Financial Briefing Paper

Board Meeting 29th June 2022

Note: This briefing builds upon and should be read in conjunction with the Finance section of the CEO Report to the June Board meeting.

1.0 Introduction and Glossary

The HSE is required to report its Income and Expenditure (I&E) on an accrual accounting basis. It is also required to separate its reporting on day to day running costs, referred to as **Revenue** Income and Expenditure, from its reporting on costs funded by exchequer capital monies, referred to as **Capital** Income and Expenditure. The HSE also reports on its use of **Cash** by comparing total cash paid out at to the end of each month against the initial monthly breakdown of cash, referred to as the "cash profile", that is submitted to the Department of Health (DOH) early in each financial year. Cash reporting is available one month ahead of Revenue & Capital income and expenditure reporting.

When costs are less than the available budget, this will be referred to as a surplus. When costs are higher than the available budget, this will be referred to as a deficit. Deficits may be shown either before, or after, what is referred to as time related savings or TRS. TRS refers to once-off savings, for example savings that naturally occur when a new post is funded for a full twelve months but is first filled part way through the year.

Costs and funding related to COVID-19 are treated separately to the Costs and funding in respect of CORE services (i.e. non-COVID costs). The bulk of the CORE Revenue funding received by the HSE is typically **recurring** in nature with a relatively small amount of **once-off** funding. The opposite is the case for COVID funding, which is all once-off in nature i.e. needs to be applied for again each year.

Glossary

Cat. / CAT. – Category
CBD – Cross Border Directive
CCH – Cabinet Committee on Health
CCO – Chief Clinical Officer
CHO – Community Healthcare Organisation (9 within HSE)
CORE – Excl. costs reported as COVID-19
CNU – Community Nursing Unit (typically a HSE run Nursing Home)
Deficit – When costs are higher than the available budget
DLS – Demand Led Schemes
DOH – Department of Health
DPER – Department of Public Expenditure and Reform
ELS – Existing Level of Service
EMT – Executive Management Team
FEMPI – Financial Emergency Measures in the Public Interest
Funded – costs for which budget is available
HG – Hospital Group (6 within HSE)
IFMS – Integrated Financial Management System
HRA – Haddington Road Agreement
MHC – Mental Health Commission
NAS – HSE National Ambulance Service
NHSS – Nursing Home Support Scheme (Long Term Care aka Fair Deal)
Non-Pay – Costs of bought in goods and services
NSP – National Service Plan
Ops – Operations / Operational Services
PCR – Gold Standard test to confirm COVID-19 (Polymerase Chain Reaction)
PCRS – Primary Care Reimbursement Service
Q1 – Quarter 1 (January to March)
Run Rate – Average level of costs for a given period
SCA – State Claims Agency
Surplus – When costs are less than available budget
TAS – Treatment Abroad Scheme
T & T – Test and Trace Programme
TRS – Time Related Savings (Once-off)
WIP – Work in Progress
WTE – Whole Time Equivalent
YTD – Year-to-Date

2.0 Quarter 1 (Q1) Forecast - Introduction

The process to draft this Q1 forecast has been a combination of both "bottom up" and "top down" efforts. Bottom up refers to the signicant inputs into the forecast from our Community Healthcare Organisations (CHOs), Hospital Groups (HGs), Primary Care Reimbursement Service (PCRS) and other national teams. Top down refers to the consolidation, review and adjustment to the forecast carried out by the Chief Financial Officer (CFO), his team and other colleagues in the HSE centre.

We have produced two forecast scenarios i.e. a high scenario, which is mostly based on the bottom up inputs, and a low scenario, which is the result of the top down review and adjustment of the high scenario. Engagement with the revelevant national directors and their teams is ongoing so in most cases the top down review, and the low scenario it has produced, reflect the preliminary views and judgement of CFO and his team.

It is important to put the level of deficits we are now seeing in our Q1 forecasts in context. The level of COVID costs likely in 2022 and the fact that there was a higher than normal level of financial risk within our CORE budgets was clearly flagged in our estimates submissions and discussions with Department of Health (DOH) colleagues last September / October. These issues were detailed again in our discussions around the national service plan and are clearly flagged in the NSP 2022 document that was subsequently adopted by the Board and approved by the Minister, following consideration by both DOH and DPER.

In terms of reasonable expectation management, given the scale and complexity of the health sector, and the significant system limitations, it is important to note that this forecast is based on only 3 months data i.e 1st January to 31st March 2022. A forecasting margin of error of 1.0% on our €20bn budget would equate to €200m, with every 0.1% therefore equating to €20m.

There is a large body of supporting documentation that has been prepared to underpin this bottom up Q1 forecast, including further details in respect of the drivers of growth, drivers of once-off time related savings (TRS) and drivers of deficits. This represents a significant element of our ongoing efforts to enhance our financial reporting, in advance of the introduction of our single integrated financial management and procurement system. This is being implemented via the IFMS project, with the first HSE run services expected to go live on the system in 2023.

Currently the finance forecast scenarios appear to indicate a level of net additional WTE growth that is beyond what the data available to HR colleagues would support as being likely. Work is ongoing to compare the available finance and HR data sets. The lack of integrated financial and HR systems makes this a complex task. At best we can expect to be able to arrive at an assessment as to what adjustments may need to be made to enable the two sets of data to be reasonably aligned at a fairly macro level.

2.1 CORE (Non – COVID)

For both the high and low scenarios we have we have summarised below some of the key outputs:

1. **Deficit before** the benefit from any once-off time related savings **(TRS)** – this is a key figure, since TRS is generally once-off, meaning this deficit, unless otherwise addressed, will put very significant pressure on any 2023 additional funds that can be secured via the estimates process.
2. Time Related Savings **(TRS)**
3. **Deficit after** the benefit of **TRS**
4. **Growth** in costs predicted to year end that is the above average level of costs running by the end of Q1. This is divided into funded growth and unfunded growth, with the latter driving an element of any deficit.
5. **Growth** assumed to be **related to** the recruitment of net additional whole time equivalent staff **(WTEs)**

Table1 – Q1 Forecast CORE

Output	High Scenario	Low Scenario	Comment / Note
1.**Deficit before TRS**	**€714m**	**€610m**	Note 1
2. TRS	€436m	€544m	
3. **Deficit after TRS**	**€278m**	**€66m**	Note 1
4. **Total Growth** beyond Q1 run rate	€1,108m	€897m	Note 2
4.1 Of Which – Funded Growth	- €828m	- €720m	75% (H) - 80% (L) of Total
4.2 Of Which – Unfunded Growth	- €281m	- €177m	25% (H) – 20% (L)of Total
6. **Total Growth** assumed to be **re WTEs**	€290m	€225m	

Note 1: The deficit figures, in both high and low scenarios, reflect the following assumptions:

I. That 30% / €71m of the following figures are excluded from the CORE deficits on the basis that they are driven by COVID i.e. the shortfall on Acute Private Income (€118m), the related provision for bad debts (€30m) and the cost of care issues within our public Community Nursing Units (CNUs – net €89m)

II. That the cost of reimbursing the State Claims Agency (SCA) for costs it incurs in managing HSE claims will not exceed the budget available. While this allows for growth of €104m beyond the Q1 run rate, it is difficult to accurately predict and may understate the end of year position.

III. That the cost impact of the Government decision in April 2022 to implement what is known as the "reversal of the Haddington Road Agreement (HRA) hours" with effect from 1st July 2022, is not reflected in any of the cost growth or deficit figures in either scenario and will need to be dealt with separately.

IV. That the final 2021 Revenue I&E deficit of €195m, as reported in the recently published HSE Annual Financial Statements, is not reflected in any of the deficit figures in either scenario. This deficit becomes a "1st charge" on 2022 funds however it is all COVID related and is therefore included under the COVID forecast.

Note 2: The growth and deficit figures in the bottom up High scenario have been reduced by €84m in relation to Acute Hospital growth predicted by HGs that was considered by the central finance team to be unlikely given the levels of net additional staff recruitment it appeared to be based upon.

Q1 CORE Forecast – discussion

In getting to the low scenario deficit after TRS of **€66m**, we start with a deficit before TRS of €610m and utilise €544m of once-off time related savings, with an element of these savings unrelated to WTE funding. Within this €610m deficit before TRS there is:

1. **€315m** - related to financial issues flagged in the NSP 2022 i.e. 1. Un-funded FEMPI award, 2. Winter Flu 2022/23 and 3. Acute Private Income shortfall & Public CNU Cost of care issue
2. **€94m** – related to new post NSP issues i.e. Ukrainian response, New Bank Holiday, Extra Recruitment Costs, Non-Pay Inflation, Kerry CAMHS (Maskey report) and Disability Assessment of Need (High Court case)
3. **€92m** – related to pensions (€70m) and demand led areas including PCRS (€39m excluding GP costs of next Winter Flu programme) and CBD / TAS / Local Demand Led Schemes (€38m)
4. **€109m** of other deficit issues.
   €610m

For context, what this analysis confirms is that €501m / 82% of the deficit before TRS relates to issues flagged in NSP 2022 as beyond the HSE's capacity to fund, issues that arose after the NSP was approved, and issues related to the pensions and demand led areas, which are less amenable to financial control actions.

The HSE has an obligation in governance terms to take all appropriate and practical steps to further reduce this currently forecast CORE deficit of €610m before TRS, and €66m after TRS.

Taking such steps:

I. Will support our case to be allowed to utilise the once-off time related savings (TRS) to offset the €610m above. Much of the TRS relates to inevitable phasing of new developments and requires DOH support to be utilised in this way.

II. Is one core measure of our financial performance in 2022, alongside the need to maximise the recruitment of as many of our funded development posts as possible and make full use of our access to care funding to address waiting lists and waiting times.

III. Will assist in the likely difficult task of securing sufficient additional existing level of service (ELS) funding in 2023, given the expected significant pressure on, and competing demands for, government finances.

The EMT has agreed that we need to consider steps to further reduce our unfunded cost growth / costs by up to c. €66m in order to try to deliver a CORE breakeven, albeit this will be subject to the same assumptions as set out in Note 1 above, including the exclusion of HRA related costs, which were not known or provided for at the time of the adoption and approval of the NSP 2022.

2.2 COVID-19

There are a combination of manual and automated processes in place which seek to identify and report on COVID-19 related costs. Some of these represent a significant burden on our local, regional and national finance teams in terms of the complexity and effort to operate them. For example, constructing multiple manual journals on a monthly basis to move estimated COVID-19 related costs from CORE onto COVID cost centres.

Our aim in doing this is to try to identify the bulk of the costs that are expected to be funded from the ring fenced COVID budgets available to the HSE. However we recognise this is never likely to represent the totality of all costs that could be considered as being caused or influenced by COVID. This is because some COVID related costs are too intertwined with CORE services to be fully distinguishable and also because our efforts to separate out these and other COVID related costs are "best efforts" given the complexity involved and the system and process constraints we operate within.

Accordingly any financial reports and forecasts related to COVID-19 costs must be read and utilised with these constraints in mind, which are as likely, or probably more likely, to lead to a risk of understating COVID related costs, as they are to do the opposite.

The Q1 Forecast in relation to COVID-19 costs seeks to predict costs to the end of 2022 and also give an early indication of 2023 costs. It is largely the result of a top down exercise using a number of costing models that have been developed in respect of the major COVID programmes. For each programme a high and low scenario has been prepared along with a mid-point, which in some cases we have sufficient confidence in the figures to indicate a likely point.

Table 2 – Q1 Forecast - Summary COVID–19 Costs

COVID-19 Programme Heading	2020 €m	2021 €m		Low 2022 €m	High 2022€m	Mid-point / Likely 2022 €m		Low 2023	High 2023	Mid-Point / Likely 2023 €m	Mid-Point / Likely 2023 as % 2020
Testing Tracing and Public Health	203	714		395	457	426		162	215	189	93%
PPE	918	287		134	134	134		35	42	39	4%
All other including Hospital and Community Covid responses	1,372	872		504	771	638		237	320	278	20%
sub-total Programmes in Place in 2020	**2,493**	**1,873**		**1,034**	**1,362**	**1,198**		**434**	**577**	**505**	**20%**
Vaccinations		532		465	557	557		180	247	214	N/A
COVID Therapeutics				20	70	20		5	10	8	N/A
COVID Pandemic Recognition Payment				127	160	144		0	0	0	N/A
COVID excess costs over CORE savings 2021 / 1st Charge 2022				195	195	195					N/A
Total	**2,493**	**2,405**		**1,841**	**2,344**	**2,113**		**619**	**834**	**726**	
As % of 2020 (excluding 1st charge)		**96%**		**74%**	**94%**	**85%**		**25%**	**33%**	**29%**	

Note 1: We need to add €71m to the 2022 forecast COVID costs in Table 2 above in respect of costs currently reported within CORE which are assumed to be driven by COVID i.e. 30% of the shortfall on Acute Private Income (€118m), the related provision for bad debts (€30m) and the cost of care issues within our public Community Nursing Units (CNUs – net €89m). ***See also Note 1. on page 4 above)***

Note 2: The cost figures set out in the various scenarios in Table 1 above are based on the following key assumptions:

I. **Personal Protective Equipment –** That the locations supplied, utilisation volumes, price movements, stock buffer levels, obsolescence levels and storage / distribution costs are in line with the ranges modelled.

II. **Testing & Tracing –** That actual costs occur in line with the scenarios that have been modelled using currently known factors, policy direction and data modelling on the likely pathway of the programme for the remainder of 2022 and into 2023.

III. **COVID-19 Vaccination Programme** – That actual costs occur in line with the scenarios that have been modelled in respect of the Vaccination Programme, with differing assumptions around vaccine cohort uptake, multivalent availability and the COVID – 19 VAT derogation remaining in place for 2022-2023.

IV. **COVID-19 Therapeutics** – the committed costs are presented alongside a higher level specific 2022 patient dosage scenario.

V. **The COVID-19 €1,000 front line staff recognition payment** – payment to staff is underway and costs have been modelled largely on the basis of likely eligible staff employed by the HSE and s.38 funded voluntary organisations. Further clarity on the eligibility of relevant health and social care staff outside of the employment of the HSE / s.38s, and the process to identify and pay such staff, is being worked through with DOH colleagues.

VI. Acute & Community COVID-19 responses: Pending, and without prejudice to, the outcome of the HSE's Operations led evaluation exercise, a preliminary assessment of what responses and costs may need to stay, at what intensity, and for how long, has been made. This is based on the draft clinical evaluation framework document produced by the HSE's Chief Clinical Officer.

Q1 COVID Forecast – discussion

There remains significant uncertainty around the trajectory of the COVID-19 disease and our forecasts for 2022 and 2023 must be viewed as indicative in that context. However there are clear trends visible in the cost of responding to COVID if we look across the four years from 2020 to 2023, using the mid-point / likely figures in respect of 2022 and 2023 for simplicity.

1. COVID costs in 2022 will be c.85% of what they were in 2020, with 2023 costs expected to be c.29% of what they were in 2020, albeit clearly representing a continued significant state investment in public health at €726m (High / Low range is €619m to €834m).

2. If we focus on the programmes that were in place in both 2020 and 2022, and therefore exclude vaccination, therapeutics, and pandemic recognition payment, which were not a feature of our 2020 costs, the 2022 costs are expected to be just under half (48%) of the costs in 2020 on a like for like basis. The same sub-set of 2023 costs is c.20% of the 2020 level.

3.0 Haddington Road Agreement (HRA)

Additional working hours across most but not all grades in a number of sectors within the wider civil and public service came into force from 1st July 2013 under the Haddington Road Agreement. They were considered at the time to be the only alternative to a proposed third pay reduction being imposed under the Financial Emergency Measures in the Public Interest (FEMPI) Legislation.

By virtue of a Government decision in April 2022, the recommendations within the January 2022 Report of the Independent Hours Body chaired by Kieran Mulvey, and as provided for in the Building Momentum 2021-2022 national pay agreement , are being implemented. In summary this involves the reversal of the additional hours with effect from 1st July 2022.

Both the HIGH and LOW scenarios within the CORE forecast above **exclude** whatever cost will in due course be agreed and funded in respect of the replacement of HRA hours. There are significant likely challenges ahead in attempting to reach a shared view between HSE, DOH and DPER in terms of:

1. What hours need to be replaced
2. When could they practically be replaced, whether initially by agency / overtime or eventually by direct employment
3. What would this cost, and
4. How and when this should be funded.

There is significant work ongoing aimed at being ready to make the changeover as and from the 1st July as per the recent government decision. A process is in place to gather and then review the self-assessed view from local services as to what they believe they need to replace.

The HSE's cost estimate for 2022 has been calculated as being in the range of €177m to €227m with this being a half year cost i.e. €355m to €454m in a full year. The lower end of the range assumes all lost hours need to be replaced, and can be immediately replaced, using directly employed staff. The upper end of the range assumes all lost hours need to be replaced and this is done in the first year via agency and overtime, while efforts are progressed to prioritise directly recruited staff. The assumption around 100% full replacement of hours is a placeholder pending the review of what is identified as services as needed.

In practical terms, it is unlikely that the health service can in the short term recruit the c.4,000 WTE that 100% of the lost hours equates to in the context of trying at the same time to recruit to offset the annual 9,500 "churn" and also recruit the NSP minimum target of an extra 5,500 WTE. It is also unlikely that agreement would be forthcoming from DOH and DPER that 100% replacement was appropriate.

The HRA is clearly a post NSP event that was not provided for in the funding allocated to HSE or indeed any Government department or agency as part of their 2022 approved vote / expenditure determination.

It is essential that HSE, DOH and DPER reach a settled position as to the necessary level of replacement of lost HRA hours and then agree a funding approach to deal with same. There is an element of making a virtue out of necessity here.

The reality of the recruitment market constraints mean that we will only be able to recruit a finite number of WTEs and there seems little further we can do to increase that number this year, given the significant steps already taken to strengthen our national and local recruitment capacity. Accordingly, we will have to prioritise the number that we can recruit as between replacing "churn", replacing HRA lost hours, which is a new form of "churn", and filling new developments.

In that context it seems reasonable to seek to agree with DOH and DPER that, once a % replacement rate is settled, the 3 organisations adopt an element of "monitor and fund as appropriate via a combination of initial allocation and supplementary as validated and agreed".

This fits with the reality that it will take a number of financial years most likely before the HSE manages to replace the HRA hours and do so net of the other churn that takes place as well as net of the already approved and funded development posts.

4.0 Next Steps

4.1 **COVID** – Complete the evaluation of Community and Hospital COVID responses and formulate plan based on same to reduce these costs to year end as appropriate.

4.2 CORE

It is proposed that steps should now be taken by the EMT to reduce the expected level of growth in order to deliver a 2022 breakeven on CORE, assuming SCA breaks even and without factoring in HRA.

1. Review forecast growth with operations and other colleagues and agree actions, including any clarification or revision to budgets where appropriate, to reduce forecasted growth, by at least €70m, with as much of this as possible targeted as a reduction to unfunded growth.

2. Explore any appropriate opportunities to permanently reprioritise, with DOH approval, some development funding towards commissioning existing unfunded service costs, such as emergency residential costs for people with disabilities, particularly where such costs are reasonably aligned to the objectives of the development.

3. Provide additional practical support to service colleagues who are trying to deal with the most significant areas of unfunded cost pressures, including:

    I. Enhanced financial management messaging to the System – CEO memo to issue shortly.

    II. High Cost Residential Placements / Emergency Placements (Mental Health and Disabilities including changing needs and regulatory driven costs)

    III. Public Community Nursing Units – costs relatively stable and fixed but being spread over a lower level of beds given a significant level bed closures and under occupancy.

IV. Acute Hospital Private Income and non-pay costs
V. Non Pay Inflation

4. Haddington Road Agreement - continue to engage with DOH and DPER to reach as much of a shared view as practical as to the level of replacement needed and the cost and funding of same.

5. Other as appropriate – including review of Non-Pay funding for development posts 2021-2022 and identification of existing unfunded "developments"

6. Begin engagement with DOH and DPER in respect of 2023 costs and funding, particularly in relation to the main cost pressure areas listed above.

5.0 Conclusion

Our Q1 Forecast indicates that there has been a concerning level of unfunded CORE costs year to date, and that this trend is currently predicted to continue through 2022. We are also seeing a slower than expected fall off in COVID specific costs in community and hospital given the pattern of the disease over the last five and a half months. If left unchecked this will leave many of our services significantly exposed financially as we enter what is expected to be a very difficult estimates process for 2023. There is very real pressure on general Government finances, and there are very significant competing demands for same from across the public sector. The build-up of a very significant amount of unfunded costs within the health sector is a very serious matter in this context.

It is true that a significant element of this was flagged in the estimates process in September / October 2021, and that it is also clear from the resulting HSE 2022 National Service Plan that was adopted by the Board and approved by the Minister. Nevertheless, the levels of unfunded costs that we are seeing and that are likely without action to be carried into 2023 are beyond what was previously expected. Elements of this, such as the re-emergence of strong price inflation pressures, are largely beyond our control but there is a need to take additional steps to satisfy ourselves that every action that can be reasonably taken to mitigate all unfunded costs is being effectively and efficiently taken.

These matters formed part of the discussion at the recent Cabinet Committee on Health meeting and in summary:

1. There was explicit and strong support for the HSE's intention to:
    a. Continue to make every practical effort to recruit as many of our funded development posts as possible this year and
    b. To maximise the benefits of our total available funding, including the specific access care monies to mitigate waiting times and numbers waiting for services.
2. The evaluation exercise around Community and Hospital COVID responses and the resulting plan for management to year end and into 2023 is a very significant priority in terms of its completion and input into the overall consideration of COVID related costs and their funding.
3. There is an expectation that the HSE should substantially break even on its CORE budget for 2022, albeit further discussion is required on whether / how this relates to HRA.