capital expenditure provided?

Mr. Jim Breslin: The capital expenditure goes through the HSE's accounts and is a capital grant to the national paediatric hospital development board.

Chairman: I am asking for figures on spending on the national children's hospital during 2017. Money went into the HSE under revenue and capital.

Mr. Jim Breslin: The capital is the one that is really of interest.

Chairman: The national children's hospital is a big issue and the largest capital investment programme, yet it is not specifically mentioned.

Mr. Jim Breslin: The figure will be big in 2018 when we will see it jump.

Chairman: I ask the witnesses to send the committee an update on the current position regarding funding for the project. The HSE and the Department may have to do that jointly. At this stage, we have exhausted the witnesses.

Deputy Catherine Murphy: Could I have a copy of that protocol?

Mr. John Connaghan: We will get it to the Deputy tonight.

Chairman: I thank the witnesses from the HSE and Department of Health, as well as the Comptroller and Auditor General, for their forbearance. It has been a long day. The witnesses from the Department of Public Expenditure and Reform, whom I also thank, got off lightly today. Given that the HSE is the largest State organisation with turnover of €15 billion, witnesses will understand that a discussion of seven or eight hours was warranted. We tried to complete proceedings in one day rather than have the witnesses appear on two days. I thank them for their time. We look forward to receiving the follow-up information we have requested as soon as possible. We will do a periodic report as a result of today's meeting in the autumn, for which we would like to have all the information we requested as soon as is practicable. The next public meeting will be next Thursday when the committee will discuss the accounts of the National Treasury Management Agency.

Mr. Jim Breslin: Did the committee conclude on the Department's accounts?

Chairman: We do not dispose of them. We are holding off on that.

Mr. Jim Breslin: I will provide a 2017 appropriation account very shortly.

Chairman: At the end of September. Is Mr. Breslin looking forward to an early visit?

Mr. Jim Breslin: Yes. If the committee closes the 2016 account, I will have an appropriation account for 2017 open when we next appear.

Chairman: We will do it when we make our periodic report rather than doing it every single time. We have changed our practice. We decided as a matter of principle, because we have not been able to get any transparency or accountability in respect of public-private partnerships,

that we are not disposing of any accounts where there is a significant PPP element as we have not been able to examine them to our satisfaction. We have held off closing off any such accounts in recent times. When we come to our periodic report we will do them all in a batch. That is no disrespect to the group. It is just that we have changed our procedure.

Mr. Jim Breslin: It was worth a query.

Chairman: At least Mr. Breslin is watching carefully.

The witnesses withdrew.

The committee went into private session at 6 p.m. and adjourned at 6.35 p.m until 9 a.m. on Thursday, 12 July 2018.