

DÁIL ÉIREANN

AN COISTE UM CHUNTAIS PHOIBLÍ COMMITTEE OF PUBLIC ACCOUNTS

Déardaoin, 16 Deireadh Fómhair 2025

Thursday, 16 October 2025

The Committee met at 9.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Ardagh,	Deputy Aidan Farrelly,
Deputy Cathy Bennett,	Deputy Séamus McGrath,
Deputy Grace Boland,	Deputy Joe Neville.
Deputy Albert Dolan,	

DEPUTY PAUL MCAULIFFE IN THE CHAIR.

The committee met in private session until 10.22 a.m.

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

Business of Committee

An Leas-Chathaoirleach: Members are all very welcome to today's meeting of the Committee of Public Accounts. Before we proceed, I have a few housekeeping matters to go through. Members are reminded of the provisions within Standing Order 226 that the committee shall 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. Members are also reminded of the long-standing parliamentary practice that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable. I remind members of the constitutional requirement that in order to participate in public meetings, they must be physically present within the confines of the Leinster House complex. Members of the committee attending remotely must do so from within the precincts of Leinster House.

The agenda for today is to discuss the accounts and statements and, second, the correspondence and, third, upcoming meetings. We will then suspend and begin the engagement with officials from the Health Service Executive, hopefully at 10.30 a.m.

Seven sets of accounts and financial statements were laid between 6 and 10 October 2025 and are due to be considered today. We are joined by the Comptroller and Auditor General, Mr. Seamus McCarthy, who is a permanent witness to the committee. I will ask him to address these before opening the floor to members.

Mr. Seamus McCarthy: First we have the Commission for Regulation of Utilities for 2024. It received a clear audit opinion.

Next, we had the financial statements of Teilifís na Gaeilge for 2024. It received a clear audit opinion.

No. 3 is the financial statements of the Approved Housing Bodies Regulatory Authority for 2024. It received a clear audit opinion.

No. 4 is the financial statements of the Land Development Agency for 2024. It received a clear audit opinion, but I drew attention to an undue payment of €420,000 made to an existing supplier due to human error, which was subsequently recovered. I also drew attention to a material level of procurement non-compliance.

No. 5 is the financial statements of An Bord Pleanála for 2024. It received a clear audit opinion.

No. 6 is the financial statements of the Kerry Education and Training Board for 2024. It received a clear audit opinion.

No. 7 is the financial statements of the Social Insurance Fund for 2024. These also received a clear audit opinion. I drew attention to a number of chapters in my annual Report on the Accounts of the Public Services 2024, in which chapters 16, 17, 18 and 24 all relate to matters

concerning the Social Insurance Fund. I imagine the committee will wish to examine that in due course.

An Leas-Chathaoirleach: Gabhaim buíochas le Mr. McCarthy. Do members wish to comment? When referring to the work programme, I noted that the misclassification of workers, covered by No. 7, which is on the Social Insurance Fund, is one to which the committee will return.

Deputy Séamus McGrath: Attention was drawn to non-compliance by the LDA on the procurement side of things. I note that in the explanatory note it is to carry out a review this year. Could we seek an update after that review? Would that be appropriate?

Mr. Seamus McCarthy: Is that from the LDA?

Deputy Séamus McGrath: Yes.

An Leas-Chathaoirleach: We will ask the clerk of the committee to send correspondence seeking the outcome of the review. Are there any other items? Could we agree to note the listing of accounts and financial statements?

Deputy Joe Neville: Before we agree, I want to make the point about next week that other people will want to come in.

An Leas-Chathaoirleach: Yes, it will be dealt with further on. Could we agree to note the listing of accounts and financial statements? Agreed. They will be published as part of our minutes.

We will now consider items of correspondence that have been received from Accounting Officers in Government bodies. These items were received between 26 September and 14 October 2025. The committee has agreed to note and publish the following items: No. R0289 is correspondence received from the Chairman of the Office of Public Works, dated 26 September 2025, providing an update to the committee. We agreed to note and publish that but the committee reserves the right to return to that item.

No. R0303 is correspondence received from the chief executive of The Digital Hub, dated 7 October 2025. No. R0304 is correspondence received from the Department of Culture, Communications and Sport dated 9 October 2025, informing the committee of a delay in the laying of accounts for TG4.

No. R0305 is correspondence received from Mr. John Coleman, chief executive officer, PSM governance and policy unit of the Land Development Agency, dated 9 October 2025.

No. R0309 is correspondence received from Mr. David Gunning, chief officer of the National Paediatric Hospital Development Board, dated 14 October 2025.

No. R0310 is correspondence received from Ms Anne Coyle, chief executive officer of Beaumont Hospital. The committee has agreed to note and publish those items? Is that agreed? Agreed.

The committee has scheduled the following meetings. On Thursday, 23 October 2025 there will be no Dáil session, although the committee has agreed to proceed with our meeting on that

Thursday morning. That decision was made earlier in the meeting. The meeting is with the Department of justice.

On 6 November we will meet Uisce Éireann. On 13 November we will meet the Office of Public Works. On 20 November we will meet the Peter McVerry Trust, the Charities Regulator and additional witnesses, including former chief executive officers of the trust. On 27 November we will meet Inland Fisheries Ireland. On 4 December we will meet the Department of Transport. On 11 December we will meet Revenue. On 18 December we will meet the Department of Social Protection. The dates are to be confirmed. We will give the secretariat discretion to move meetings between dates where that is required. Is that agreed? Agreed.

Deputy Grace Boland: I have asked, repeatedly, for the NTA to be put on the programme. Could I get an update on if and when we are likely to see the NTA being put on the work programme?

An Leas-Chathaoirleach: Yes.

While we were in private session, we had a discussion around the work programme. We have agreed, for the slots in the early January, that we will be able to schedule additional meetings. At the next work programme meeting, we can discuss including the NTA.

Deputy Grace Boland: I thank the Leas-Chathaoirleach. I apologise, I was at the children's committee.

An Leas-Chathaoirleach: The Deputy was at a different committee. She assisted us with the quorum, so we appreciated that. Are there any other items the committee wishes to discuss? No. We will now suspend for five minutes or less to allow the clerk to bring in our witnesses.

Sitting suspended at 10.30 a.m. and resumed at 10.34 a.m.

Financial Statements 2024: Health Service Executive

Mr. Bernard Gloster (*Chief Executive Officer, Health Service Executive*) called and examined.

An Leas-Chathaoirleach: This morning, we will engage with the Health Service Executive to discuss its 2024 financial statements. We are joined by the following representatives from the Health Service Executive: Mr. Bernard Gloster, chief executive officer and Accounting Officer; Ms Sara Long, regional executive officer, Dublin and north east; Mr. Stephen Mulvany, chief financial officer; Mr. Damien McCallion, chief technology and transformation officer and deputy CEO; and Dr. Philippa Ryan Withero, assistant national director, national human resources division. We are also joined by the following officials from the Department of Health: Ms Louise McGirr, assistant secretary, resources division; and Mr. Patrick McGlynn, principal officer from the central finance and accounts unit.

We have received apologies from our Chair, Deputy Brady, and from Deputies Connolly, Geoghegan and Kenny.

We are joined by officials from the Office of the Comptroller and Auditor General, including the Comptroller and Auditor General, Mr. Seamus McCarthy, who is a permanent witness to the committee, and Mr. John Byrne, audit manager at the Office of the Comptroller and Auditor General. They are all very welcome.

I wish to explain some limitations to parliamentary privilege and the practice of the Houses as regards reference witnesses may make to other persons in their evidence. The evidence of witnesses physically present or who give evidence from within the parliamentary precincts is protected, pursuant to both the Constitution and statute, by absolute privilege. This means they have an absolute defence against any defamation action for anything they say at the meeting. However, they are expected not to abuse this privilege and it is my duty as Leas-Chathaoirleach to ensure it is not abused. Therefore, if witnesses' statements are potentially defamatory in relation to an identifiable person or entity, they will be directed to discontinue their remarks. It is imperative that they comply with any such direction.

Witnesses are also reminded of the long-standing parliamentary practice that they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable or otherwise engage in speech that might be regarded as damaging to the good name of the person or entity. Therefore, if their statements are potentially defamatory in respect of an identifiable person or entity, they will be directed to discontinue their remarks. It is imperative that they comply with any such direction.

I now call the Comptroller and Auditor General, Mr. Seamus McCarthy, to make his opening statement.

Mr. Seamus McCarthy: The Health Service Executive's financial statements for 2024 record total expenditure of €28.3 billion. This comprises recurrent spending of just under €27 billion, and capital spending of almost €1.4 billion. A total of €24 billion of the HSE's funding for 2024 was from the health Vote. Funding for specialist disability services of €3 billion was provided to the HSE by the Vote for children, equality, disability, integration and youth. Receipts from retained employee pension contributions and other payroll deductions totalled €447 million. Income from patient charges amounted to just under €334 million. Receipts from the National Treatment Purchase Fund amounted to €26.7 million. Non-capital expenditure in 2024 exceeded income by €760 million and this deficit was carried forward to be met as a first charge from the funding provided from the health Vote in 2025. On the capital side, there was a deficit of €29 million in 2024. I issued a clear audit opinion in relation to the financial statements. However, in my report, I drew attention to a number of matters which I will briefly outline now.

The HSE incurred charges of €22.7 million in respect of stocks of personal protective equipment and €11.1 million in respect of vaccines held at the year-end, which will reach their respective expiry dates before they can be used. In 2024, the HSE also incurred storage costs amounting to €2.1 million in respect of stocks of obsolete personal protective equipment and hand gel from prior years. My audit found from a sample of eight HSE hospitals examined, that losses of private patient income totalling €2 million were incurred in 2024 as a result of delays in submitting completed health insurance claims.

The executive estimates that losses for the remaining hospitals it manages amounted to a further €2.1 million, resulting in an estimated total loss of €4.1 million for 2024.

As in previous years, my audit report for 2024 drew attention to non-compliant procurement, which remains a significant issue for the HSE. Some €1.5 billion, or 28% of the HSE's spend on procurement of goods and services, was subject to review. From this subset of invoices, HSE managers reported that 9%, or €132 million, had been procured in a manner that was not

compliant. In itself, this is a significant non-compliant procurement level. However, the true rate of non-compliance could be higher because the procurement within the scope of the review may not be representative of the executive's overall procurement of goods and services.

An arrangement was put in place with the supplier of a medical device without either a competitive procurement process or a formal written contract. This supply arrangement continued from 2020 until 2024 with prepayments being made to the supplier each quarter from mid-2022 to mid-2024 for supply of a standard number of devices, to be drawn down as required by individual hospitals. The HSE did not maintain central records of the total number of units paid for. The number of devices received by hospitals or paid for and remaining undrawn from the supplier is not known. The HSE also identified a duplicate payment of €723,000 made to this supplier that was not recovered. I understand the chief executive officer has provided the committee with an update in regard to this matter.

The HSE's internal audit reported concerns around procurement of clinical services by University Hospital Limerick from companies owned or part-owned by HSE employees in apparent insourcing arrangements. The audit found that, without undertaking competitive procurement processes, the hospital had paid external service providers a total of €14.2 million from HSE access to care funding to reduce waiting times. Within those service providers, it was found that two providers were companies that were owned or part-owned by the hospital's own staff members and a staff member from another HSE hospital was a director of a third supplier company. The payments under the three contracts totalled just over €2 million. Even though holding a contract for the supply of goods or services to a public body is a standard category of declarable interest, the HSE was unable to provide required declarations of registerable interests from the employees concerned.

In 2024, the HSE provided non-capital grant funding of €7.7 billion to voluntary hospitals and other health sector agencies. Even by the year end, only 74% of the funding issued to such agencies for 2024 was covered by a completed bilateral agreement of the appropriate type. This percentage has been falling in recent years. Furthermore, within the group of grant recipients that had signed agreements, the audit noted a number of instances where the grant-aided bodies had issued side letters to the HSE disclaiming aspects of the agreements, such as budget targets or projected levels of activity. In my opinion, such side letters undermine the validity of the funding agreement process and the executive's capacity to hold grant-aided bodies to account for performance of the agreed terms.

I noted that the statement on internal control discloses weaknesses around the control and management of fixed assets in the HSE. These include inconsistencies in the application of HSE financial regulations, instances where assets no longer in use remained on asset registers, and capital projects where some costs were not included on asset registers. I also referred to the writing off of €800,000 in respect of the depreciated value of an asset that had never been used for its intended purpose since its acquisition in 2009 at an original cost of €1.4 million.

Mr. Bernard Gloster: I thank the committee for the invitation to meet to discuss the 2024 HSE financial statements. I am joined by my colleagues, who have already been introduced by the Chair, and I am supported by Ms Sara Maxwell, the general manager from my office.

The committee has received a briefing note on the 2024 annual financial statements, including a number of specific related topics that the committee would like to discuss. Together with colleagues, I am happy to discuss the detail further.

At the outset, I would like to refer to supplier controls as indicated by the Comptroller and Auditor General, which are reflected in the 2024 accounts and in my view are indicative of the need for the reforms, reforms that are now in late 2025 far more substantially advanced. Between 2020 and 2024, the HSE maintained an unprocured relationship with a supplier of respiratory technology, considered quite effective in some instances for monitoring respiratory conditions during the pandemic. Between 2020 and 2024, the HSE spent €15 million with the provider. On becoming aware of this case, I instructed several examinations and legal advice.

In very simple terms and I want to be unequivocal with the committee, the HSE was buying an unprocured product, was discharging payments on invoice with no adequate check as to the stock received, made a double payment of €723,000, cannot fully estimate the stock not drawn down and has no hope of loss recovery. The overall loss could be in the order of €5 million to €7 million based on the advice available to me. While I believe the context and circumstances of this case are extreme, it clearly indicates the need for expedited reform of the HSE control environment and systems.

On taking up post in March 2023, I outlined major priorities, including timely implementation, and this included pursuing at pace the much and long-awaited integrated financial management and procurement system, IFMS. Stage 1 of the project has implemented IFMS in the statutory healthcare system, that is to say throughout the HSE. Since 1 July 2025, all HSE regions and services use this single integrated platform and master dataset. This represents over 80% of HSE funded expenditure. IFMS has also been implemented in Tusla, the Child and Family Agency, since 2023 as it is a shared partner in our financial systems. The project is now moving forward with IFMS stage 2, which extends the delivery of the system, including national standard finance and procurement processes, supported by a shared services operating model, to the 58 voluntary organisations in scope, which comprise all organisations funded under section 38 of the Health Act 2004 and the larger section 39 organisations also funded by the HSE. The Minister for Health has requested of me an accelerated roll-out that would at least include the major section 38 organisations, most notably first the voluntary hospitals. On that basis and subject to detailed planning, I am advised that the aim is to have 100% of acute spend on IFMS by the end of 2027, and over 97% of disability spend on IFMS by the end of 2028, with 100% saturation by the end of 2029. To clarify, when I say "acute spend", I mean the voluntary sector. It is already implemented in the HSE's acute spend.

Cumulatively, from 2016 to the end of August 2025, €198.1 million has been spent on the finance reform programme of which IFMS is the major element. This comprises €92.2 million in ICT capital costs, €59.4 million in IFMS project in-house revenue expenditure, and €46.5 million in revenue expenditure on software and operating costs.

A number of benefits relating to earlier reporting, greater visibility and transparency, and implementation of a strengthened national standard internal control environment have already been achieved. In parallel with progressing an accelerated roll-out to the voluntary sector, work is ongoing to make the necessary changes to business practices in those areas that now have IFMS. That is to ensure we have the full benefit from the new system. In line with this work

and to strengthen controls, I have recently approved the change in authority limits for sign-off of expenditure.

There are significant learnings from our past history of weak, disjointed and dated systems, the majority of which were inherited from the health board era.

The majority of these were inherited from the health board era. The introduction of IFMS and, in the case of the people management system, the national integrated staff records and pay system, NISRP, are now combining to strengthen governance and allow the HSE to operate in a more integrated system environment that is easier to control.

Overall in 2024, the HSE, as a service provider, and its partner organisations saw significant levels of demand and response to our 5.5 million people. This is a growth of 100,000 people in the previous 12 months. We saw a record 1.47 million attendances at our accident and emergency departments and a corresponding reduction of trolleys by 10% in that year. In 2024, 73% of people were waiting less than nine months for an elective procedure. Major improvements in waiting times across outpatient departments, OPD, and scope lists have been achieved. It was the first year we reached the maximum intended target in the delivery of home supports to older people, delivering 23.7 million hours. We supported 24,000 people in nursing home care.

Our progress and reforms at several levels continue in 2025, with a principal focus on the productivity of our system and, increasingly, across an extended standard week. Perhaps our greatest challenge in 2026, apart from the obvious one, being access, is consistency. We now have tried and tested examples of best practice and reforms. It is the scaling of those that will feature in the plan for the year ahead. The year 2025 has seen strengthened financial controls and better outcomes now in the HSE's finances in the health Vote, with work yet to be done on the disability Vote. The outturn projected for 2025 is one of the better financial outturns in the HSE's history over the years.

I will make one amendment to the briefing document provided to the committee members. I want to ensure absolute clarity on the information. We have advised that out-of-date stock is due to be destroyed by the end of this year. It will be properly destroyed and there will, therefore, be no further cost to its storage. I have become aware this morning that there is a separate supply of masks that are not yet out of date but which, based on the volume we are carrying versus the volume we are using, I believe will come to fall out of date in 2026 and 2027, and certainly by 2028. I want to make the committee aware of that as it would be disingenuous to not have included this in the first instance.

An Leas-Chathaoirleach: I thank Mr. Gloster. Our lead speaker for today is Deputy Albert Dolan.

Deputy Albert Dolan: Cuirim fáilte roimh, Mr. Gloster. Does Mr. Gloster believe he has control, as CEO, of the organisation?

Mr. Bernard Gloster: I believe I do have control of the organisation but I believe there are weaknesses in the control systems because it is such a distributed organisation.

Deputy Albert Dolan: I will now compliment Mr. Gloster. I have here a copy of a memo that was sent out in which Mr. Gloster identified €30 million a year being spent on postage. When I heard about this, and Mr. Gloster's efforts to try to reduce that spend, I was concerned.

I thought the message had not gone out, or perhaps not clearly, but in fairness, I see it is very clear from the memo that where contact with any individual can be moved to an SMS or e-mail, that should be done. How has that gone?

Mr. Bernard Gloster: It is a slow burner; there is no doubt. Individual hospitals and sites are telling me that they just do not have the technical capability to immediately switch to SMS. The chief technology officer is here and he will be able to talk to that further if the Deputy wishes. We are assisting the system in doing that. It is very slow. I am told that the switch---
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Deputy Albert Dolan: What system is in place at the moment? If a patient is in the hospital and a doctor is working with the person, how does the HSE get that person to move from getting letters to receiving an SMS? Is that system available to every hospital?

Mr. Bernard Gloster: I will ask the chief technology officer to answer that. It is different in every hospital.

Mr. Damien McCallion: There are multiple patient administration systems in hospitals, which is one of the issues. We are deploying a single system across the country in advance of the electronic health record. This is very well advanced now, with probably about 75% of our hospitals on that system. In Beaumont Hospital, for example, which I know was with the committee, the system is 35 years old. It just upgraded two weekends ago. We have put in a standard two-way texting system, which will integrate with the system so there is no manual intervention in the middle. I would say about 20 of the hospitals are on that, and the plan is to extend it out from there.

Deputy Albert Dolan: Ms Long is the regional executive officer for the Dublin area. How is it going in her hospitals? Has she tried to roll this out and implement it?

Ms Sara Long: Yes, we have. I would say it is a mixed picture across the hospitals. As Mr. McCallion has said, it depends on the systems they have been on. It is certainly where we are going and it is also-----

Deputy Albert Dolan: Of all the patients who come through the hospitals every day, what percentage does Ms Long think are being asked for their SMS and email contact details?

Ms Sara Long: I would not have a percentage to be able to give the Deputy.

Deputy Albert Dolan: Does Ms Long think any patients are being asked?

Ms Sara Long: Yes, I think they are. It will depend on what hospital they visit.

Deputy Albert Dolan: The point I am making is that the feedback I have received is that this is not happening and that the postage costs are not going down. Every year, €30 million in postage is being spent on reminders for appointments and account statements. The HSE is sending out €30 million worth of post per year. Mr. Gloster was right to identify that this cost has to be brought down. I just want to know by what percentage it has been brought down.

Mr. Bernard Gloster: I issued the control earlier this year and it is a slow burner. The system tells me that, as we move now to single patient administration systems on our way to the electronic health record, it is probably going to take between 18 months and 24 months to

achieve a substantial reduction. The principal point of the direction I have given is the system now has to progress that direction and achieve that.

Deputy Albert Dolan: I appreciate that, and I wish Mr. Gloster well with the implementation of that, but I just think the HSE should mandate that for every single patient who walks through its doors, the first thing that is captured is that piece of data. When patients come through the door is when the HSE has it and then it never has to send that person a letter again. I accept there will be elderly people for whom post is the only way of communicating. I accept that post will always be a percentage but the HSE should be relentless in reducing this cost.

It is really interesting from the statement of revenue, income and expenditure that total expenditure rose from €17.2 billion in 2019 to €26.9 billion in 2024. This is an increase in nearly €10 billion in five years. Within that, the non-pay spend went from €11.2 billion to €17.6 billion. This is an increase of over €6 billion. Are those figures correct?

Mr. Stephen Mulvany: The total figure for non-pay figure I would need to check-----

Deputy Albert Dolan: I find it interesting that the chief financial officer says he will have to check the non-pay figures. When I sum up that non-pay spend, it amounts to about €89 billion across six years. Is that where procurement sits?

Mr. Stephen Mulvany: Yes, but a large part of the non-pay spend goes out to voluntary organisations. That accounts for about €7 billion a year of the current €24 billion. The primary care reimbursement service accounts for another €4.5 billion or €5 billion. They are not procured in that context. Procurement spend is more like €4.5 billion or €5 billion.

Deputy Albert Dolan: I know that €7 billion is going to outside agencies, and I will come to that later. Given the level of non-pay spend, can Mr. Mulvany explain how the HSE monitors and manages it?

Mr. Stephen Mulvany: We have a devolved budgeting system, so every manager gets a budget, starting with the CEO and going right down to the senior leadership team and out to the regions. That comprises pay, non-pay and income. It is set annually in line with the Estimates process and the national service plan. Actual spend is managed and monitored monthly against target. It is divided between clinical, non-clinical and other operational expenditure.

Deputy Albert Dolan: Mr. Mulvany is depending on each manager, organiser and hospital to stay within the budget they are given.

Mr. Stephen Mulvany: It is performance managing. The regions and the other national directors performance manage the budget management of their staff. Effectively, as I said, we now have much better central visibility and it is improving further with the single IFMS that we have. It is closely monitored on an ongoing basis.

Deputy Albert Dolan: I do not believe it is closely monitored. I say this because I have asked parliamentary questions on how many tenders came in on budget or over budget and the HSE was not able to tell me. Does the HSE have oversight of all tenders within the organisation and does it have a contract management system for managing that?

Mr. Stephen Mulvany: Not as yet. That is part of one of the benefits we will deliver with the IFMS. It depends on which type of tender the Deputy is talking about.

Deputy Albert Dolan: At the moment, the HSE cannot track performance at the contract level.

Mr. Stephen Mulvany: If the Deputy talks about tenders for ICT projects, we can absolutely track them; they are tracked. Tenders for large construction projects absolutely can be tracked. These are two of the largest types of projects and there are huge controls over those. There is ongoing monitoring and performance management around those. We absolutely can track all of those.

A lot of the other tenders we are talking about are tenders for the purchase of consumables, where we estimate the value that is being purchased and then we offer or make that contract available and the people buy off it. The control is whether they are operating within their budgets or not. In some cases, people would go over budget and that is a matter to be dealt with through the accountability and performance management process.

In the context of big contracts for systems, buildings or projects, yes, we do have visibility-----

Deputy Albert Dolan: In terms of spending and non-compliant procurement, I want to define what constitutes non-compliant procurement. It is essentially where the rules for procurement are not followed. Is that correct?

Mr. Stephen Mulvany: Essentially, the EU public procurement rules are designed to ensure value and transparency and are necessarily quite complex.

Deputy Albert Dolan: The HSE self-assesses its procurement. In 2024, it reviewed 29,012 invoices involving amounts over €25,000. Is that correct?

Mr. Stephen Mulvany: That is correct.

Deputy Albert Dolan: Does the HSE have any checks in place for consistent invoices coming in at €24,000 or €23,000 or for any anomalies such as that which we are discussing?

Mr. Stephen Mulvany: We have financial regulations that require people not to split purchases to avoid the various controls, including the €25,000 threshold. The reality is that in advance of IFMS, we did not have a single system that gave us the capacity to monitor non-pay purchase orders at the level we wanted. The Comptroller and Auditor General is correct-----

Deputy Albert Dolan: Does Mr. Mulvany believe there are companies which are invoicing the HSE for less than €25,000 in order that they can go under the radar?

Mr. Stephen Mulvany: No, it is not in their interests to do so. The risk is that in determining whether they need to go through a particular type of procurement process, people estimate that the need will typically be lower than the threshold.

Deputy Albert Dolan: It is in their interests if they were not properly procured.

Mr. Stephen Mulvany: Not in terms of invoicing.

Deputy Albert Dolan: If they were non-compliant in the process of procurement and then come in under the amount-----

Mr. Stephen Mulvany: No, that is a matter for the organisation rather than the supplier. Once we order a product from a supplier, the supplier will deliver it along with the invoice for the project. If we have received the product that we ordered, we will pay for it.

Deputy Albert Dolan: Mr. Mulvany is right that it is a matter for the organisation. If an individual in the organisation is a related party or is connected to any of these companies, it is in their interests to go under the radar.

Mr. Stephen Mulvany: If it is a related party, there is a list of possible conflicts. If I could just say-----

Deputy Albert Dolan: I know there is a list, but the HSE does not have a register of declarable interests.

Mr. Stephen Mulvany: We do. People are required to fill out an annual SIPO declaration under the Ethics in Public Office Act.

Deputy Albert Dolan: Representatives from Beaumont Hospital were before the committee last week. They confirmed that 25% of the hospital's consultants have not complied with their SIPO obligations. Does Mr. Mulvany have an idea as to what the compliance rate is across the HSE?

Mr. Stephen Mulvany: It has improved since last year. It is 65% or 66%.

Deputy Albert Dolan: So 33% of people in the HSE who have SIPO obligations have not complied. We, as public representatives, must comply with our SIPO obligation to declare our interests. If I walk into the HSE today, I would find that one in three people has not bothered to fill out the form.

Mr. Stephen Mulvany: It is an area in which we are improving. Yes, we accept it is an issue-----

Deputy Albert Dolan: What is the HSE doing to improve compliance?

Mr. Stephen Mulvany: It has increased in each of the past three years. One of my colleagues probably has the figures. There is a concerted effort between our communications team and our HR team to drive up and maximise compliance. As I said, it has increased from a percentage in the mid-50s last year to 63% or 64% this year. Deputy Dolan is absolutely right that it needs to be driven to 100%.

Deputy Albert Dolan: That is scandalous. If one in three people in the HSE is not complying with their SIPO obligations, it means they could potentially have a declarable interest or a conflict of interests which they are not declaring. I think I am correct in stating that non-compliant procurement accounted for more than 9% of the HSE's procurement spending.

Mr. Stephen Mulvany: That is correct.

Deputy Albert Dolan: The HSE's procurement spend is massive. It has ballooned over the past three to four years. Would Mr. Mulvany agree that this is the case?

Mr. Stephen Mulvany: I would agree that the State continues to make a significant investment in the delivery of services. This involves pay and non-pay expenditure. The Comptroller and Auditor General is correct that the self-assessment exercise, which is a manual

retrospective self-assessment exercise that will be replaced in time by the IFMS system, only looks at more than €25,000.

Deputy Albert Dolan: On the IFMS, and I apologise for cutting across Mr. Mulvany but I am passionate about this and I want to see results, are there people in the HSE who are frustrating the IFMS being implemented because they do not want to see it implemented because they are happy with the way things are?

Mr. Stephen Mulvany: No, I do not believe so. Change is difficult. There will always be people who struggle with it. Since 1 July, the IFMS system has been rolled out to 100% of the HSE's directly run services.

Mr. Bernard Gloster: Just to assist and to be totally upfront, I have seen many systems implemented. IFMS, like many systems, is SAP based. It is a rules-based system and people cannot go around the rules. We are not an organisation traditionally given to following the same rule-set nationwide all of the time. It is part of the culture change of the organisation. There is no point in me telling Deputy Dolan anything different.

Mr. Stephen Mulvany: We have gone from a situation where all of the invoices arrived in various places around the entire HSE. Every invoice now arrives in one central place and goes through a single central process. Invoices are rejected if the suppliers involved do not have purchase orders. We are making the business practice changes that I have-----

Deputy Albert Dolan: That is very important.

Mr. Stephen Mulvany: -----but there are a number of years' work-----

Deputy Albert Dolan: I thank the HSE for publishing all of its purchase orders involving amounts of more than €100,000 in one machine-readable format. It is very useful and helpful. Will Mr. Mulvany confirm that once the IFMS is fully integrated, purchase orders of more than €20,000 will be published for the whole of the HSE?

Mr. Stephen Mulvany: Our aim is to publish details of purchase orders for over €20,000 from the fourth quarter of this year or the first quarter of next year.

Deputy Albert Dolan: That was confirmed to me in reply to a parliamentary question, and I appreciate it.

I want to speak about the provider of €15 million worth of goods to the HSE. Somebody paid those invoices without confirming that the stock had been received.

Mr. Bernard Gloster: That is right.

Deputy Albert Dolan: Did they lose their jobs?

Mr. Bernard Gloster: A number of the people involved in signing off various aspects of this are no longer with the organisation, so it is-----

Deputy Albert Dolan: Did they leave of their own-----

Mr. Bernard Gloster: They left of their own volition, absolutely. This issue came to light last Christmas. The only reason I became aware of it was a story in a newspaper in which the company involved claimed that it was the HSE's fault that it was heading into liquidation.

Obviously, when I inquired into the matter, it was anything but the HSE's fault that it was heading into liquidation. This is why the loss is not recoverable.

Deputy Albert Dolan: The HSE reckons it has lost €5 million to €7 million on this, and the people who paid out the invoices have just walked away. Is there any ongoing investigation into this matter?

Mr. Bernard Gloster: The advice I have is that it is not recoverable. The advice I have is that the key people who were central to the decision-making process in the main are not available now for investigation. This will make the investigation-----

Deputy Albert Dolan: When Mr. Gloster says that they are not available, does he mean they have left the country?

Mr. Bernard Gloster: If they do not work for us, they are not available. I have no jurisdiction to investigate anybody who no longer works for us, and that is the truth of it. I do not have any compellability for investigation whatsoever. The reality is, and, again, whether we like it or not -,and just to be absolutely clear with Deputy Dolan,- that I am looking back retrospectively and I was not involved at the time. This occurred during Covid. It occurred during a period when there was very high demand for things to be fast moving, agile and so on. Most controls were either relaxed or set aside to some degree. What we find when we look back on a situation such as this and question someone is that suddenly 25, 30 or 35 people are all cited at different levels in different ways. It is simply impossible to get to a level of accountability on it. This is a big regret because I am a huge believer in accountability. People did fail in their job here. People failed in their duty regardless of Covid.

Deputy Albert Dolan: There are not 25 or 30 people who have left.

Mr. Bernard Gloster: No, but in fairness, what we have to do in a situation like this is see what were the more senior levels of the decision-making that brought it in.

Deputy Albert Dolan: One of the biggest frustrations the public has is in respect of accountability. We try to achieve that here. The problem now is that Mr. Gloster has told me that €15 million was paid to the company and the person who approved the payments has left the HSE and is not available. The public will not accept that.

Mr. Bernard Gloster: Just to be clear, it was not one person. On the question of accountability, because it is important, I am a firm believer in it. I have told committees that I got into difficulty earlier this year for being so bold as to suggest I would make a referral to the Garda about a matter I was concerned about, and I did. On a completely unrelated matter, I have pursued one of the highest levels of accountability and disciplinary investigation against senior officials. That investigation is ongoing. I do not have any fear of accountability but, equally, I have to be honest with the committee and the board when I say I believe that something is exhausted. If it is exhausted, it is very difficult when all of the players are not available.

Deputy Catherine Ardagh: I thank our witnesses for coming before us. We have received disappointing news about the children's hospital, which is located in Dublin 8 in my constituency of Dublin South-Central. Will Mr. Gloster confirm the revised completion date and how it has moved from previous targets?

Mr. Bernard Gloster: The children's hospital.

Deputy Catherine Ardagh: Yes.

Mr. Bernard Gloster: As I understand it, the paediatric hospital development board has advised the committee in correspondence this week that the latest date from BAM is towards the end of November. I am not sure whether it intends to revise that further.

I can only rely on it giving us a programme and making sure that programme is compliant, and the only people who can make it compliant are in BAM. I am more confident about this. I have been looking for several months for CHI to get early access to the site so it can start to do some of the commissioning preparation. However, I am in the hands of BAM - it owns the site; I do not - and I am told that early access will be possible from mid- or late November. However, the simple reality and shame of it is that work on a building that needs a small percentage of work to bring it to completion has dragged on to this extent. I do not know whether the date of 25 November will change. I would regret it if it does, but I am very much in the hands of the contractor.

Deputy Catherine Ardagh: As of today, can Mr. Gloster give me the up-to-date costs of the hospital?

Mr. Bernard Gloster: I do not have that with me right now. I am sure we would be able to get it before the session is over, or certainly shortly after it. I just do not have it to hand.

Deputy Catherine Ardagh: Mr. Gloster mentioned that he was trying to get ahead of any future delays in staffing and readiness of the hospital. How long will it take for the clinical aspect to be ready? If we get keys on 25 November, does he think clinical readiness will take a year, six months or another timeframe?

Mr. Bernard Gloster: The commissioning timeframe that CHI has put on the process to date is in the order of nine months. I believe it can be substantively done in less than that time, possibly in fewer than eight months. I also believe that a hospital of that size will be commissioned and opened and then we will incrementally build on services, because there will be new services there.

Deputy Catherine Ardagh: It will be late 2026 before the first children will be seen. Is that Mr. Gloster's view?

Mr. Bernard Gloster: It is difficult to be exact. I am still saying, as I have repeatedly said publicly, that the end of the second quarter, which is halfway through 2026, is the desirable time to see clinical activity in the hospital. I continue to hold that view and any time I, the Minister or anyone else digresses from that view, we simply give more time for people to be involved in things that delay the hospital opening, and I do not accept we need to be in that position.

Deputy Catherine Ardagh: I will go back to the 2024 accounts and the fixed assets. The Comptroller and Auditor General outlined in his opening statement that there was a disclosure by the HSE where it wrote off €800,000 in 2024 relating to an asset that was constructed in 2009 but had not been used for its intended purpose. The original cost of the asset was €1.4 million. The public might be interested in what this asset and its intended use were.

Mr. Stephen Mulvany: It was a hydrotherapy pool intended for clinical use for patients in 2009 and 2010. It was only brought into use for a short period. It was eventually used for storage and then written off. It was a development that never really proceeded properly.

Deputy Catherine Ardagh: Did Mr. Mulvany say the pool was used for storage or put in storage?

Mr. Stephen Mulvany: It was initially used for a short period, as I understand it, for its intended purpose, but funding had not been secured on an ongoing basis to staff it. It ceased being used, was then used for storage and was then removed.

Deputy Catherine Ardagh: What was stored in the pool? Was the pool used for storage or in storage?

Mr. Stephen Mulvany: When the pool is not in use and there is no water in it, it is a void into which whatever is appropriate can be put.

Deputy Catherine Ardagh: Where is the pool now?

Mr. Stephen Mulvany: As I understand it, the pool has been disposed of.

Deputy Catherine Ardagh: It has been disposed of. Do we have the cost of that disposal?

Mr. Stephen Mulvany: I do not, but we can seek it. The original cost of the pool was €1.4 million and, as the Comptroller and Auditor General said, the write-off was €800,000.

Deputy Catherine Ardagh: Mr. Mulvany mentioned it was not used because the HSE did not have staff who were trained to use it. Is that correct?

Mr. Stephen Mulvany: Sufficient staffing to run it was never secured. It is a project that happened more than 12 or 15 years ago so some of the information is difficult to obtain.

Deputy Catherine Ardagh: Why did it take until 2024 to write it off?

Mr. Stephen Mulvany: That is one of the weaknesses the Comptroller and Auditor General pointed out and that we reflected in our statement of internal control in the annual report. We need to, making use of the integrated financial management and procurement system, IFMS, which is now available to us, improve some of our controls around some of the technical aspects of fixed asset management.

Deputy Catherine Ardagh: This is an asset from 2009. Does Mr. Mulvany envisage that other dodgy assets will be written off and those write-offs will be drip fed to us over the next few years?

Mr. Stephen Mulvany: That would certainly not be our intention. I cannot sit here today and say one will not emerge. Until we go through the process, now that we have IFMS, of cleaning through all of the fixed assets and addressing some of the issues we are aware of and which the Comptroller and Auditor General pointed out, including making sure assets move properly through the different stages of asset recognition in the accounts, such as depreciation, I cannot say we will not come across something, but it is not the intention in any way to drip feed them. We will make them visible as soon as we become aware of them.

Deputy Catherine Ardagh: On the grant funding for section 38 and section 39 organisations, the Comptroller and Auditor General noted that 74% of grant funding in that year was not covered by signed service-level agreements. This question might be for Mr. Gloster. How many disability service providers operated in 2024 without a valid or current service-level agreement?

Mr. Bernard Gloster: I do not have the figures by care group, but I will be certainly be happy to provide them. Generally, compliance with signing service arrangements and agreements is far too slow. Agreements often do not get signed until the middle of or late in the year in which they apply. It is quite frankly a bit ridiculous not to have an agreement about a year until late in the year. We have made some progress on that but we have a long way to go in improving the oversight of those funded agencies. The simple reality is that the only leverage we have when people do not sign their agreements is to control or cease their funding, and we cannot do that because live services are being provided.

Deputy Catherine Ardagh: I understand that.

Mr. Bernard Gloster: It is therefore difficult.

Deputy Catherine Ardagh: Where did the culture of using side letters come from? It seems as though they are used, especially where people are disclaiming elements of performance targets and elements of their budgets. What steps can the HSE take to force better compliance?

Mr. Bernard Gloster: Ideally, as the auditor pointed out, we would not need side letters, letters of comfort or anything else. However, the simple reality is that most of these organisations come from an historical context in which they can point out the things that are not in their control and problems they have that they did not create and that affects them signing a service agreement without some level of qualification. That is what led to it. Ideally, that would not be the case. Strengthened service arrangements and grant aid agreements are the only way to go. However, most members of the committee will be familiar with many of these organisations. They have good reputations locally and do good work locally and it is an enormous pressure for us to see how far we can push for compliance when we know they might have weak succession on their boards or poor systems of corporate governance. It is a real balancing act, but for the bigger organisations, we should be getting beyond the notion of letters of comfort or anything else. We have never failed to catch out-----

Deputy Catherine Ardagh: I apologise for interrupting. I only have a minute left. Some €7.7 billion in grant funding goes to these organisations and many of them are amazing organisations that do incredible work, but their boards are on occasion weak and their governance is weak. Has there been discussion at a higher level to take some of the work into the HSE directly?

Mr. Bernard Gloster: Where an organisation is in fundamental difficulty and is a service provider - in other words, it needs to continue working - that cannot continue working, we would step in, but that is rare.

Deputy Catherine Ardagh: Does Mr. Gloster think it is right to wait until an organisation is in huge difficulty before the HSE steps in? Should we look at these organisations, especially those where the governance is weak? Many were set up as charitable organisations and perhaps the people who are running them or are the founders-----

Mr. Bernard Gloster: We do not have the legal power to take them over. We only have the power to fund them or not. If we do not fund them, some level of service discontinues.

Deputy Catherine Ardagh: As a head of an organisation, would Mr. Gloster like the HSE to have the legal power to do that?

Mr. Bernard Gloster: There is definitely room for a serious conversation about the relationship between the State and funded service providers, which should include questions of sustainability.

Deputy Catherine Ardagh: I thank Mr. Gloster very much.

Deputy Joe Neville: I thank all the witnesses for coming today. I know it is never easy coming to a meeting like this. I also thank the Comptroller and Auditor General and his team for their detailed work.

I have issues to highlight and I will follow on from some of the queries raised earlier. What steps are being taken to address the significant level of non-compliant procurement we have in the HSE and the bodies related to it?

Mr. Stephen Mulvany: As the Comptroller and Auditor General mentioned, in terms of those payments over €25,000, we are continuing with the current process. In 2024, we achieved a 100% return rate, which was an improvement on the previous year, and a 91% compliance rate. As the Comptroller and Auditor General also points out, though, that only looks at payments over €25,000. We have now, therefore, started doing a sampling exercise to give us a 95% confidence level on all payments between €5,000 and €25,000 and between €0 and €5,000. This will allow us to estimate the overall level of compliance.

We also want to move away from that system, because it is a manual self-assessment retrospective process and it is quite a burden on the staff and everybody else. What the IFMS has already allowed us to do is to ensure we receive invoices into one central point. We now reject invoices that arrive without a purchase order because, obviously, the purpose of the purchase order is not to be an invoice to be paid but to order the goods. What we need to do progressively now is make the business practice change so it will allow us to ensure all purchase orders are issued well in advance. The additional and difficult aspect is to ensure all purchase orders are issued with the right level of line item detail. When they are received and goods are receipted, we will then be able to effectively trap whether they are compliant from the point at which the purchase order was issued and not to address the situation retrospectively. There is a big exercise there.

Deputy Joe Neville: Perfect. With that, has the integrated financial management system been rolled out across the HSE?

Mr. Stephen Mulvany: Yes. The last of our areas went live on 1 July 2025 and they came out of Hypercare at the end of August. This means that 100% of the HSE's directly run services are on the IFMS. We are now moving to the planning stage for the voluntary sector.

Deputy Joe Neville: Have any of the voluntary hospitals got the integrated financial management system in place?

Mr. Stephen Mulvany: No. That will be the next step. While we are working on our own implementation to ensure we are now making the business changes necessary, we have also

completed a plan and are engaging with the Department to finalise and get approval for it and to roll it out to all the voluntary hospitals.

Deputy Joe Neville: If the HSE has been able to fully roll out the system to the rest of the hospitals, why has it not been possible with the voluntary hospitals? How many hospitals are on the voluntary side?

Mr. Stephen Mulvany: There are 16 acute voluntary hospitals.

Deputy Joe Neville: Is any pushback being received from them on this?

Mr. Bernard Gloster: Yes.

Deputy Joe Neville: The HSE is getting pushback. Which of the hospitals is pushing back on it?

Mr. Bernard Gloster: It is in general. The hospitals have a collective group that is called an association. Through that association, these hospitals have expressed to me the view that they require a separate legal agreement with us for the introduction of the IFMS. We firmly hold the view that that is not the case.

Deputy Joe Neville: How is that possible? The HSE obviously funds them.

Mr. Bernard Gloster: Yes, almost 100%.

Deputy Joe Neville: Let us take the Mater hospital as an example. It is one of the acute hospitals. What is its total funding for the year?

Mr. Bernard Gloster: I will give the figure to the Deputy in one second, although I have what its likely cash position will be this year. Actually, I have it here. My apologies. The Mater hospital will have €625 million this year.

Deputy Joe Neville: The HSE is funding the Mater hospital to the tune of €625 million, yet it is pushing back on a control system that will help it in its business?

Mr. Bernard Gloster: Well, I do not want to misquote the hospital or be unfair. It has said that it welcomes the introduction of systems across the voluntary hospital sector, but that these hospitals' belief is that their structures, their company structures and various other things mean they would require certain legal agreements apart from the service agreement we have with them. I fundamentally do not believe that is the case. I believe that the provisions of the Health Act 2007 and all that flows from them are more than adequate for this. Our intention is to press ahead with the introduction of the IFMS into that sector.

Deputy Joe Neville: Looking again at the Mater hospital, it was in the news recently. There has been a lot of overspending in the hospital. Is this correct?

Mr. Bernard Gloster: One of the things about individual institutions is the question of when something is an overspend or is underfunded. There are disputes about this. I would say, however, that I met the CEOs and chairs of every voluntary hospital at the start of the year. I recognised the challenge they had coming into the year and I assured them that, provided they did not grow that challenge without our approval, they would be cashed out and cash-managed this year. This is the intention and the plan. The State has to pay its bills. These are public

service bodies and their staff are public servants. The debate as to whether there is underfunding or overspending probably requires more time.

Deputy Joe Neville: Yes. I can see that, under the new Minister for Health, there has been a huge push to increase productivity and control spending. Is that correct?

Mr. Bernard Gloster: Yes. It is 100% correct.

Deputy Joe Neville: This has been to the forefront. The chairperson of the Mater hospital resigned recently. Was this because there were differences of opinion, potentially, on productivity and spending levels within the hospital and that these were to be monitored?

Mr. Bernard Gloster: In fairness, that was a well-publicised matter. I do not want to speak for the chair of the hospital.

Deputy Joe Neville: Does it speak to the overall issue?

Mr. Bernard Gloster: I would say that differences in views as to the role of the relationship with the State formed part of those discussions, yes.

Deputy Joe Neville: Is that not the key here? If the State and the taxpayers are ultimately funding these hospitals, surely they should be brought under the umbrella for basic spending infrastructure. We are sitting here talking about duplicate payments and write-offs, and these are all fundamentals to all of us in the system. All I mean regarding these voluntary hospitals is that, in a context where the HSE has been able to engage with all its own hospitals, it surely does not seem to make any sense that some group would be opting out and feeling itself to be different.

Mr. Bernard Gloster: I could not agree with the Deputy more. I just want to be clear so there is not any sense of unfairness, perceived or otherwise. These hospitals do and have done good work. There is no disputing that. There is some clinical excellence in these services of the very highest standard. I have two views, though, that I am happy to share after 38 years in this work now. First, I think Ireland has too many health governance systems for the size of the country. I think there are too many entities as opposed to a single system. Second, for whatever entities we choose to have that are not the HSE, that are charitable status, NGOs or whatever we want to call them, I believe the relationship between the State and those organisations is fundamentally misplaced and misunderstood in terms of what independence and autonomy mean. If the State is 100% funding your costs, then it is entitled to mandate the system and the controls and checks and balances of the discharge of that expenditure. It is as simple as that.

Deputy Joe Neville: I fully agree. To be honest, this is why I was asking the question. As was said, the system has been rolled out among the HSE's own hospitals. I was just not sure about the voluntary side. Ultimately, this is significant spending. What would be the full amount of money spent on those voluntary hospitals?

Mr. Bernard Gloster: The spending on the 16 voluntary hospitals would be in the region of €5 billion.

Deputy Joe Neville: It is €5 billion a year-----

Mr. Bernard Gloster: Roughly, yes.

Deputy Joe Neville: -----and the HSE is getting pushback on putting a proper system in place to ensure we are able to monitor all the payments.

Mr. Bernard Gloster: I am sure that some of them would not describe it as pushback, but I would.

Mr. Stephen Mulvany: Just to say, our plan, once we get final planning and approval from the Department, is to roll out the system to all those voluntary hospitals and get to 100% or high above 90% before the end of 2027. That is the plan.

Deputy Joe Neville: If there is any feedback from this meeting today and from this committee, it is that we firmly believe the systems need to be in place in those hospitals as well as the others. There should be no sense of people feeling they should be able to push back or have a different opinion than anybody else. If this system is working on SAP, and I know it is a great system that can work really well, then we need to send this message out. I assume everybody else feels the same in regard to the HSE making sure it gets implemented.

Mr. Bernard Gloster: Just so nobody loses sight of it, this is about more than the IFMS. The State has to mandate systems. When we come to have an electronic health record system and spend an enormous amount of money on it, there can be no equivocation. The entire health system has to be a part of it. When we introduce a personnel management system like the national integrated staff records and pay programme, NISRP, the entire health system has to be a part of it. When we introduce lab technology, the entire health system has to be a part of it. Otherwise, we are going to have independent entities doing their own thing with public money and creating enormous differences in how the control environment and efficiency environment could ever work.

Deputy Joe Neville: Dare I say it, but who do these people think they are if they feel they can push back on such significant funding and some basic systems that we need to put in place?

My last question is on public-private partnerships and how they work. In my second round of questions, I might ask more about consultants. How do PPPs work in hospitals? How does the cost of, say, ICU units or blood banks get brought back to the private consultants? Is there some methodology used? Obviously, private consultants can operate privately and look after patients in that way, which is fine, but how do we ensure that they are willing to charge us on the one hand and, on the other hand, that costs go back to them?

Mr. Bernard Gloster: There are two different parts to that, Deputy. If I understand the question correctly, in a public hospital where a private patient is being cared for and is an insured patient and the insurance company is being charged, all of the various diagnostics, bed stay and medicines are charged to the insurance company in accordance with the guidelines. That is a very straightforward process. Where it becomes a little bit more difficult is if you have private and public hospitals alongside each other in the same entities and if they have shared services.

Deputy Joe Neville: Like St. Vincent's.

Mr. Bernard Gloster: There is nothing wrong with a shared service like a lab or anything like that at all. It makes sense. You could not be building two of everything. The tracking and tracing of that back is much more fundamental and difficult. In all of the engagements that I

have had in recent times where those types of issue arise, we have asked for greater clarity around any public utilisation of resource for private effort.

Deputy Joe Neville: I might pick up on that later.

Deputy Cathy Bennett: I thank all the witnesses for coming in today. They are very welcome. My first questions are on the restructuring of the HSE into six new health regions. Why are new health regions being developed?

Mr. Bernard Gloster: According to Sláintecare, the health structures across the country were complex. In simple terms, you had community healthcare and acute hospitals. There were two different management systems within the HSE. I was a chief officer in a community healthcare area myself for a very long time. Sláintecare recommended that all the health structures be brought together, not really for the structure, but to improve the service that the population got by having one system. If you take all of the services now in north Dublin and what essentially used to be the North-Eastern Health Board, Ms Long now has full delegated control from me of all of those services. She can create more seamless pathways between them and the better use of resources. That is it in a nutshell.

Deputy Cathy Bennett: Why the other areas are lagging so far behind in restructuring compared with Dublin?

Mr. Bernard Gloster: No, they are not. The six are in place.

Deputy Cathy Bennett: Are the six in place?

Mr. Bernard Gloster: Yes.

Deputy Cathy Bennett: Are they all at the same stage?

Mr. Bernard Gloster: There is always going to be a difference. Perhaps Ms Long will answer.

Ms Sara Long: I think we are all at the same stage. The six REOs work collectively together in implementing the change. That is something, right from the outset, we have committed to doing. We are working our way through the implementation of the regions and we are doing that collectively. There may be some small local variations. There always will be. Overall, though, I would say we are doing that together.

Deputy Cathy Bennett: Will staffing remain as is or change?

Ms Sara Long: Staffing will remain as is.

Deputy Cathy Bennett: Will the staff who are currently *in situ* remain in their positions?

Ms Sara Long: They may change roles. In fact, there are a number of staff who will absolutely change roles as we move away from the concept of managing community services or acute services potentially separately and we move to those integrated healthcare areas. For example, there are four of those in my region. The management will be around managing those populations and areas.

Deputy Cathy Bennett: So, there will be no backfilling of positions. There will be no need to fill any positions as none will be taken out of the loop-----

Ms Sara Long: No.

Deputy Cathy Bennett: -----or moved into higher positions.

Ms Sara Long: No. There will be changing roles, but there will not be fewer roles.

Deputy Cathy Bennett: All right. What is the current status of the data analyst position that has been vacant for some time?

Mr. Bernard Gloster: I ask Mr. McCallion to answer.

Mr. Damien McCallion: We advertised for a chief data analytics officer last year. That role is filled but I suspect that might not be the position referred to by the Deputy.

Deputy Cathy Bennett: Yes, it is. I suppose the HSE is collating data to predict staff vacancies due to maternity leave, retirements, etc.

Mr. Damien McCallion: There is a couple of things, Deputy.

Deputy Cathy Bennett: Is all the data there for that?

Mr. Damien McCallion: I guess the chief data analytics officer will look across the system to make sure we can do it, whether one is looking at hospitals, mental health facilities or different areas. On the HR side, the NISRP system the CEO referred to captures information around human resources and all our people in terms of the different types of leave mentioned and so on. That is in the statutory system now. The intention, similarly to the IFMS, is to roll that out to the section 38s and the voluntary sector as well.

Deputy Cathy Bennett: In terms of the children's disability network teams, CDNTs, we do not seem to have enough staff for any disability services in counties Cavan and Monaghan. What are Mr. Gloster's thoughts on that?

Mr. Bernard Gloster: I could not agree with the Deputy more. I think we are better off CDNT-wise than we were 18 months ago or even when I came into this role just under three years ago. The Government has committed further funding next year. The difficulty is the supply of the workforce. In most CDNTs, the core therapies are speech and language therapy, occupational therapy and physiotherapy. Every part of the health service is recruiting those professionals. Disability services are a very complex area of work and it is harder. I have looked at ways to see if we can do better retention and career opportunities for people within it. The situation is better but I would have to be fair and say to the Deputy that we are a long way off where we need to be in responding to children's disability services. I recently tendered for private services to support the public services while we are building capacity. I am hoping that will help a little. Children are waiting for these services, and this is perhaps the part of the health service that I am most sad about. We just have not responded well at the level we should be able to respond to.

Deputy Cathy Bennett: I am sad about it as well because there are children who have not had any therapy.

Mr. Bernard Gloster: That is right.

Deputy Cathy Bennett: They are ten years of age now. It is an awful situation for these children and parents. They are not getting services that should be provided to them by the HSE and disability services.

Mr. Bernard Gloster: The only thing I would say is - this afternoon, I will attend the Cabinet subcommittee on disabilities - that, to be fair, nobody has anything but the wish for it to be better-----

Deputy Cathy Bennett: Yes.

Mr. Bernard Gloster: -----and to find ways to make it better. I do believe that the assessment of need process in the legislation has to be reformed. Legislation has not kept up to date with modern-day practice. We need to get on with providing services to children rather than consuming all of our resources in just assessments that actually do not give children anything.

Deputy Cathy Bennett: I thank Mr. Gloster for that reply.

I have submitted several questions on CT and MRI scanners in Cavan hospital that have not been in operation. I have letters that contain the figures. The scanners have not been in operation for quite a bit of time. One of my top priorities is that we would have services like this available in Monaghan hospital. The Cavan hospital has machines that do not function most of the time. When people go to that hospital, they cannot get services and must travel to Dublin to get a scan done using an MRI or CT scanner. For the people of counties Cavan and Monaghan, it is not good enough that we do not have scanners or CT machines in operation in either hospital. I ask Mr. Gloster, as the representative of the HSE, to have machines available in both hospitals and operational at all times?

Mr. Bernard Gloster: I will ask Ms Long to respond.

Ms Sara Long: The MRI scanner in Cavan hospital has had intermittent repair requirements recently and we attempted to promptly reschedule any patients who were affected. The hospital has made an application to the HSE's national equipment replacement programme to replace the existing MRI scanner located in Cavan General Hospital. The project has been approved, so we expect works to commence.

Deputy Cathy Bennett: Is that in Cavan hospital?

Ms Sara Long: That is in Cavan.

Deputy Cathy Bennett: What about Monaghan hospital?

Ms Sara Long: There is not currently an MRI scanner in Monaghan hospital and I do not believe that the population base would warrant a second MRI scanner. Returning to the productivity and efficiency discussion, what we need to do is make sure that we utilise the scanner in Cavan hospital as much as we can so that it can serve the populations of both Cavan and Monaghan.

Deputy Cathy Bennett: The issue is that we do not really have a scanner in Cavan hospital because it has not been working and we do not have a scanner in Monaghan hospital either. I feel that the people of Cavan and Monaghan have been forgotten about. Services are available in Dublin because these machines are available in Dublin. Why are we not entitled to have machines operational in these two counties?

Ms Sara Long: It would be our intention that the MRI scanner in Cavan be replaced and that the new scanner would be utilised for as many hours a day and as many days a week as it can be in order to serve that population.

Deputy Cathy Bennett: There are huge backlogs for the use of these machines, which leads me back to a matter I consistently raise. If Monaghan Hospital was in use more, there would not be the backlogs in Cavan, particularly as the latter serves Monaghan, Cavan and other surrounding counties. Will the HSE consider Monaghan for a CT scanner and an MRI scanner in order to provide some relief for the doctors and professionals in Cavan Hospital? Some of the services could be brought to Monaghan Hospital.

Ms Sara Long: We rely heavily on Monaghan Hospital in terms of discharging patients from Cavan into Monaghan, and to be able to use our diagnostics, etc., there. It is a very valued part of our hospital network.

Deputy Cathy Bennett: What is Mr. Gloster's salary?

Mr. Bernard Gloster: The published salary of the CEO of the HSE is €393,000. Mine is 5% less than that, because I was a pre-existing public servant, and rightly so. That is all subject to pension contributions, USC deductions and all of the normal statutory deductions.

Deputy Cathy Bennett: I thank Mr. Gloster. He is very upfront and honest about it. What is the salary of the director of the National Ambulance Service?

Mr. Bernard Gloster: I gave a direction last week for someone to write to the Joint Committee on Health. I think the letter issued yesterday. The director of the National Ambulance Service is paid as an assistant national director. In addition, he receives the advanced paramedic allowance. He holds that because on his appointment in 2011, he was a registered advanced paramedic. He continues to maintain his registration and it is part of his contractual entitlement at this stage.

Deputy Cathy Bennett: Even though he is not a practising paramedic, he gets paid the additional €10,000.

Mr. Bernard Gloster: He could practise.

Deputy Cathy Bennett: He does not, and he gets €10,000 for that.

Mr. Bernard Gloster: I do not know whether he voluntarily assists with calls when they happen in proximity to him. The point is that I did check this out because I am aware of the discussion at the health committee. Notwithstanding the view of anybody, to be fair to the director, that was the salary that was approved for him at the time. It was properly approved by a national director that he reported to in 2011. He has a contractual right to it. Whether anybody views it as the right use of an allowance or not, it is part of his terms and conditions. That is not going to change. To be fair to him, it is important to say that. If there is any fault in that, it is on the side of the HSE.

Deputy Cathy Bennett: I am on the side of the ambulance drivers who are constantly under pressure and who do the work on the ground. They are not being paid as correctly for the hours they are doing. The director gets paid this additional amount and he does not even have to do the work for it.

Mr. Bernard Gloster: He runs the entire National Ambulance Service, which is an enormous burden. Every ambulance driver, every paramedic and every advanced paramedic gets the allowances attached to their role. I get the point that they do not believe that remunerates them fairly. That is why we have public sector pay agreements and SIPTU and others represent them. I never ever pass the opportunity - I have been out on the road with them - to say that they are a wonderful workforce on which we rely heavily. I hope future pay agreements will recognise that.

An Leas-Chathaoirleach: Twenty-seven billion euro is huge amount of money. It can be difficult for people to contemplate that sort of scale. It is often the examples where controls were missed that point to broader issues. It is the issue of the €15 million spent between 2020 and 2024. In his opening statement, Mr. Gloster was incredibly honest and open about it. I want to flesh it out a little in order to try to understand and to allow the public to understand. What were the devices? How did it come about that it was not a standard procurement process? Why did it continue for four years?

Mr. Bernard Gloster: I will let Mr. McCallion explain the actual device. In fairness, I was not here, as CEO, at the time, but I have to own that on behalf of the organisation. It came about because there is a constant push that the HSE is too slow to embrace new technology. We were told you could go to the Netherlands and buy a software package off the shelf that would run everything for us and it would be great. You can see what happens when we buy off the shelf. There are reasons why due diligence is applied to public sector technology projects. It was in the unique circumstances of Covid. It was absolutely well motivated. I am not aware of any conflicts of interest on the part of any of the people who were involved in bringing it into the organisation.

In real simple terms for the public to understand, we were buying sensors that are used to monitor people. Those sensors have a shelf life of a couple of days. The people who were paying the invoice were not checking if the sensors were being drawn down from the company to be used at the rate at which we were paying for them. As a result, we ended up paying for more sensors than we actually received or drew down. When the company went to the wall, there were no sensors and no money. That might sound almost trite, but that is the most brutally honest way I can describe it. The system just broke down.

An Leas-Chathaoirleach: These sensors were part of the diagnostic for respiratory-----

Mr. Bernard Gloster: Mr. McCallion will describe it.

Mr. Damien McCallion: They came in the early part of the pandemic. They allowed staff to monitor deterioration in terms of respiratory illness. At the time, with Covid-----

An Leas-Chathaoirleach: Which would have been important during the Covid period.

Mr. Damien McCallion: The context in which it was set up at the time in terms of looking back was around getting that into the hospitals as quickly as possible and being ready.

An Leas-Chathaoirleach: Do we know how many devices were drawn down over the periods?

Mr. Damien McCallion: Not in total. Mr. Mulvany might be able to add to that. The Department of Finance did look at this to see what was there, but we know there would have

been a shortfall. The way it was set up is a certain amount was available to be used, a bit like a lot of the other facilities at the time. In terms of the total number of devices, I could not give an exact figure in terms of what was there.

An Leas-Chathaoirleach: Was a regular or quarterly period agreed?

Mr. Damien McCallion: A quarterly payment was set up.

An Leas-Chathaoirleach: What was the agreement for the quarterly period? What was the number of devices that was agreed?

Mr. Damien McCallion: Mr. Mulvany might have the actual numbers, but the way it was structured is that it was paid quarterly and people were able to draw down from that in terms of what they needed at the time it was going through.

An Leas-Chathaoirleach: I accept that. The CEO said it.

Mr. Stephen Mulvany: For the devices or sensors, per quarter we were being billed about €900,000, approximately €2,500 per pack. There were six in a pack. The estimate we have given is based on the best estimate people could make. Each of them lasted about three days on the patient. If you look at the wards they were in, they were only in certain wards in certain hospitals, as Mr. McCallion said, for respiratory patients. They allowed for remote monitoring, which was very important during Covid. Unfortunately, the local process to receive them in stock did not work appropriately. They were delivered directly to wards. The central process, as the CEO said, was paying an invoice without that basic check to see-----

An Leas-Chathaoirleach: The invoices were being paid. I am struggling with the maths. How many devices were received per quarter?

Mr. Stephen Mulvany: I will get that information if I can.

An Leas-Chathaoirleach: Mr. Mulvany can come back with that. A certain number of devices were received per quarter and were drawn down in individual hospitals. They are small devices. Storage was not going to be an issue. Were the people responsible for drawing down those devices aware of the total available quantity? Who had responsibility for drawing down the invoices?

Mr. Bernard Gloster: I am not sure about the awareness of the quantity involved. They were certainly aware of the availability. There were varying levels of difference and indifference to the continued use of them. Some places thought they were good and kept using them. Some places did not bother any more as they did not need to as time progressed through the pandemic and so on.

An Leas-Chathaoirleach: I am sure it is not unique, for example, for items to be available in a hospital and the front-line people do not think necessarily where they come from. They take whatever equipment, plasters or whatever the different devices are. At that level, there would not be an expectation for them to be aware of it. As you start to come up the line, at some point, somebody must have been managing the total drawdown of all products or some version of a delivery docket to say a certain number were received and it was therefore appropriate to pay a particular amount for them.

You would wonder whether, if only a certain number are drawn down, the contract would allow for non-used items to be drawn down in further quarters.

Mr. Bernard Gloster: You would think that, would you not? Again, what I can say to the Deputy is that the gap between the signing of the invoices and the actual utilisation or checking was so wide as to be absolutely inexplicable. There is no point in me trying to dress that up in any other way. It was one of the most defining collapses of corporate governance that I could see.

An Leas-Chathaoirleach: This particular one?

Mr. Bernard Gloster: Yes. This was extreme, not because it happened once but because of its continuing. That is just the reality. Nobody called it out, nobody said "Stop", and nobody asked for a check. It did not even come about through our proactively finding out about it; it came about because of changes in the structure.

An Leas-Chathaoirleach: That is the point. Mr. Gloster's admission here is that he became aware of the matter because of the perceived grievance of the company that was in liquidation to the effect that the HSE owed it money.

Mr. Bernard Gloster: Yes.

An Leas-Chathaoirleach: Given Mr. Gloster's contribution here, that is a breathtaking assessment by the company. Surely the flow of other products is managed, so the question arises as to why the contract in question was different from that for other products whose draw-down is stock managed.

Mr. Bernard Gloster: I think there are two reasons, and perhaps the chief financial officer can add to them. The first is that the control environment was substantially relaxed – I will not say "dispensed with", but close to it – during the period of pressure to get things done during the Covid pandemic. The second is that parts of the organisation became very excited about buying technology that they thought was great and would do wonderful things for them. While that might have been great at the level of innovation, it was a shocking abdication at corporate level to continue to pay invoices for something you did not even know you were getting. That is the truth.

An Leas-Chathaoirleach: My question was on how the procedure differed from that for bed sheets, towels and toilet rolls.

Mr. Stephen Mulvany: The most basic control measure – you cannot even use the lack of the IFMS at the time to explain this – is the check to see goods have been received before paying the amount invoiced for. That is the fundamental control. Essentially, an invoice was being received for an amount that might have made sense during the Covid pandemic when the volumes were, perhaps, small, but certainly did not make sense at another time. The basic check was not in place until somebody at the centre, in fairness to them, asked, albeit far too late, why we were making the payment and who got the products. Once that question started to be asked, we stopped paying. The supplier started screaming blue murder, and what happened happened.

On the Deputy's other question, €12.8 million is what was paid for sensors as part of the overall cost. Accounting for individual sensors rather than packs, that amounts to 218,000

sensors to be explained over the period 2021 to 2024. When we use the estimate – which is very sensitive, three days being the average – and given no good local or central stock-control records, there are 218,000 sensors to explain. Products worth from €5 million to €7 million were not accounted for or were never received. It was nugatory expenditure, effectively. The figure relates to between 91,000 and 132,000 sensors. We were being billed-----

An Leas-Chathaoirleach: So, there could be up to 132,000 sensors never received.

Mr. Stephen Mulvany: That is what the estimate of €5 million to €7 million represents, given a cost of €58.51 per sensor. That is the number.

An Leas-Chathaoirleach: To return to the accountability issue, I understand why, in the rush to innovate in response to Covid, that could happen, but surely in the accounts department there is no difference between one payment and another. I cannot understand why this particular invoice was not subjected to the same checks as others. What department or section of the HSE continued to make the payments without checking the delivery dockets?

Mr. Bernard Gloster: My understanding, without wanting to be unfair to anyone, is that the origin was in what we might call the wider technology part of the organisation. I want to be fair to the many there who might have had something to do with it. The matter then transitioned to another part of the centre of the organisation in our old structure, namely, the national office for hospitals, which no longer exists. Then it started to progress out to the regions or local areas, and that is actually when the flag was run up the pole.

Deputy Séamus McGrath: I thank everyone for being here. Like the Leas-Chathaoirleach, I thank Mr. Gloster for his opening statement. It was very clear, plain and honest, which I appreciate.

Much of the issue of the unprocured products has been covered, so I will not dwell on it. Some €5 million to €7 million is effectively the estimated amount of irrecoverable money. Could that figure possibly increase?

Mr. Stephen Mulvany: No, I do not believe so. The estimate is based on the number of days and is very sensitive to that. If the number of days was two, the figure would drop substantially. The estimate of €5 million to €7 million is the best estimate we have.

Deputy Séamus McGrath: The best estimate.

Mr. Bernard Gloster: I think we have gone to the outer side of it in order to make sure that there is no potential for creep.

Deputy Séamus McGrath: Mr. Gloster is confident it will not creep further up. Does it relate to just one supplier?

Mr. Bernard Gloster: One company, yes.

Deputy Séamus McGrath: I will move on because I know other members have touched on accountability and related issues. It is a significant figure, obviously.

Let me move on to the out-of-date stock. Again, the witnesses were frank at the outset in relation to additional products, masks and so on. The Comptroller and Auditor General

indicated in his report that the total figure, between vaccines and protective equipment, was €33.8 million. Is that a figure Mr. Gloster agrees with?

Mr. Stephen Mulvany: Yes.

Mr. Bernard Gloster: To be fair, what happens with vaccines is that they differ by fridge life, shelf life and date life. That is the first thing. The second is that, because the vaccines are Covid-related, we buy them on advice from the Chief Medical Officer and the national immunisation advisory committee. The Deputy will recall the panic there was to get a vaccine-

Deputy Séamus McGrath: Absolutely.

Mr. Bernard Gloster: -----and also the panic to make sure Ireland secured its supply. We became part of EU agreements to buy certain amounts of vaccine so the companies could produce them-----

Deputy Séamus McGrath: Is all the out-of-date stock related to Covid?

Mr. Bernard Gloster: Two things can happen: either vaccines go out of date or they are replaced by more efficacious versions because of how the virus mutates. It is a combination of the change of vaccine type and the date timeline. That is essentially it.

The position on the personal protective equipment, PPE, is a little more complex.

Mr. Stephen Mulvany: The biggest part of the disposal cost for PPE and other items, which we reckon will amount to about €7.5 million by the time the disposal is finished this year, relates to the disposal of alcohol-based hand gel. That is very tricky to dispose of; you cannot pour it down the sink or incinerate it. The cost amounts to between €5.5 million and €6 million.

Deputy Séamus McGrath: Could Mr. Mulvany clarify that all these products are Covid related?

Mr. Stephen Mulvany: They are all pandemic related.

Deputy Séamus McGrath: All are pandemic related. Okay. Are we coming to the end of it now?

Mr. Stephen Mulvany: Subject to what the CEO said.

Deputy Séamus McGrath: In terms of masks.

Mr. Stephen Mulvany: In terms of surgical masks.

Deputy Séamus McGrath: Could that be quantified for us because it is obviously not included in the €33.8 million?

Mr. Bernard Gloster: Roughly, based on the information available to me this morning and what we are drawing down today by way of masks to use in our hospitals, we probably have a supply for between seven years and nine years. They will become obsolete within two to three years. If you do the maths, you will conclude you are using five or six years-----

Mr. Stephen Mulvany: They were all purchased in 2022 and 2023 and they would all have had a five-year shelf life at the time. The number would have been right but the number being used each week has gone down.

Deputy Séamus McGrath: What is the estimated loss in relation to the additional issue of the masks? Are we talking about millions of euro?

Mr. Stephen Mulvany: We are talking about millions of euro. I do not have the actual figure and I would not want to mislead the committee. We will be disposing of a substantial number of masks.

Mr. Bernard Gloster: When this was brought to my attention this morning – this is why I introduced this at the end of my opening statement – I wanted to stress that even though the products have not gone out of date yet, the issue is important to the substance of what the committee is talking about.

Deputy Séamus McGrath: Mr. Gloster is foreseeing that-----

Mr. Bernard Gloster: We will assess the cost in the coming days to the best degree possible and we will then notify the Comptroller and Auditor General and the committee. It is extremely important that, when the committee talks about losses through the likes of obsolescence status, we anticipate what might become obsolete rather than just state what already is.

Deputy Séamus McGrath: What was the sense of buying a seven-year supply of stock?

Mr. Stephen Mulvany: The current weekly usage number is 55,000. These are the surgical masks, the plain masks, referred to as FFP2 masks. When they were bought in 2022 and 2023, the usage number was an awful lot higher than 55,000 per week. We bought masks during the pandemic for all of the public service.

The level of usage has fallen now. In two or three years' time, as the CEO has said, these masks will be obsolete. We are looking to see if there is anything we can do to offload them, but we would not want to raise expectations. That has never proven to be practical.

Deputy Séamus McGrath: Obviously the surgical setting is critically important, but are there other settings where they could potentially be used or less onerous-----

Mr. Stephen Mulvany: Potentially. These are the most basic masks. The average cost per mask is 30 cent.

Deputy Séamus McGrath: Overall, we are looking at an additional amount of €1 million.

Mr. Bernard Gloster: There are certainly options because the timeline on them has not run out yet. I would say the first thing we have to consider is if there are clinical services across the country - not even just HSE but also voluntary services or nursing homes and other settings - that wants to draw them down and utilise rather than waste them, we would be very happy for that to happen.

Deputy Séamus McGrath: The controls and the integrated financial system and so on have been discussed. Where is the HSE at with the digitalisation of patient records?

Mr. Bernard Gloster: Mr. McCallion is leading on that.

Deputy Séamus McGrath: If I am right in what I am saying, anyone who has attended a hospital knows that you see the doctors and there is paper and a clipboard in front of them. It is not digital. As I understand it, if I go to one hospital in Cork and then six months later I go to another, the record of my previous visit is not available to the doctors attending me. This is prehistoric, with respect. Where are we with the digitalisation of patient records?

Mr. Damien McCallion: We focused on this in Digital for Care 2030. That is good, and there is increased investment. There are a couple of pieces to it. The first is that we are developing a national shared care record, which will go live in Waterford and Wexford next month. That will try to pull together some of the existing information that is in the heavy charts to try to make it available. For example, if something happened to me in Dublin and I lived in Sligo, the information would be available. We will gradually roll that out over the next couple of years. We will also expand the information that is available within it. This is one piece.

The other, bigger piece is around our electronic health record programme, in respect of which we have brought forward a preliminary business case. This is going through the approval process at the moment with the various Departments. We are hopeful that we will get it through in the next couple of months, which would then allow us to proceed to the prior information notice stage for tender for the project. In parallel, in view of the fact that this will take many years, as well as the shared care record, we are also putting in solutions into certain services. The Deputy mentioned Cork. If one went to the maternity hospital there, one would see a full electronic health record for staff. We are also allocating appointments to patients through the health app.

The three main legs include the app, which is live now. Hospital appointments were mentioned earlier. They are now available for patients via the app. We are seeing that grow every day. Second, there is the shared care record, which should build up a picture of the chart that we have at the moment. Third, there is the full electronic health record, which is to say we have a full-----

Deputy Séamus McGrath: Overall, in simple terms, when will we see full digitalisation of patient records?

Mr. Damien McCallion: It will be gradual process. I was in Northern Ireland yesterday. They have a full electronic health record rolled out across their trusts. They did that over ten years. It is a gradual process, but it will not be a case of waiting until the end; it will be building up as we go.

Deputy Séamus McGrath: It will be in phases, but for the entire health service-----

Mr. Damien McCallion: Our aim is by 2030 to be substantially on the way with that. Certainly, with things like the shared care record, everyone should have some contact. Even today, all hospital appointments for the vast majority hospitals are available to all of us if we download the health app.

Deputy Séamus McGrath: It just seems that as an organisation the HSE has been very slow to move in relation to digitalisation.

Mr. Damien McCallion: Just to say-----

Deputy Séamus McGrath: If I attend the Mercy Hospital in Cork and six months later I go to Cork University Hospital and the doctor who is attending does not have a record of-----

Mr. Bernard Gloster: To be fair, the Deputy is 100% correct that we have been slow as a system and not just in the health service but in general in the public sector in terms of digitalisation. I would say, however, that in the last two years we have been faster than we have ever been. We have gone from the health app, to the shared system-----

Deputy Séamus McGrath: They will have to move faster here now as well. I appreciate that.

Mr. Bernard Gloster: We are moving to the shared care record, and that would be the basis of the electronic health record. It is a very exciting time ahead.

Deputy Séamus McGrath: I thank the witnesses. Going back to the children's hospital and the integration of CHI into the HSE, this is progressing and is welcome. Deputy Ardagh touched on the matter earlier. The further extension of the substantial completion date to the end of November is very serious. Does that have implications? We were given a date of June 2026 for the start of treatments and so on at the hospital, and that it will be on a phased basis. Do we expect it not to occur in June now?

Mr. Bernard Gloster: As I said earlier, I would still expect it between the end of the second quarter and sometime in the third quarter, which is next summer. We have to continue to press for clinical services to have commenced in the new hospital. If the early access that CHI have been promised happens in November, regardless of the finish date by BAM, that will expedite this and will help. Again, I have to say we are ultimately reliant on BAM to tell us when they are finishing and to stick to that. That is the fundamental issue.

Deputy Séamus McGrath: I thank Mr. Gloster. Moving on to the use of external consultants by the HSE, it has been reported that €250 million was spent over a two-year period in relation to external consultants. Just be clear, these are not medical consultants these are management consultants. The figure seems very high.

Mr. Bernard Gloster: Yes.

Deputy Séamus McGrath: As chief executive, is Mr. Gloster putting in place a plan to reduce dependency on external consultants? Do we expect that in 2026, for example, that we will be spending similar amounts of money on external consultants? Is there a plan to reduce the HSE's reliance on external consultants?

Mr. Bernard Gloster: There is not only a plan, there has already been a reduction. There are three categories of consultants that we use. One is for information technology and developing the digitalisation, one is for experts in major building projects, and one is for general management consulting. The expenditure in general management consulting since I first reduced it has now probably reduced by close to half at this stage.

Mr. Stephen Mulvany: It is between one third and one half.

Mr. Bernard Gloster: I have already reduced it by between one third and one half. It is very controlled and that will continue to be the case.

Deputy Séamus McGrath: That is about €125 million per year. Do the witnesses see that figure coming down substantially in the coming years?

Mr. Bernard Gloster: In my first year it was about €114 million on generic management consulting. We brought it back down I think to around €60 million.

Deputy Séamus McGrath: I might come in again, but my final word now is to wish Mr. Gloster well.

Mr. Bernard Gloster: Thank you.

Deputy Séamus McGrath: I know you are going to leave the organisation in a few months' time. Overall, I think you have had a very good tenure as chief executive. I wish you well.

Mr. Bernard Gloster: I thank the Deputy. I am very grateful for that.

Sitting suspended at 12.06 p.m. and resumed at 12.22 p.m.

Deputy Grace Boland: As my mother repeatedly reminds me, we pay for our health services three times as taxpayers: once as a taxpayer, once with our private health insurance and once at the point of service. Getting control of our overspending and making sure that goods and services are procured appropriately and there is good control and oversight are essential. In terms of the non-compliant procurement, is there a trend that Mr. Gloster sees in HSE-run facilities or sites versus voluntary groups? Is there a greater level of non-procurement in one or the other?

Mr. Bernard Gloster: To be fair, I do not have the immediate insight to be able to say that. What I would say to the Deputy - and I was here long before the HSE and the health board system - is that local practices develop and when things are being purchased locally or small purchases are being made one gets everything from three quotes in the post, to an official advertised process, to no process at all. If the Deputy looks at the way our spend has increased, I am not sure if the rate of non-compliance is growing rapidly. The IFMS is going to help us knock that on the head.

Deputy Grace Boland: Does Mr. Gloster think the IFMS will substantially deal with the non-compliance found?

Mr. Bernard Gloster: I do, yes. It is a rules-based system and people cannot go around it. I think it will cause terror for a few months because people are used to doing things locally and quickly. It does not mean they are bad people. However, the scale of the spend of the Irish health service is such that if we do not have top to bottom line of sight, we do not have control.

Deputy Grace Boland: I have worked in organisations that had SAP. It is a good system and is something we need with our health service. Are the service agreements with the voluntary hospital groups negotiated annually?

Mr. Bernard Gloster: We have service arrangements for everything above €250,000. There are two parts to it. The first is part one of a service arrangement, which is about overall compliance, rules of engagement and so on. The second part is about the particular detail of the particular year, be it the amount of staff, money and so on. They are done quite often. The problem is there is too much of a gap between getting them started and getting them finished. It is one of the things that a multi-annual funded system would help us with. Even with the

single annual funded system we have, we are often a bit slow at getting them out and organisations are very slow at agreeing to sign off on them.

Deputy Grace Boland: Are there particular repeat offenders in terms of delaying signing off on them?

Mr. Bernard Gloster: Some of the larger hospitals are very slow in their-----

Deputy Grace Boland: Can Mr. Gloster give me a few examples?

Mr. Bernard Gloster: I will get my list out. We spoke about the Mater hospital this morning. It has presented us with challenges. It would say that they are legitimate challenges. I do not want to be unfair and misrepresent the hospital. I do not believe they are legitimate challenges because there has never been a case where the HSE did not fund the hospitals to pay their cash bills in a year. The State always pays its bills. I believe that some of the approaches to the service agreements by some of the organisations have been pedantic. I do not accept that they need go as far into the year unsigned. I have just been told that the Mater signed in the past 24 hours. This is October. To me, signing an agreement in October for a year in which ten months have already elapsed is not an agreement.

Deputy Grace Boland: That is unsustainable and not acceptable.

Mr. Bernard Gloster: That is the point I am making. To be fair, the CEO of the Mater hospital is a wonderful person and I have no criticism of her or her skill set. The service arrangement process just does not work well or in the way it is intended to.

Deputy Grace Boland: I assume that from year to year the agreements are fairly similar. Speaking as a lawyer, it would be very strange that one would have to negotiate for another 11 or 12 months.

Mr. Stephen Mulvany: Yes. Part one, as Mr. Gloster said, is the bones of the agreement. Its text is periodically reviewed every few years. I chaired the most recent review. It was done in a partnership process with the representative bodies mentioned earlier over approximately 12 months. It is the part two, what is called the HPSR, or health policy and systems research, that is often the bit that is difficult. It asks: "What is the money, with what staff and for what level of service?" While it is not something to celebrate - we should have them signed at the start of the year - as matters stand today, there is about twice as much by value fully signed off than there was at the same time last year. That is not something to celebrate but it is an improvement.

Mr. Bernard Gloster: It is improving. My predecessor once removed - I am not sure what the title is - Tony O'Brien introduced a system several years ago under which a percentage of the funding would be withheld from organisations that did not sign the agreement by the end of February. It is the only strategy we have, but it can cause consternation. I am always worried in those circumstances that it would cause unintended harm to people.

Deputy Grace Boland: I appreciate that. I am just conscious of the time. Voluntary groups are citing obstacles or challenges, but can it not be put into the service agreement that they must integrate IFMS?

Mr. Stephen Mulvany: Clause 9.2 of the service arrangement, which was agreed through that partnership process over the past 12 months, says exactly that. It requires them to proactively adopt the IFMS.

Deputy Grace Boland: Have they already signed it?

Mr. Stephen Mulvany: Those that have signed the agreement have effectively signed up to its clauses, and that is one of them.

Deputy Grace Boland: Are there hospitals that do not sign up to the service level agreement on an annual basis?

Mr. Stephen Mulvany: Typically, they will all eventually sign. The issue, as noted, is-----

Deputy Grace Boland: It is retrospective.

Mr. Stephen Mulvany: -----that it is too late in the year to be signing it.

Deputy Grace Boland: How do the service level agreements work? With a hospital, does the HSE say that if it does X number of heart surgeries, it will give it Y amount of funding or does it just give the hospital an open-----

Mr. Bernard Gloster: No, traditionally we block-granted or block-funded the hospitals. We are increasingly attempting to move to a position of activity-based funding that would give those types of efficiencies. Some hospitals say that they would very much welcome that. It is a slower process. We are able to do the measurements around it but we have not got to that level of a funding model. We do specify new developments, and those are easier to measure. The overall pay bill and everything else stays pretty constant.

Deputy Grace Boland: Does the HSE have any suspicions that the taxpayer is paying for services that are not being delivered?

Mr. Bernard Gloster: This is where I think it is important to be fair to section 38 hospitals and everybody else. It is not just them. We have our own hospitals too. I would say the taxpayer is paying for services that are expected in the annual service plan from the Minister to the HSE, or expected historically, and that do not come up the standard or level that is expected.

There may be different reasons for that, but I would say we have a way to go in our health and social care system before we can stand over saying we are delivering what we are funded to deliver.

Deputy Grace Boland: What can the HSE use to get that oversight to understand what the position is?

Mr. Bernard Gloster: We now have a much more mature performance reporting system of all of the data. For example, the six regional executive officers now report directly to me. There are no layers between us. I meet Ms Long every couple of weeks. I have a standard performance report and we publish it on the website for everyone to see. I am able to get a regionalised version of that report, and go through it with Ms Long. It includes her own services and her section 38 hospitals and agencies. We are able to see where performance is slack or in trouble and go after and performance manage that. We have a better performance management system than we did.

Deputy Grace Boland: That is good. In terms of the section 38 hospitals, will the service level agreements include performance levels?

Mr. Bernard Gloster: Yes.

Mr. Stephen Mulvany: Currently, we include the level of inpatients and day-case volume and ED attendances, as well as the staffing.

Deputy Grace Boland: Going forward will we be able to track that?

Mr. Stephen Mulvany: We can and we do. There is complete information available from the hospital inpatient inquiry system as to what is the level of activity actually being done across every hospital in the State.

Deputy Grace Boland: Is SAP HR being deployed across all HSE sites and voluntary hospitals and is there any pushback on that?

Mr. Stephen Mulvany: Dr. Withero might want to address the NISRP system across the HSE.

Deputy Grace Boland: Dr. Withero does not have long.

Dr. Philippa Ryan Withero: That programme is delivering a single, integrated staff record system. We have rolled this out to all of the statutory side. This involves approximately 110,000 employees. We are now moving into the section 38 agencies. The first tranche of the section 38 organisations will cover approximately 8,000 employees. Delivery preparations are well advanced for go-live dates in quarter 1 and quarter 2 of 2026.

Deputy Grace Boland: Is there any pushback from those hospitals?

Dr. Philippa Ryan Withero: At the moment, we are working very well with the hospitals and agencies as well, because it does not only include hospitals-----

Deputy Grace Boland: Will it address all of the overpayments, etc?

Dr. Philippa Ryan Withero: In terms of the SAP system and the overpayments issues, SAP obviously has a process that is in compliance with our consolidated salary scale and allows us to have full level of detail and transparency in terms of payments.

Deputy Grace Boland: I thank Dr. Withero.

Deputy Aidan Farrelly: I thank our witnesses for being here this morning. I will focus my contribution on two areas, number one being the IFMS. With regards to phase 1 of the project, what are the main differences between phase 1 and phase 2 of the system?

Mr. Bernard Gloster: Basically, phase 1 is the application of the system across the HSE in three staged groups. Phase 2 takes us on to the major funded organisations, including all section 38s and the top-ranking section 39s.

Deputy Aidan Farrelly: Who develops phase 1?

Mr. Bernard Gloster: It is developed by a programme board. We have a programme board that oversees IFMS. The Department of Health is involved in that, along with the Department of public expenditure and obviously ourselves. It is overseen and reports into the CFO.

Deputy Aidan Farrelly: Who developed the software?

Mr. Damien McCallion: It is based on the SAP S/4HANA system. SAP software comes from an international German company. SAP is the market leader in enterprise planning systems. SAP spends more on research than most of its competitors on turnover and is seen as the market leader.

Deputy Aidan Farrelly: How much did that cost to develop and implement?

Mr. Stephen Mulvany: So far, as it says in our opening statement, to the end of phase 1, the entirety of costs is €198 million. If we put that in the context of €20-odd billion a year, which is actually supported in terms of us managing spend, those costs are then broken down into ICT capital costs, which is largely software, licences and systems integrators. That is €90-odd million, and then we have costs for the revenue part of that. There is a revenue part of licences. Every time we buy a licence through capital, we pay about 22% per annum afterwards. Then there is the cost of the actual project team, which is about €59 million to date out of that €198 million. These are all costs that have moved on from what was reported in 2024 in the Comptroller and Auditor General's report on IFMS.

Deputy Aidan Farrelly: Is there an annual fee that goes with the software as such?

Mr. Stephen Mulvany: The model of licences in SAP will change. They are seeking to change it. The standard way we buy licences is to pay a capital fee, and then pay 22% or 23% per annum for maintenance revenue out of current operational expenditure.

Deputy Aidan Farrelly: When Mr. Mulvany says it is seeking to change the licensing arrangement, what does that mean?

Mr. Stephen Mulvany: It is a long, complicated story, but basically it is seeking to move more to revenue and less to capital. That is commercially sensitive and a negotiation that is ongoing. For now, we are not moving away from the standard but it is an ongoing live issue. It all depends on how we want to pay the overall money and where to get the best value. Our aim is to ensure the best value but I cannot say much more.

Mr. Damien McCallion: Just to say Deputy, that many companies use SAP for this software-

Deputy Aidan Farrelly: Are there external consultants in the HSE to augment that implementation?

Mr. Stephen Mulvany: Yes, the other big part of the capital cost is what is called the systems integrator. That is an external consultant expert in the actual piece of software. For us, that is IBM. It has been for the past number of years.

Deputy Aidan Farrelly: What does that look like in practice? Is that people working directly? How many people is that and what is the cost associated with that?

Mr. Stephen Mulvany: I can get the cost for the Deputy. It is a combination of people who are onshore and offshore. There are people who come to some of our offices, people who are based in Europe, and they access experts all over the world, including places like India. It is an entirely external resource. It is a core, essential part of any large enterprise's resource planning implementation. I will come back with the actual cost.

Deputy Aidan Farrelly: Mr. Gloster said in his opening statement that the Minister for Health has requested an accelerated roll-out of this system. What was his response to the Minister?

Mr. Bernard Gloster: I was delighted that we are being pushed to the limit of what we can do to roll this out as fast as possible and that is no reflection on anyone who has been involved in it. The reality is that the HSE has had a reasonable expectation and effort to introduce IFMS since 2016. It is only this year and last year we have actually seen it rolled out in the HSE. That is far too long. It is a long investment, there are reasons for it such as Covid-19, a breakdown with suppliers and all those kinds of wonderful things. However, as I said earlier, Ireland is a very small place. We have too many individual health governance systems and that is a decision for the Government for the future. However many governance systems we have in independent organisations, the one thing we cannot have is different financial control or management systems. I am delighted and we are pushing on.

Mr. Stephen Mulvany: Within the €92 million ICT capital part I mentioned, €68.9 million is for the systems integrator.

Deputy Aidan Farrelly: If that licensing arrangement changes, is that potentially going to be more costly for the organisation going forward?

Mr. Stephen Mulvany: The figure I gave the Deputy just now is for the systems integrator, that is, for IBM. As for the licensing fees, all I can say here is we do not intend to allow it to get more expensive, certainly not if we can help it. It is always about driving value but it is a market.

Deputy Aidan Farrelly: Is the HSE tied in to an annual contract or multi-annual contract? How does that work? How often is the licensing agreement up for negotiation?

Mr. Stephen Mulvany: I would have to check the exact fees. The way the contract works is the organisation has to engage periodically on the licences and the cost of the licences, and typically it is retrospective, depending on what you have used in a period gone by. Obviously, you then forecast what you need going forward. A contract allows for that kind of engagement over the price, and we are focused on making sure we continue to get the best value that we can.

Deputy Aidan Farrelly: I thank Mr. Mulvany.

With regards to Baggot Street and the disposal of the Baggot Street hospital, there is mixed reporting. Was the LDA offered the site?

Mr. Bernard Gloster: I believe so, yes. All of the information available to me on Baggot Street is as follows. The LDA was aware that we had no strategic use for it and were thinking of moving it on, Dublin City Council similarly and so on. Since the end of 2022, we have disposed of 53 or 54 properties. We have disposed of them to other State bodies. I would say we are one of the better State agencies for ensuring that when we are disposing, we give other State agencies a chance. Baggot Street has been up on the register as surplus to our requirements since mid-2024. We cannot continue to carry the risk of an empty building and the cost of security and maintaining it. We put it on the open market. Regardless of what the view might be of the engagement with LDA or DCC or anybody else, if any State agency wants

to write to me today and express a strategic interest in procuring that building, we will take it off the market.

Deputy Aidan Farrelly: Any agency at all?

Mr. Bernard Gloster: Any State agency that is comprehended by the guidelines.

Deputy Aidan Farrelly: Does that include the Department of housing?

Mr. Bernard Gloster: Yes, the Department of housing.

Deputy Aidan Farrelly: In the context of the reports in the media, I would like to query the accuracy as to the cost of whatever works would be required to do that. Is Mr. Gloster's understanding that millions of euro would be required?

Mr. Bernard Gloster: Yes, our understanding is that the cost of bringing it into use for any purpose we would use it for would be punitive. In terms of return on investment, it would not make any sense for us to do it. It would Hoover up an enormous amount of capital that we badly need for other things. What the cost would be for other State agencies which might have a different use for it, for example, for housing or accommodation, I am not sure. I would not be expert in that, but, to be fair, it would be costly. However, I am more than happy to dispose of it on the interstate agency transfer system if any other entity wants it. However, I will have to be informed of that because I cannot just take it off the market and be lumbered with trying to mind it again for the next five years. If somebody wants it, they can have it, within the guidelines and rules. If nobody wants it, we are going to sell.

Deputy Aidan Farrelly: That is an impressive number. Mr. Gloster said 50-----

Mr. Bernard Gloster: It is about 57%. There have been 51 property transactions with other State agencies since the end of 2022.

Deputy Aidan Farrelly: Would they be crystallised in the accounts? Is there ever a financial transaction as part of that?

Mr. Bernard Gloster: Yes. There is a market value transaction for that, but how they reflect in accounts I am not 100% sure.

Mr. Stephen Mulvany: If we receive payment for them, it would be reflected in the annual accounts.

Deputy Aidan Farrelly: When the HSE receives payment for those premises, where would the funds go?

Mr. Stephen Mulvany: We are able to hold onto disposal values up to a certain amount, but that is something that has to be agreed between ourselves and the Department. Often, these properties, as I understand it, depending on what the market value is, may be given for a value lower than the market value if they are being transferred to a State body.

Mr. Bernard Gloster: If there is a health related benefit to the community from it we can transfer it at below market value. For example, we recently had a small health centre building we owned in Kilcullen in County Kildare. The local community had invested money in it. The council was interested in it. There was absolutely no problem. That will go for below market value.

Deputy Aidan Farrelly: Then the HSE apportions that funding into its overall accounts.

Mr. Bernard Gloster: There are rules with the Departments of Health and public expenditure about the utilisation of funds we receive and dispose of. Normally, we would not be using them for revenue costs. They would either go towards our capital programme or it would be held, essentially, in account until there is an agreement with the State as to what to do with it.

Mr. Stephen Mulvany: It goes into the capital allocation for any given year, and the Department would be aware of the overall disposal. It is taken into account in the overall setting of the available capital funding for the organisation. It is transparent.

Deputy Aidan Farrelly: How many other sites are currently up for disposal? What is the potential market value?

Mr. Bernard Gloster: I do not have the potential value, but we have a potential disposal programme for in the order of 150 to 200 sites. I will get clarity on that for the Deputy. Many of those are small cottage health centres in small villages that we no longer use. I will get the Deputy the full details. Our board made a decision this year to do a nationwide disposal of any properties we no longer had strategic interest in keeping.

Deputy Aidan Farrelly: Thank you.

An Leas-Chathaoirleach: We are going into our second round. I will give speakers five minutes. Deputy Dolan is next.

Deputy Albert Dolan: I want to focus on Portiuncula hospital. I represent the constituency of Galway East. I was born in Portiuncula. My mother worked there. She was a GP. Portiuncula is part of the fabric of Galway.

Mr. Bernard Gloster: Absolutely.

Deputy Albert Dolan: It serves a wider region comprising eight counties. There has been huge hurt and upset over the handling of the downgrading of maternity services at Portiuncula. I understand that when there are serious issues, a serious response is required. I just want to ask for clarity on a certain element of this.

Mr. Bernard Gloster: Yes.

Deputy Albert Dolan: About two weeks ago, Dr. Martin Daly TD asked Mr. Gloster if the Walker report had been implemented. The response he received was that it had not. As a result, he went into the Dáil and asked a question of the Minister for Health, Deputy Carroll MacNeill. Deputy Daly said it was not implemented but the Minister said that there was an independent HIQA review which confirmed that all the measures in the Walker report were implemented. Can Mr. Gloster confirm whether the Walker report was implemented or not?

Mr. Bernard Gloster: I do not want to confuse anybody, particularly as I am very conscious that there is a community involved and that people have concerns and a level of anxiety. We have wonderful staff down there as well. Dr. Daly will certainly agree that what I tried to reflect or what I hope I reflected to him was that regardless of what anybody says about the implementation of the Walker report happening at the time and the recommendations being followed, you clearly could not state today that they were implemented and sustained. To be fair to the Minister, as I understand it, HIQA did validate them at a particular point for the

region. The region ticked the recommendations as being implemented but clearly what happened was that as matters progressed into 2023, there was a very significant slippage in the safety standard measurements at the hospital. I have no doubt of the bona fides of the people who said they were implemented at a certain point, but, in light of the evidence that I have, you could not credibly say that the implementation was maintained and sustained.

Deputy Albert Dolan: I have listened to the Minister on this. She maintains that there are other level 3 hospitals with maternity services in the country at a similar resource level that are performing very well. Is it a resource issue in Portiuncula or is it a culture issue?

Mr. Bernard Gloster: I certainly do not think it is a resource issue. Attracting to and retaining skill sets in smaller maternity units is an increasing challenge. We have 19 maternity units in Ireland, so that is part of it. We had a review carried out of all the individual recent cases, some of them very harrowing in their outcomes. Fundamentally, we have moved higher risk pregnancies from being booked at Portiuncula to being booked in other units. That is about 20% of the workload of deliveries in Portiuncula. That has to be the case in the face of the evidence until such time as we are satisfied that something has been identified that could change.

Deputy Albert Dolan: Is Mr. Gloster in a position to elaborate on whether progress is being made at Portiuncula towards bringing services back there? Is the culture changing? Are we seeing improvements in service that can give people confidence when they go to Portiuncula for care?

Mr. Bernard Gloster: For higher risk pregnancies, I could not say that right now.

Deputy Albert Dolan: Okay.

Mr. Bernard Gloster: For pregnancies that continue to be supported there and the deliveries that are happening, however, I operate a very simple principle that if I did not believe it was safe, I would not continue to do it. What is being done is being managed. There is an expert team in there that is independent of the hospital. It continues to be on site; it has been there since the start of the year and will be there right to the end of this year. That gives me a level of assurance. However, in terms of higher risk pregnancies, I could not say that right now.

Deputy Albert Dolan: Can Mr. Gloster confirm whether the downgrade of maternity services at Portiuncula University Hospital was entered on the corporate or regional risk register before implementation? If so, when did that happen and what was the risk rating?

Mr. Bernard Gloster: I would be misleading the Deputy if I said I had the detail of that in front of me. I do not, but I will absolutely get it from the region-----

Deputy Albert Dolan: It is just that there was no indication in the maternity services plan out to 2026 that there was going to be any change to service levels.

Mr. Bernard Gloster: No. To be fair, however, when the maternity services plan out to 2026 was written, that was in the phase where things had really improved post the Walker report. That is my point about the recommendations at the time. I do not want to split hairs, but, to be fair, what the Minister was told was exactly correct. The deterioration was very rapid from late 2023 into 2024.

Deputy Albert Dolan: The Walker report was implemented. It was confirmed by HIQA that it was implemented. As soon as HIQA had left, however, standards began to slip.

Mr. Bernard Gloster: I do not know if there is a correlation regarding when HIQA left, but the standards did slip.

Deputy Albert Dolan: I appreciate that. I thank Mr. Gloster.

An Leas-Chathaoirleach: I thank Deputy Dolan. Next is Deputy Neville.

Deputy Joe Neville: I must keep an eye on the clock because I have to leave for Questions on Promised Legislation. I want to pick up exactly where I left off. We were using the example of St. Vincent's hospital and talking about blood banks and ICUs. Is University Hospital Limerick a voluntary hospital?

Mr. Bernard Gloster: No. It is a fully HSE-operated hospital.

Deputy Joe Neville: How does it work with the likes of blood banks and ICUs in the context of charges? I know that in University Hospital Limerick, there was discussion about companies being paid and of consultants who work in both the public and private spheres. How do you differentiate between who is using these companies? If companies are coming in and using the HSE's-----

Mr. Bernard Gloster: I think I understand where the question is coming from. If you go away from things like blood products, the companies we talk about in what we call third-party insourcing come into our hospitals and will employ existing staff of the hospital to work at weekends or late evenings.

They use all our equipment and facilities to clear our waiting lists and look after our patients. Those companies would not be charged back for product.

Deputy Joe Neville: They would not?

Mr. Bernard Gloster: No.

Deputy Joe Neville: Okay, that is fine. That is clarified in the framing of the price. To go back once again, I wish to clarify some issues on a topic I did not raise the last time, regarding the potential write-off of PPE and vaccines. Is that all related to a build-up around Covid-19 or since then?

Mr. Bernard Gloster: Yes.

Deputy Joe Neville: Is there a rolling contract or are all those contracts finished now? There was a reference by Mr. Mulvany, although it might have been in a different context, about a build-up in 2025, 2026 and 2027. Was that related to Covid-19 or what was the situation?

Mr. Bernard Gloster: In terms of masks, the purchasing and the build up for 2025 2026 and 2027 originated in Covid-19. In relation to the PPE being disposed, that was all from the Covid era. The vaccine and vaccine write-offs are part of the Covid era but the supply of vaccines into the country continues. As vaccines change or go out of date, we of course continue to procure those.

Mr. Stephen Mulvany: We are currently contracted to the end of 2026, as the CEO said previously, as clinical variants change, we always want to use for people the best and most up-to-date vaccine based on the advice from the Department and Mr. Gloster. These are not out of date, in some cases, but they will not be used before they are out of date because we have moved on to a different variant or strain of the vaccine to match the circulating-----

Deputy Joe Neville: I have no problem with that. Is the contract up to the end of 2026?

Mr. Stephen Mulvany: On the vaccines.

Deputy Joe Neville: Does that mean we have to buy a certain amount? Are we contracted to purchase a certain amount in that period?

Mr. Stephen Mulvany: Yes.

Deputy Joe Neville: When did we sign that contract?

Mr. Stephen Mulvany: Those contracts were made at EU level. It would have been during Covid. I would have to check the exact date. The Deputy will remember that at the time there was a major push to get contracts in place and that contract has been there for a few years.

Deputy Joe Neville: Who are we buying them from?

Mr. Stephen Mulvany: Primarily, Pfizer, Moderna and a couple of other companies.

Deputy Joe Neville: Have we got contracts with Pfizer, Moderna and those huge companies? Are we saying that we do not need this?

Mr. Stephen Mulvany: We are continuing to vaccinate certain cohorts.

Deputy Joe Neville: Yes, but obviously there is an excess building up.

Mr. Stephen Mulvany: Yes, what is happening is, as the different strains of the virus change, the clinical advice that comes from the Department and the Chief Medical Officer and the advice they take changes. We have vaccines, and as newer versions of those vaccines come out, it is always the preference that the most potent vaccine that is appropriate for people's health is applied. That means we end up having vaccines which were contractually bought and paid for which are not yet obsolete but they will never be used because the clinical advice has moved on to say this is a better version for what people are experiencing now, and that always takes precedence. Therefore, this contract takes us up to the end of 2026 and the assumption is something else will be negotiated before we get to that point. We will continue to need vaccines-----

Deputy Joe Neville: I have no problem with continuing to-----

Mr. Stephen Mulvany: -----as we do for all respiratory illnesses.

Deputy Joe Neville: There is no problem about continuing to update to a better product, but at the same time, that might mean that we are buying too much in between those products, if we are building up a reserve, no matter which way you skin it. Everyone should always buy the updated, better products, but at the same time, we are still building something up and have to get rid of it. Maybe we are buying too much, evidently, as we are going.

On a separate issue, Beaumont Hospital came before us last week. We were here for two and a half hours and it was only in the last half hour that the main issue became open. It was about the new HR system. The cost was going to be €1.9 million but it went to €4.8 million. There was no governance, no procurement, no tender process, there was nothing in place. I have just one question. If we had the proper systems in place, if a financial management system was in place, could this happen?

Mr. Bernard Gloster: Regarding the system that Beaumont Hospital bought, the first thing is I have asked that it be used for the longest period possible before we put the national integration staff records and pay, NISRP, system and other stuff into them so that at least some value is got from the money on that. It goes back to my fundamental, earlier point about the understanding of agencies entirely funded by the State that believe their level of independence is such that they can buy what they want when they want. We pay for it, we pay the bill and they pick the system. Whether it is an integrated financial management system, IFMS, NISRP or a lab system, I have discussed with the Minister throughout this year since she came into office and I have communicated with the hospitals on her behalf as well as on behalf of the HSE, saying we are not prepared to accept a position where any organisation believes that is an appropriate way to discharge public money.

Deputy Joe Neville: I thank the witnesses.

An Leas-Chathaoirleach: I will take up that point later. I want to take the opportunity to touch on two issues which are relevant in my own constituency. After an appearance at the disability committee, Mr. Gloster very kindly came to visit An Saol, a rehabilitation service in my constituency for people who have very significant and profound acquired brain injuries. The proposal is to build a new home for An Saol but also to use the site as part of the Ballymun masterplan and perhaps additional community facilities for the HSE itself. Does Mr. Gloster know where things are at with that project?

Mr. Bernard Gloster: I thank the Leas-Chathaoirleach for the invitation to that and for the advocacy he has advanced on behalf of it. It is an outstanding service both in terms of its model of care and its approach. Shortly after I came back from that visit, I wrote to the Department of disability and outlined the commitments that had been given in the previous, Thirty-third Dáil towards it. I fully recommended it, but obviously it is within a range of funding that I require the Department's agreement on because, to be fair, the Department has a capital envelope with many other calls on it. In the past few days the Secretary General of that Department came back to me to say it may be within the HSE's own decision-making gift. I hope to talk to him in the next two to three days about it. The fact that Dublin City Council is making available a site to be purchased behind our primary care centre, a very valuable piece of land, that presents us with the opportunity to develop other health infrastructure there as well as look after An Saol means it would be a dreadful shame if we did not go ahead with it. However, obviously I cannot make the sole decision on it. I am hoping to get some clarity in the next few days.

An Leas-Chathaoirleach: Mr. Gloster might stay in touch with me on that.

Mr. Bernard Gloster: Completely, yes, of course.

An Leas-Chathaoirleach: Ms Long might be able to assist me with the other big capital project in my area, which is Finglas primary care centre, something that has taken a number of

years. We had to do a significant number of land swaps with the ETB, with local schools and with Dublin City Council. If she is not able to provide me with an update here, she might be able to update me as to where things stand with the project at the moment.

Ms Sara Long: Yes, I will provide you a more fulsome update, but I believe that the project is due for completion in quarter 4 of this year.

An Leas-Chathaoirleach: Yes. Obviously, at that point it has to move to construction and so on.

I want to return to the point Mr. Gloster made earlier about the section 38 and section 39 entities. This is actually one of the first occasions that I have heard the HSE articulate it in that way in terms of the level of control or influence that we have or do not have over acute hospitals and many other bodies. Many of those, in particular the section 39 entities, and I am thinking of the issues with St. John of God, have difficulties with training in terms of their funding. Equally, with some of the hospitals, we had that discussion on resources versus performance or under-resourcing. The decision has been made to incorporate CHI into the HSE.

Mr. Bernard Gloster: Yes.

An Leas-Chathaoirleach: On what basis was that made? Obviously, it was done for a whole host of other reasons but on what legal basis is it allowed for that to be done for CHI? Is that being examined for other section 38 or 39 entities?

Mr. Bernard Gloster: Regarding the legal basis, CHI is set up under a very particular and quite complex piece of legislation. For that reason the Minister indicated 2027 for a full migration. There is a very complex legislative unwinding to be done, and the CHI legislation itself comprised the bringing together of three other previously separate entities. However, the decision on CHI was primarily because CHI has brought together the three hospitals. It will bring them into the one new hospital. Essentially, the CHI project to that extent would have been achieved. I certainly recommended to the Minister that I believe the full integration of the national children's hospital into the full health system is a better way of integrating the service. We do not need two governance systems. That is that piece.

Regarding the decision on other section 38 entities and hospitals, fundamentally it is a decision for Government as to the structure of the health service and how many governance systems there are. The Minister has been on the record as saying, as have I, that there are too many governance systems for the size of the island. Fundamentally, that is a call the Government has to make.

The job of the HSE in the meantime, regardless of that structure, is to get a better level of consistency across the whole health service, including public and section 38 bodies, a better level of control, standardised systems and consistency so the public benefits to the maximum.

An Leas-Chathaoirleach: Side letters attaching to new SLAs were not mentioned earlier but they touch on the same point. We have seen how side letters have got other organisations into difficulty. How does the HSE permit them to exist? Are they effectively disregarded and the agreement itself is taken as the legal document?

Mr. Stephen Mulvany: If we keep separate the notion that, at times, it is necessary to have people put challenges on record,-----

An Leas-Chathaoirleach: Of course, yes.

Mr. Stephen Mulvany: -----the strict legal position is there is a clause in the contract that obviates anything that seeks to attach itself to the contract if it is not actually in the contract. Side letters are not in the contract so they do not have any legal standing.

An Leas-Chathaoirleach: Side letters form part of the correspondence as opposed to being a legal-----

Mr. Stephen Mulvany: They do not form part of the contract.

Deputy Séamus McGrath: I want to return to the issue of insourcing. The chief executive outlined it was his belief that a certain part of it should be discontinued. What is the update on its discontinuation?

Mr. Bernard Gloster: Third-party insourcing became an individualised issue off the back of an unpublished-but-published 2022 CHI report. Very quickly off the back of that, there was some NTPF reporting on Beaumont Hospital. I was very clear that, notwithstanding any of the examinations, we were developing a level of dependency on third-party insourcing that was not going to be sustainable. It was also going to stop us reforming the health service because we could not get people to move to a five over seven working system if, at the weekend, they were working for private companies in our facilities where they were being paid very high premiums.

Deputy Séamus McGrath: The same individuals working in the public hospital were then-----

Mr. Bernard Gloster: They were working in a different capacity or payment system at weekends.

Deputy Séamus McGrath: But in the same building.

Mr. Bernard Gloster: Yes.

Deputy Séamus McGrath: Using the same facilities.

Mr. Bernard Gloster: Yes.

Deputy Séamus McGrath: Mr. Gloster said it was a disincentive for them-----

Mr. Bernard Gloster: It was a perverse incentive.

Deputy Séamus McGrath: A perverse incentive.

Mr. Bernard Gloster: Absolutely.

Deputy Séamus McGrath: To ask a straight question, does Mr. Gloster believe there was wrongdoing in some of the activities that went on in the insourcing?

Mr. Bernard Gloster: In the majority of cases that I have seen, the evidence would not suggest to me that anybody did anything wrong. They certainly did not do anything illegal. I would say it strays close to the boundaries of ethics and appropriateness.

Deputy Séamus McGrath: A conflict of interest.

Mr. Bernard Gloster: A conflict of interest particularly.

Deputy Séamus McGrath: But Mr. Gloster does not see anything criminal or anything like that.

Mr. Bernard Gloster: I do not. I did have a concern about one particular report, which was the CHI report that I referred to the Garda. The Garda has assessed that there is not space for further criminal investigation.

To say where third-party insourcing is at now, I essentially put a cessation on it other than in exceptional circumstances. I have now allowed it to be reintroduced in a very controlled way because we do need to continue to provide services. Between now and next June, the Minister is assessing the best level and timeframe in which she can eradicate the dependency on third-party insourcing.

Deputy Séamus McGrath: I need to move on, if that is okay, and I thank Mr. Gloster.

Rightly or wrongly, there is a perception of the HSE being top-heavy in management. In terms of salaries, I know from newspaper articles that more than ten people were paid more than €500,000. I suspect they are consultants and clinical people. What is the overall figure for non-clinical and non-health professionals working in the HSE? I am speaking about administrators and managers. Do we have an overall headcount?

Mr. Stephen Mulvany: None of them earns more than €500,000.

Deputy Séamus McGrath: I understand that.

Mr. Bernard Gloster: Perhaps Dr. Ryan Withero knows the percentage of the workforce in management and administration grades?

Dr. Philippa Ryan Withero: As of August, the total workforce was 149,074 WTEs and management and administration accounted for approximately 24,750 WTEs. A number of the management and administrative staff work in front-line clinical services.

Deputy Séamus McGrath: I understand that.

Mr. Bernard Gloster: After the pay and numbers strategy was introduced, the number decreased significantly. The greatest reduction in staffing numbers was in management.

Deputy Séamus McGrath: Does Mr. Gloster believe there is still scope to reduce management levels in the organisation?

Mr. Bernard Gloster: I do as we introduce more systems and efficiencies.

Deputy Séamus McGrath: I have a question on the pay scales. How many of these 24,000 people earn more than €200,000?

Mr. Bernard Gloster: Very few.

Mr. Stephen Mulvany: We can get that for Deputy McGrath as it is reported every year in the annual financial statements.

Deputy Séamus McGrath: Mr. Mulvany does not have the information to hand.

Mr. Stephen Mulvany: I will give it to Mr. McGrath before the end of the meeting.

Deputy Séamus McGrath: I thank Mr. Mulvany.

To be a little bit more parochial, I want to speak about Cork and the plans for a new elective hospital there. It is very important, as an elective hospital is needed in Cork, given the huge demand on the current hospital network and the increasing population. There is a lot of frustration with the delays in progressing the project. I got a reply from the HSE, which was not very encouraging, on the timeline. What is Mr. Gloster's position on the roll-out of a new elective hospital on the site in Glanmire?

Mr. Bernard Gloster: There has been a lot of debate since the allocation of the NDP as to whether the elective hospital was funded. My instructions from the Minister are, thankfully, to proceed as quickly as possible to design and planning and bring it to being shovel ready. The Minister will secure the funding. This is the plan and Cork is in the plan. Deputy McGrath knows the site configuration issues with regard to Sarsfield, Glanmire and other issues.

Deputy Séamus McGrath: There are infrastructural issues.

Mr. Bernard Gloster: I would say the limitations external to us will probably be a bigger factor in that timeline but I am pressing on and I am looking for it to be planning ready very shortly.

Deputy Séamus McGrath: I would like to press Mr. Gloster a little on what he means by "planning ready". I have seen some commentary that there were delays with progression to planning. Are we looking at a planning application being lodged in the next six months or 12 months?

Mr. Bernard Gloster: It will not be 12 months. I am hopeful that it will be six months and in the first half of next year. The problem is that if there are major infrastructure or road access issues when we go to planning, we will be shot down.

Deputy Séamus McGrath: There are issues with access.

Mr. Bernard Gloster: I could not agree more with Deputy McGrath that it is a badly needed facility in Cork.

Deputy Séamus McGrath: That is good. I thank Mr. Gloster.

Deputy Grace Boland: I want to pick up again on the HR systems I was speaking about in the previous round. Beaumont Hospital deployed a payroll and HR system that is going to cost approximately €4.8 million, with an overrun at that, which will be completely and utterly replaced by the SAP HR system. Is this correct?

Mr. Bernard Gloster: That would be my intention but I also intend to put it in a schedule in such a way that at least a good level of value is derived from what it did buy. It will help with the migration to the new system. It is not a complete write-off, to be fair to the hospital. I would have preferred if it had not done it that way.

Mr. Damien McCallion: On SAP, we would expect that because of the investment, there will be a minimal cost involved in that particular hospital transitioning to the national system, given that it is the same product.

Deputy Grace Boland: Has SAP confirmed this?

Mr. Damien McCallion: No, we will be working with it on that. We are dealing with this issue at the moment.

Deputy Grace Boland: Is the current provider to Beaumont Hospital SAP?

Mr. Damien McCallion: The current provider of its new system is SAP. The previous provider was an external company.

Deputy Grace Boland: The €4.8 million system is external.

Mr. Damien McCallion: It is SAP, and IBM is also the partner for our national HR system.

Deputy Grace Boland: It will be SAP in Beaumont Hospital.

Mr. Damien McCallion: It will be SAP, yes.

Deputy Grace Boland: So there should be a very minimal cost.

Mr. Damien McCallion: Correct. We will be making this very clear to SAP and IBM, which are our partners for the national HR system and are the partners in Beaumont. This was part of the rationale in Beaumont at the time, as I understand it from the meeting of this committee last week.

Deputy Grace Boland: It is not as bad as it first seems.

Mr. Damien McCallion: We expect the transition will be much more seamless.

Mr. Bernard Gloster: It is not as bad as it first seems. It is just that it is indicative of the wider context of what we are speaking about with regard to independent organisations making decisions about systems that fundamentally are not consistent or a standardised system mandated by the State.

Deputy Grace Boland: This committee sees systemic issues across the public service in the deployment of IT systems. Has the IFMS deployment overrun? Is it over budget or delayed? Have there been lessons?

Mr. Stephen Mulvany: There are many lessons. It is a major transformation project and it has been difficult for all of the staff involved. I commend them for sticking with it. There has been delay, if we think about it. In total, we are approximately 16 months behind what we originally planned a long number of years ago. Most of this is due to a number of external factors. We experienced the pandemic, the cyberattack and major industrial action. Other than that, there has been about six months worth of internal project delay where we had a particularly difficult time after the first series of roll-outs. A lot of lessons were learned from that. Let us say there is a six-month project delay along with a longer delay overall, most of which is external.

Deputy Grace Boland: Are those lessons learned written down and captured? Are they then fed back to the Department of public expenditure or the Office of Government Procurement? The public service as a whole needs to learn from the deployment of these projects.

Mr. Stephen Mulvany: They are certainly written down. From each of our series of roll-outs - we call them implementation groups - there is a written set of lessons learned that feed into the planning. The last set from what we call implementation group, IG, 3, which is the

last for the HSE, has fed into the planning for the voluntary sector. We have members from Government Departments on our steering group and our programme broad. It is fair to say we have not formally shared them but we certainly can.

Deputy Grace Boland: We need to do that. We are seeing serious issues right across the public service and there does not seem to be any one Department taking the lessons learned from a series of issues, including the overruns and delays.

Mr. Bernard Gloster: On lessons learned, while it is not an IT-based thing, it is important to show lessons learned. The approach we are now taking to the finalisation of the contract for the building of the new national maternity hospital is heavily informed by the learnings of what happened with the children's hospital.

Mr. Damien McCallion: We have increased investment in the Digital for Care strategy. We now have a national office stood up that is looking at the learning from every project to see are there things that people should look at. It also then reviews the project plans and so on to try to make sure they are incorporated in it. Within the health system, given the wider investment, we are trying to make sure those lessons are filtered through from every project. I would argue that each project has some lessons learned from the process.

Deputy Grace Boland: I do not have any hospital to ask the witnesses about. I would like to say that the area I live in is one of the youngest in the country. Balbriggan is the youngest large town. It is the most culturally diverse town. Our primary care centre and CDNT are chronically understaffed, which has been a persistent issue for a long time. The waiting lists are from four to seven years. There are some children who are now in sixth class who never got therapies and have been on the list since before they entered primary school. I urge the HSE to please staff this primary care centre. Both Balbriggan and Swords have the longest waiting lists in the country.

Mr. Bernard Gloster: I could not agree more. To be fair, the Minister for Health has recently given me the approval to make an intervention on primary care waiting lists. The Minister for disability is likewise on the CDNT. Specifically on the CDNTs, as I said to one of the Deputy's colleagues, critical to the reform of children getting access to therapy services in disabilities is the reform of the assessment of need process; I want to stress that is without removing the right. It is so outdated and so litigious. We are wasting endless hours of therapy resources. I question their value to children.

An Leas-Chathaoirleach: We have about ten more minutes left. If members want to have short interactions of a minute or two, they should come in at this point.

Deputy Albert Dolan: I will make two last points. The HSE does not publish prompt payment reports online. State bodies have been mandated to do so since 2009. I submitted a parliamentary question. The answer I got essentially stated there are eight legacy payments and eight legacy platforms and the HSE is not in a position to publish the reports. Do the witnesses think that is acceptable?

Mr. Stephen Mulvany: No. It is the reality but we accept it is not something that is appropriate. As we make use of the IFMS, it is something we will be attending to and we will return to publishing it. As was said earlier, we are publishing the payments over a certain

figure. We will publish the lower value figure from either quarter 4 this year or quarter 1 next year. We need to return to publishing data around the prompt payment Acts.

Deputy Albert Dolan: When does Mr. Mulvany anticipate the HSE will publish the prompt payment reports?

Mr. Stephen Mulvany: From next year.

Deputy Albert Dolan: From next year, once the IFMS is in place.

Mr. Stephen Mulvany: It is in place, but there are a number of business process changes we have to make to make sure we get the full benefits.

Deputy Albert Dolan: Obviously, the HSE tracks the spending that occurs within the big six consulting firms that supply to the HSE. These are PFH, EY, PwC, Deloitte, KPMG and Accenture. Between 2022 and 2024, I can account for €361 million worth of spend across those six. The HSE is tracking the spend and is employing them for all these services, but who is measuring the value they provide?

Mr. Stephen Mulvany: In fairness, it is something we can and should get better at, but they are monitored closely. They are all generally tagged to specific projects. Some of them are digital projects and some are - probably less so - staged projects. They go through fairly detailed planning approval processes and then ongoing monitoring. There is a fair amount----

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Deputy Albert Dolan: Could-----

(Interruptions)

Deputy Albert Dolan: The point I am trying to make is we have heard that about 24,000 people are working in the HSE in administration, middle management and as senior executives. Why is there a need to spend €360 million over two years on external consultants? That is the question.

Mr. Damien McCallion: One aspect of it is the area of cyber in terms of implementation of systems like SAP. We talked about IBM and so on. These are areas where very clear deliverables are applied to contracts. Someone like PFH supplies products as well. It is a reseller for certain things in terms of support services. We will always need a cadre within the digital space. In some ways, the more you invest, the more you need. We want our staff to focus on being stronger on the implementation and dealing with all of the factors around that because they know the health system. That is where we are focusing our own HSE staff. We will always have a range of partners in the digital area, but there are other areas, as the Deputy mentioned. As the CEO said, there has been a drive to push general consultancy down, but we are still investing in digital because we want to make sure we get pace into investment in the sort of areas we are talking about.

Mr. Stephen Mulvany: If we look at the IFMS programme, we simply could not roll out IFMS without having the support of the systems implemented by IBM, at least not at any pace.

Deputy Albert Dolan: Go raibh maith agat. Thanks for everything today. I appreciate it.

Deputy Séamus McGrath: The witnesses were to get figures in relation to management pay scales and-----

Mr. Stephen Mulvany: Page 139 lists everyone on over €200,000. As best I can add them up, with the calculator, it is about 2,355 people, with the vast bulk of those being consultants, given those are 2024 salary scales, all bar national directors. The national directors who are non-consultants would be in that. Everybody else should be a consultant. I can show the Deputy the page.

Deputy Séamus McGrath: Could we get an estimate of non-medical individuals? Is that possible?

Mr. Stephen Mulvany: We can come back to the Deputy with that. As I said, it will be the vast minority of that 2,300-odd.

Deputy Séamus McGrath: That is what I would like to know. We do not have any indication of that now.

Mr. Stephen Mulvany: I am one of those, just to say.

Deputy Séamus McGrath: I appreciate that. We have no indication of the quantity of that.

Mr. Stephen Mulvany: Not here, Deputy.

Deputy Séamus McGrath: This is in terms of managing the structure-----

Mr. Stephen Mulvany: We can certainly get you that. It is straightforward information. All those salary scales are published on the HSE website. They are part of the salary scales that are approved by Government. It is fully transparent, but we will get the Deputy that figure.

Deputy Séamus McGrath: I understand. It is the number of people on particular levels as well that I am interested in. Some of this is perception perhaps, but it is important we are transparent about it.

Mr. Stephen Mulvany: I agree.

Deputy Grace Boland: I have a brief amount of time and I am sure this deserves much more. How will electronic health records integrate with the shared care records?

Mr. Damien McCallion: The shared care record basically takes your lab results, including all that information sent out to GPs and medications. We have also agreed with the GPs that all of that will ultimately come together. It is like a digital picture of the chart. The electronic health record is more sophisticated. That is what our staff will use to make referrals and record clinical data, and it will integrate the ICU equipment and so on. It is much more sophisticated. The shared care record will be accessible-----

Deputy Grace Boland: Will they talk to each other?

Mr. Damien McCallion: They will talk to each other, yes. We have done things like agreeing a national health identifier, which is the PPS we are rolling out across all services at the moment in advance of electronic health records. All of these systems are being designed so they interact. As I said to one of the Deputies, we already have one of our successes. There is our national imaging system. If a young child in Donegal has a head injury, that can be read in

Beaumont immediately and a decision made to transfer or not. The last public hospitals going live on that before the end of the year are St. Vincent's hospital and then two other hospitals, Galway and Cork, which are on a different platform, will be integrated. That will give us probably our first major clinical national system with full coverage. There should be a record-

Deputy Grace Boland: Are the voluntary groups signed up to the shared care record?

Mr. Damien McCallion: They are. I do not envisage any issues. The voluntary hospitals, for example, are part of the national imaging system and all of the other projects. As we roll those out, for example, the electronic health record, we have already agreed the first region, which is under my colleague Ms Long. The Mater and Beaumont are part of that. They will form part of the implementation within that region. That will include other people outside the voluntary hospitals because this will be across hospital and community. This will be one of the key systems to allow staff to work in an integrated way between community and hospital. It is a big programme but, as I said, we are advancing the other pieces as well.

Deputy Grace Boland: On the procurement of the electronic health record, and its management from an IT perspective, does the HSE have the competence and capability to do that?

Mr. Damien McCallion: It is a really good question. We went through our approval process with our own board. We went through all of those risks and challenges. The Department commissioned what is called an external assurance process. The straight answer is we are building that competency. We have just hired someone to start this week. We have done this in other jurisdictions because, again, the scale of this will be greater than what we have done previously. I mentioned maternity, where the electronic health record has been really successful. It is a good case study with good benefits in terms of clinical, nursing and administrative time, but also from a safety perspective, with reduced medication errors on a smaller scale. We will build up that competence.

Mr. Gloster mentioned the programme board. It will be jointly chaired by the CEO and the Secretary General and will report to the Minister and our own board. We have a committee that looks at that. We are then building up competence within the team. We have appointed a strategic partner with expertise in this as well.

We want to make sure early on that we get this set up as strongly as possible for success, but it will be an ongoing risk we have to manage as we go through it.

An Leas-Chathaoirleach: The last question is from Deputy Neville. Make it a ceist bheag, Deputy.

Deputy Joe Neville: I thank the witnesses for their time today. They have been honest, open and clear in all their answers to the questions I raised. We need to focus on the hospitals and the amount of spending, the €5 billion, we do not have visibility of. If any message from me could be driven home, I ask that it be to ensure those hospitals are brought into proper governance with full transparency on that spending.

On Deputy McGrath's earlier point, I wish Mr. Gloster all the best and thank him for all his effort over the years, as a good Limerick man. My dad is from Croagh. Mr. Gloster is not too far away. I wish him the best of luck in the years ahead.

Mr. Bernard Gloster: That is kind of the Deputy. If I get to remember this as my last public accounts committee appearance, it will be a wonderful occasion.

An Leas-Chathaoirleach: I was going to say, I thank all the officials for being with us today and especially Mr. Gloster, but of course we are assuming we will not have reason to invite the HSE again before Mr Gloster's departure, and the public accounts committee would never give an Accounting Officer that kind of guarantee. I do want to say, because anyone watching you for the first time today, Mr. Gloster, might say you gave very direct and open answers, that they will not have seen your performances at the public accounts committee over many years. While we have often disagreed on very significant issues, you have always treated the committee with huge respect and provided us with the information we require. Whatever you intend to do and whether you are lucky or unlucky enough to be an Accounting Officer again in the future, you will always be welcome at the public accounts committee.

Mr. Bernard Gloster: Thank you, Chair.

An Leas-Chathaoirleach: The clerk will seek to follow up on any information and carry out the actions. Is that agreed? Agreed. The committee is adjourned until 9.30 a.m. on Thursday, 23 October when we will meet the Department of Justice, Home Affairs and Migration regarding its 2024 accounts.

The witnesses withdrew.

The committee adjourned at 1.22 p.m. until 9.30 a.m. on Thursday, 23 October 2025.