Addressing weaknesses in Financial Management and Cost Containment within the Irish Health Service Executive

A Report and Action Plan

September 2012

Executive Summary

Executive Summary

Weaknesses in financial management systems and process inherent within the previous Health Boards' structure continue to impact on financial management practice within the Health Service Executive (HSE). The foundations required to manage the health system effectively from a financial perspective are not in place. The current approach to budgeting and service planning, cost containment and performance management are ineffective. There is no system wide view of service provision which aligns capacity with current activity and future demand, essential to ensure service plans can be delivered within decreasing financial resources. An alternative approach to cost reduction is essential to enable the health sector in Ireland meet the care needs of future generations at lower cost. This should embrace the potential offered by the Programme for Government, and will require fundamental changes to financial management practice.

The HSE's current budget difficulties are a consequence of failings in financial management systems and processes over a number of years.

- There is limited evidence to demonstrate that the HSE has effective control of either the income or costs of the health system and can credibly predict an accurate year end outturn position.
- Similarly monitoring and evaluation of HSE performance by the Department of Health (DH) and Department of Public Expenditure & Reform (DPER) is not supported by the financial management and reporting processes in place.
- The budgeting and service planning processes in particular are flawed and fail to reflect activity levels and costs at a local level, resulting in unrealistic and undeliverable targets and cost containment measures. This perpetuates year on year inefficiency and drives a lack of ownership for financial performance at an operational level.
- The approach to managing the delivery of cost containment plans in year is unstructured, inconsistent and fails to meet the financial challenge.
- There is no clear link between the implementation of cost containment measures, service quality, waiting times and cash saved.
- The existing Governance and Controls framework lacks clarity, is not properly embedded and does not enable effective control to be exercised over voluntary providers.
- The operating model remains tied to the previous Health Board structure and there are multiple legacy systems in use.
- The systems and processes in place do not deliver an integrated financial performance framework which operates consistently across all Regions – this creates inconsistencies in approaches to data collection, analysis and financial performance management and does not support effective consolidation.
- Limited financial management capacity exists among the staff in the system. Where this does exist it is under significant pressure.
- **Actions to date have delivered little to address weaknesses**
- Ogden is the latest of a series of reviews which have highlighted systemic weaknesses in financial management within the HSE since its inception.
- Despite these challenges, actions to manage pay and non-pay costs have been successful in reducing spend in the HSE in the last 3 years.
- Significant effort has been made in the development of business cases to support the implementation of new financial systems. The required investment has not been approved.
- A number of local projects have been established in important areas such as Activity Based Costing, Shared Services and Procurement Transformation. Their success has been limited by a failure to allocate sufficient resource.
- Progress to address systemic weakness has been limited due in the main to a lack of funding, capability and capacity within the HSE.

Executive Summary

Immediate action is needed to take control, stabilise and transform

- The Department of Health together with the HSE must take immediate action to gain control of spending and to re-establish credibility in its financial and operational management practices.
- Failings in financial management, most notably budget management and control require immediate intervention.

Immediate first steps:

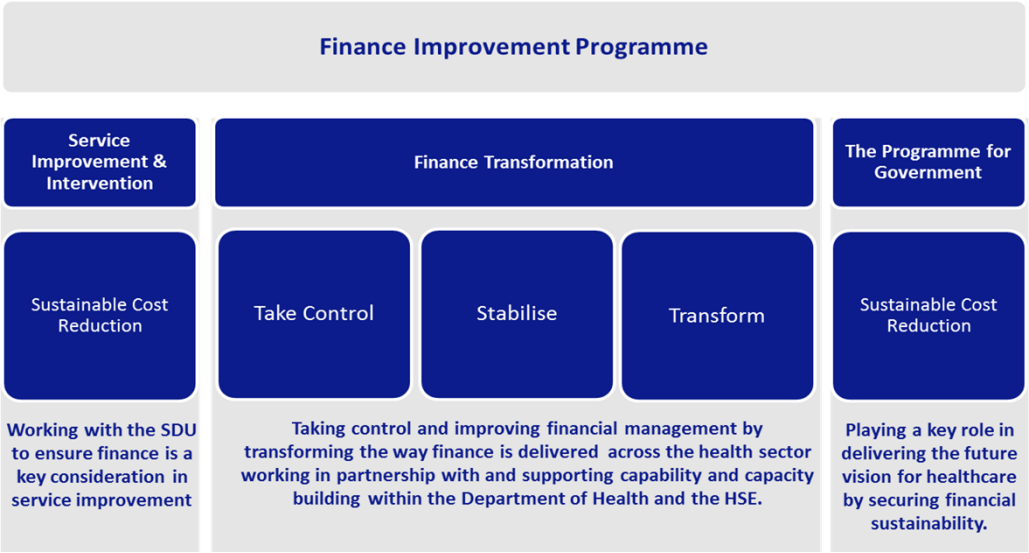
- Establish the Finance Improvement Programme infrastructure.
- Undertake Projected Outturn and Cash forecast across the Health Sector
- Develop a Revised Budget Process for 2013 based on activity based budgeting principles
- Commence targeted intervention in poorly performing hospitals to improve performance and to inform the development of a new governance and intervention model

By the Year End:

- Develop a revised Financial Controls and Governance framework
- Introduce standardised budgetary control processes and financial reporting based on dashboards
- Introduce improved performance management arrangements
- Undertake a portfolio review on systems and improvement projects including Shared Services and Procurement
- Undertake a skills and capabilities analysis of existing Finance staff supporting the health sector

A programme management approach is essential to drive change

- Delivering sustainable cost reduction through service improvement and system wide change requires a systematic approach to fundamentally challenge the way services (both back office and frontline) are delivered.
- The establishment of a Finance Improvement Programme will put the necessary infrastructure in place to support successful project delivery, the management of risks, issues and interdependencies and the tracking of financial and non financial benefits realisation.
- By investing in resources, both internal and external, the programme will provide additional capacity and build capability in Financial Management at all levels.
- The Finance Improvement Programme will improve financial management across the health sector by delivering projects to take control, stabilise and transform financial management practice.
- The programme will deliver sustainable cost reduction by playing a key role in operational service improvement and cross cutting Health Reform. The elements underpinning the programme are shown below.



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1 Introduction

Introduction

Background and Context

The Programme for Government commits to reforming the current model for delivering healthcare in Ireland, to achieve a single tier Health Service providing equal access to care based on need not income, and enabling more care to be delivered in the community. In parallel, reform of the acute sector through National Clinical Care programmes and a programme of reconfiguration and structural reform will enable the systematic changes necessary to deliver the Future Care vision.

This vision is far reaching and ambitious, and will require significant investment to reap the substantial rewards in the future. These reforms come at a time when the HSE, as with all other Irish state agencies, is working within unprecedented financial constraints. The health service budget has reduced by €2.5 billion over the last three years. The hospital sector alone has reduced by some 24% in this period.

The HSE's National Service Plan for 2012 sought to meet the challenges faced by health services this year in terms of reduced staffing levels, a reduced budget, combined with increasing demand for services. The Service Plan also reflected additional investment in areas such as mental health services, primary care, the National Clinical Care Programmes and children's services.

The National Service Plan for 2012 identified a financial challenge of €750m, and Cost Containment Plans were put in place to deliver savings to address this challenge, and to ensure that service plan targets were delivered within budget. Staff across the HSE have made significant efforts to maintain the service and to work within these new financial constraints

In May 2012, amid concerns about a lack of visibility pertaining to the HSE's financial performance, the Department of Health commissioned a review of the present state of the financial management system in place in the health sector in Ireland in the context of the serious overruns projected to occur in 2012, the continuation of a challenging financial environment for the foreseeable future and the radical reforms envisioned in the Programme for Government.

The Ogden Review reported the projected deficit based on April 2012 actuals and identified areas for improvement across all aspects of financial management in the health sector.

The financial challenges faced by the HSE have been subject to significant scrutiny in recent months, as great efforts are made to address the projected deficit in excess of €500 million by the end of the year.

Failing to address the deficit may have far reaching consequences for the Irish economy, as the EU-IMF-ECB Troika has identified the HSE deficit as an emerging problem, and will require Ministers to agree measures to rectify the deficit by the end of September.

Our terms of reference

Within this context PA were commissioned by the Department of Health to undertake a short, focused review of Financial Management within the HSE. In particular our review would deliver

- An outline of the key immediate measures to be put in place in relation to financial management and processes in the HSE having regard to the findings and recommendations of the Ogden Review;
- A 'stress-test' of the HSE's revised Cost Containment Plans of 18 July 2012 with reference to achievability of proposed savings, in particular in the acute hospital sector, within the relevant timelines;
- An analysis of the potential effect of the Cost Containment Plans on targets for Scheduled and Un-Scheduled Care in 2012;
- Identification of potential structural cost savings, in particular in the acute hospital sector, not contained in the HSE's Cost Containment Plans.

Introduction

Format of this report

The purpose of our review was to identify improvement actions in response to the findings of the Ogden Report, to critically evaluate plans in place to address the financial deficit in the current year. Consequently it focuses in the main on specific areas of weakness found.

This document presents our findings from this review, and is structured as follows

- Section 2 responds to the weaknesses in financial management identified by Ogden and outlines the key actions to take control, stabilise and transform the key aspects of financial management within Health;
- Section 3 presents our assessment of the Cost Containment Plans in place;
- Section 4 explores the key cost drivers within the health sector in Ireland and identifies alternative cost reduction opportunities which are both sustainable and focused on system wide reform;
- Our overall conclusions are presented in Section 5; and
- Section 6 presents our recommended actions in the form of high level plans over the short, medium and long term.

Although the report references specifically financial management in the HSE, the issues raised should be read as observing the broader environment of the health sector including the Departments of Health and Public Sector Expenditure and Reform.

Acknowledgements

In the course of this review we engaged with key operational and financial managers within the HSE and the Department of Health. We are grateful for the open and honest engagement and the efforts made to furnish us with financial information to support our analysis.

We recognise the efforts made by all concerned to make themselves available to meet with us and to share management information as it became available, particularly given their focus on taking action to address current financial and operational challenges.

Appendix A contains details of all staff engaged during the course of this review, and Appendix B details the financial and operational information made available to us to support our analysis.

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2 Responding to weaknesses in financial management identified by Ogden

Ogden: Key messages

In May 2012 the Secretary General of the Department of Health (DH) commissioned a review of the present state of the financial management system in place in the health sector in Ireland in the context of the serious overruns projected to occur in 2012, the continuation of a challenging financial environment for the foreseeable future and the radical reforms envisioned in the Programme for Government. The review was led by Mark Ogden during June 2012, and highlighted significant issues impacting all aspects of financial management.

Areas for Improvement

The Ogden Report identifies areas for improvement across all aspects of financial management in the health sector. Whilst isolated examples of good practice exist, these exemplars are rarely implemented across the sector as a whole.

We have categorised the areas for improvement identified by Ogden into themes as follows:

- Governance and controls
- Financial management
- Budgeting service planning and performance management
- Fit for purpose systems
- Skills and capabilities

Our remit is to develop an action plan to address the weaknesses identified by Ogden. To do this we engaged further with RDOs and key Finance staff to understand the background and context of the report's findings in more detail.

The following analysis explores these areas further, identifying the key challenges faced at present, and outlining applicable best practice principles where appropriate.

Prioritised actions aligned to the changing environment

In considering the key actions required to address the challenges identified within the review, we have prioritised these as follows:

- Those immediate actions necessary to ensure effective control mechanisms are in place to manage the significant financial pressures faced across the health sector;
- Structural improvements to be introduced in the coming year to ensure stability within the system; and
- Longer term initiatives which will transform financial management within the context of the wider health reform agenda.

We have drawn from our experience from other healthcare systems across Europe to define financial management requirements in line with leading practices.

Governance & Controls

Key challenges

High level control environment

- Ogden observed an unconventional separation in accountability for financial control and reporting and financial management responsibility at HSE National Director level;
- Accountability and responsibility for financial management and control rests with the National Director of Finance; and responsibility is delegated to Assistant National Directors of Finance at a regional level;
- Accountability and responsibility for the management of Financial and Operational Performance rests with the National Director for Integrated Service Delivery; similarly, this responsibility is delegated to Regional Directors of Operations;
- The National Director for Corporate Planning and Corporate Performance also has a role in reporting performance , both operational and financial, on a monthly basis.
- The problem arises in how these accountabilities and responsibilities are executed on a day to day basis. The part played by each of the National Directors in supporting the control environment lacks clarity and is not properly understood, resulting in inherent weaknesses in the system;
- The systems and processes used to establish the HSE have not created an integrated financial performance framework which operates consistently across all Regions – this creates inconsistencies in approaches to data collection, analysis and financial performance management;
- Ogden explicitly highlights a "Lack of clarity in the system as to whether RDOs can move money around between care groups“, indicating that financial regulations are not fully understood.
- The SDU and ISD lack common messages and this is often used to deflect criticism of poor performance.
- Governance arrangements for emerging Hospital Trusts create a further inconsistency in a complex controls environment.

Risk Assessment

- There is limited evidence of systematic quality risk assessment to assess the safety impact of reductions in spending. This is exacerbated by the multiple systems in use which means that it is not possible to assess, then hold to account, those responsible due to the levels of delegation involved.
- In particular, as part of the Estimates process between DPER and DOH and then within the HSE there needs to be better risk assessment of the global impacts of agreed national cost reduction measures as part of the budget setting process.
- Significant governance challenges exist when parallel structures are introduced without integration with existing controls and processes.

Incentive Systems and the control environment in the voluntary sector

- Our engagement has identified real challenges in exercising financial control within the Voluntary sector, where there is limited visibility of financial systems and processes, and no operational decision making responsibility on the part of the HSE, which makes it difficult to enforce cost reduction measures;
- Existing governance arrangements, where services are delivered under a service agreement, and performance against that agreement is measured in year; lack sufficient intervention measures to enforce remedial action for poor performance;
- The ultimate sanction of failing to provide weekly cash funding where annual limits have been reached is not exercised;
- A lack of visibility of the balance sheets of voluntary providers make it difficult to take a view of the potential impact of the providers trading position with the HSE on their overall viability;
- The absence of an incentive system which rewards good financial management, whilst holding those who perform poorly to account, drives a lack of cost consciousness in the system. This has a whole system impact on culture and behaviours.

Governance & Controls

What good looks like

There is an existing Governance and Controls framework in place within the HSE which is considered to reflect leading practice for the public sector in Ireland. However existing arrangements are no longer appropriate for the changing health environment and are not fully embedded within the organisation. A revised framework should clearly define:

Roles and Responsibilities

- Responsibilities and accountabilities at all levels of the organisation so that there is a link between policy development and service delivery and the achievement of outcomes, both financial and non financial;
- The Role of Director of Finance and responsibilities and accountabilities in respect of financial management, financial control and reporting clearly understood. The key responsibilities of the Finance Director are illustrated on the right;
- The role of Operational Directors and responsibilities and accountabilities in respect of financial management from an operational perspective as budget holders (as opposed to the responsibility of the Director of Finance to establish systems and processes) are fully understood.

Controls Environment

- Scheme of delegation: outlining how responsibility and accountability nationally is delegated at a regional and local level, and clearly establishing the extent of decision making responsibility at each level;
- The Controls framework should ensure appropriate systems and processes exist. These systems are common wherever possible, and processes are simplified and standardised, with systems based controls in place wherever practicable;
- There should be an ability to intervene and take remedial action to improve systems process and capabilities at a local level where evidence of poor operational and financial performance exists.

The controls framework established by Monitor to govern Foundation Trusts in the NHS in England is presented in Appendix C.

- Establishing a similar framework within the HSE would clarify the accountability of CEOs and Finance Directors within the system for operational and financial performance, enable good performance to be recognised and rewarded, and the consequences for poor performance to be properly understood across both Statutory and Voluntary providers.

The Role of the Director of Finance:

The two key responsibilities are to:

- deliver effective systems of internal controls and assurance processes to ensure probity and transparency in the spending of public funds, including monitoring the financial performance of the organisation, financial reporting and minimising financial risk; and
- promote value for money in the use of resources (e.g. workforce, buildings and medical technologies) acquired through public spending to maximise benefits for patients, families and carers.

NHS Foundation Trust Compliance Requirements

Compliance Framework to ensure NHS foundation trusts maintain their viability, including:

- staying solvent;
- being well-governed (from both a financial and quality perspective);
- operating effectively within their constitutions;
- engaging with patients, service users and commissioners;
- providing all the services that they are required to deliver by law; and
- complying with the other conditions set out in their terms of Authorisation

Source: Monitor

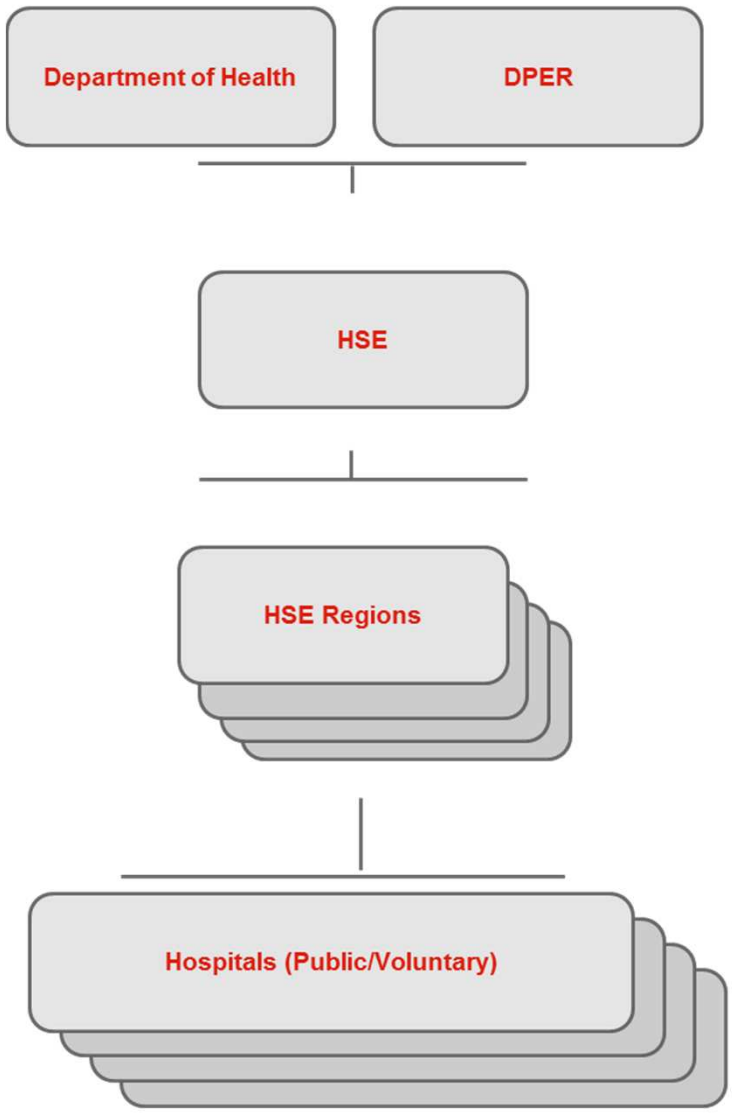
Key Actions: Governance and Controls

Take control	Stabilise	Transform

• Take immediate action to intervene in poor performing statutory hospitals which demonstrate significant problems in management of access targets accompanied by significant financial problems.
• Develop the model of intervention for all hospitals which will facilitate operational and financial improvement within hospitals which are failing;
• Provide clarity in the short term regarding roles, responsibilities and delegated authorities within existing organisation structures both at HSE and at a hospital level;
• Ensure nationally managed programmes are aligned with operational responsibility at a regional and local level;
• Ensure delegated decision making at a regional and local level is consistently applied, and reflects need to introduce spending controls in the short term;
• Ensure systems and processes are in place to measure effectiveness of delegated responsibility and accountability.
	• Design a new system of governance for Voluntary providers using Monitor's regime for Foundation Trusts in England as an exemplar and ensure that there is a clear means to link funding to service delivery whilst providing incentives to those that perform well;
	• Review current governance and controls framework and assess its effectiveness nationally, regionally and locally test whether
	  • Requirements are understood, embedded at all levels, and consistently applied;
	  • Driving appropriate culture and behaviours; and
	  • Aligned with best practice.
	• Design a new governance and control environment for the emerging HSE operating model including appropriate incentives to drive a cost conscious culture.
		• Embed new governance and controls environment within new operating model to ensure that financial resources are well managed in an environment where money follows the patient and the delivery of hospital services are provided within a group structure.

Financial Management

The financial management landscape does not support effective financial management and decision making



- Inability to establish costs at programme level makes budgeting difficult
- Lack of visibility of financial position beyond that reported externally
- Increasing reliance on Treasury forecasts and Vote management process to obtain a reliable view of HSE finances

- Impose incremental budget reductions which may not reflect local circumstances
- Limited consistent information on demand and capacity to inform robust financial decision making
- No clear link between service planning and budgeting
- National financial reporting lacks flexibility and the ability to drill down beyond summary level
- Financial information is backward looking and slow and does not support effective decision making

- Inconsistent approach to financial reporting
- Lack of financial management capability and capacity
- Monitor reported financial variances but unable to enforce corrective actions
- Consistent outturn forecasts not reported
- Limited understanding of demand, activity levels and cost implications
- Focus on achievement of "cost containment" metrics rather than cash savings

- Inconsistent approach to financial reporting
- Lack of visibility within Voluntary providers
- Low levels of financial management capability
- Focus on delivery of arbitrary cost containment plans which do not reflect degree of specialism or demand
- Limited appreciation of activity costs and cost drivers
- Limited understanding of service profitability

Financial Management

Key challenges

Financial Reporting

- There is limited evidence to demonstrate that the HSE has effective control of either the income or costs of the health system and can credibly predict an accurate year end outturn position.
- Similarly, monitoring and evaluation of HSE financial performance by the DH and DPER is not supported by the financial management and reporting processes in place;
- The financial reporting process is inconsistent across Regions and does not support the identification of an accurate I&E or Balance Sheet position for each operational entity;
- There is no common template for financial reporting in place which ensures all reporting requirements are met (e.g. Troika/DPER/DH/HSE);
- Multiple systems and a lack of a common chart of accounts and financial reporting template means that consolidations are often queried and that it is not possible to drill down comprehensively from a consolidated position of the health system from either an I&E or Balance Sheet perspective;
- There has been insufficient emphasis on embedding and achieving realistic, accurate Cost Containment Plans, and these have been developed in an inconsistent manner across the system;
- A lack of information and capacity to analyse the Balance Sheets of individual hospitals may mask levels of reserves held by Voluntary Hospitals;
- Targeting acute sector financial performance does not take account of potential savings in other aspects of the HSE budget, for example Primary Care and Community.
- There is no systematic forecasting of outturn in a consistent way and as a consequence the Department places its confidence on the Cash forecasting model as the most effective means for projecting the year end position.
- Despite these challenges, the HSE has been the subject of clean audit reports since 2005.

Realising Savings

- Limited visibility and control over the extent to which plans to reduce cost at the start of the year are reflected within the cash run rate;
- The method for managing and controlling cost containment measures and in year cost pressures is ineffective as comparisons are made with the previous year's spend not the current year's budget.
- Ogden identified limited evidence of systematic quality risk assessment to assess safety impact of reductions in spending;
- Limited evidence of assessment of how spending reductions impact on service capacity and care quality;
- The consequences of previous custom and practice in respect of the treatment of overspends in year has resulted in a widely held belief that overspendings will be funded from elsewhere.

Operating Model

- Where financial management capability exists within the system, it is placed under significant pressure because of the shortcomings of the financial systems in place.
- The lack of a common systems infrastructure makes reporting time-consuming and creates the potential for both inconsistency and inaccuracy in financial analysis; e.g. repeated errors in published performance reporting.
- Activity Based Costing is not consistently applied across the hospital system;
- There are no incentives for good financial management or consequences for poor financial management in the system;
- System limitations mean that more time is spent supporting monthly reporting cycles than in strategy, planning and decision support. Improvements to financial reporting and analysis are also constrained by staff capacity.
- An inconsistent approach to income collection and recovery leads to pressure on working capital and increased provisions for irrecoverable revenue.

Financial Management

What good looks like

Consistent Standard Reporting which meets user requirements

Based on a common chart of accounts and consistently applied financial reporting framework, key decision support reports should be produced in a consistent format, with drill down capability to an appropriate level of granularity to support decision making. The use of dashboards which highlights key areas for action, decision, or management attention will enable appropriate focus on the levers available to manage cost effectively.

Activity Based Costing

With the introduction of A Fair Deal and plans to develop a "money follows the patient" model more widely it is critical that costs are understood at an activity level.

Individual prices will be developed for services based on Healthcare Resource Groups (HRGs) or Diagnosis Resource Groups (DRGs) and those price should be based on activity based inputs.

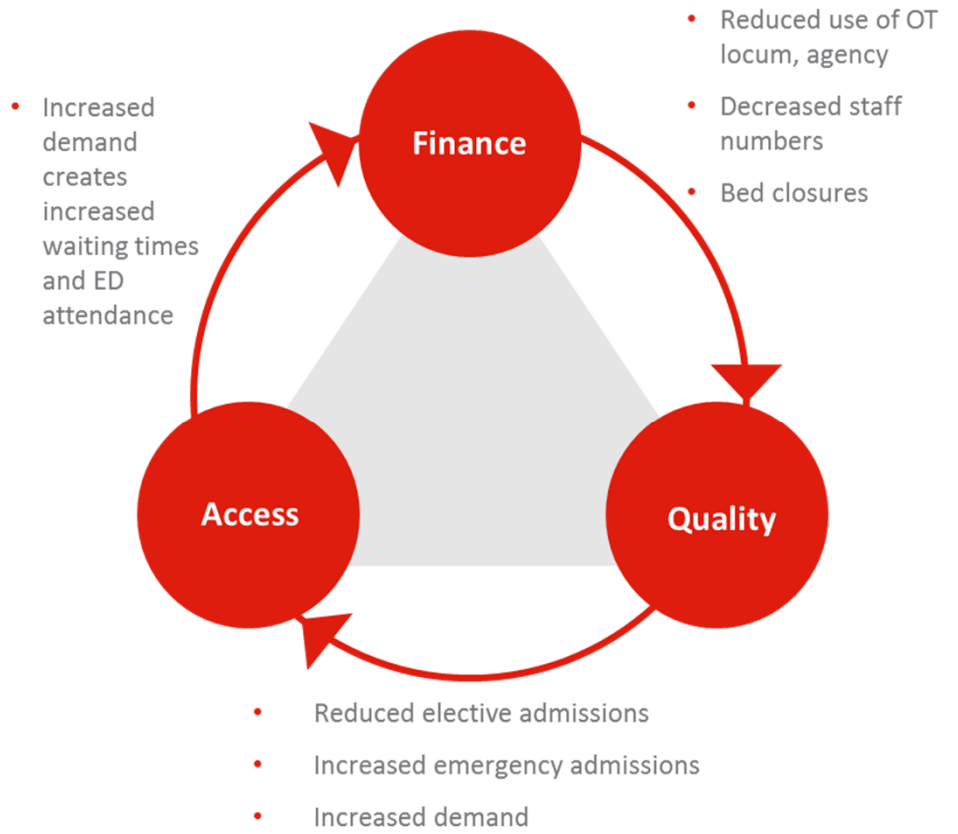
Hospitals and other Local Health Offices (LHOs) will need to develop an understanding of cost at an activity level to provide a view of financial viability.

This will have the added benefit of improved decision making and the ability to link budgets to service plans more effectively, and really understand the cost drivers associated with service delivery.

In addition, it will enable Service Agreements with Hospitals to properly reflect the relationship between activity levels and agreed funding.

Maintaining patient safety is critical in a financially challenged environment

To ensure the best to use of scarce resources within the system to meet demand, operational and policy decisions are taken having considered the potential impact on both service quality and waiting times. Understanding the cost of current operational capacity enables cost reduction measures to be aligned to system wide reconfiguration.



Financial Management

What good looks like cont'd

Service Line Management (SLM)

To respond to an increasing need to understand the financial consequences of operational decisions close to service delivery, Service Line Management reflects leading financial management practice in Health.

The principle of SLM is to devolve accountability to those in the organisation who are closer to the front line services. This enables localised decision making and service improvement.

Service lines are the equivalent of a commercial company's business units. They are the key units within which services are delivered to patients. SLM allows hospitals to be managed as a set of discrete business units with autonomy devolved closer to the frontline.

SLM requires integrated ownership of clinical, operational and financial objectives and outcomes that come together to deliver care to patients, with discrete resources used to meet a related set of patient needs. It is backed up by a performance culture and framework that pushes accountability to the front line, but also incentivises staff to deliver.

SLM empowers clinicians and other front line staff to improve and invest in their services through the provision of clinical, operational and financial information. This combination allows clinicians to make informed decisions, creates a culture of continuous improvement, gives them the power to implement these decisions and change services for the better.

The introduction of SLM to an organisation is likely to be part of a planned change programme. For the concepts to be implemented successfully a number of considerations will need to have been agreed and piloted in advance. These will include:

- Governance arrangements (particularly upward accountability)
- performance management structures and styles
- change planning/management
- skills / knowledge / roles
- reporting / information

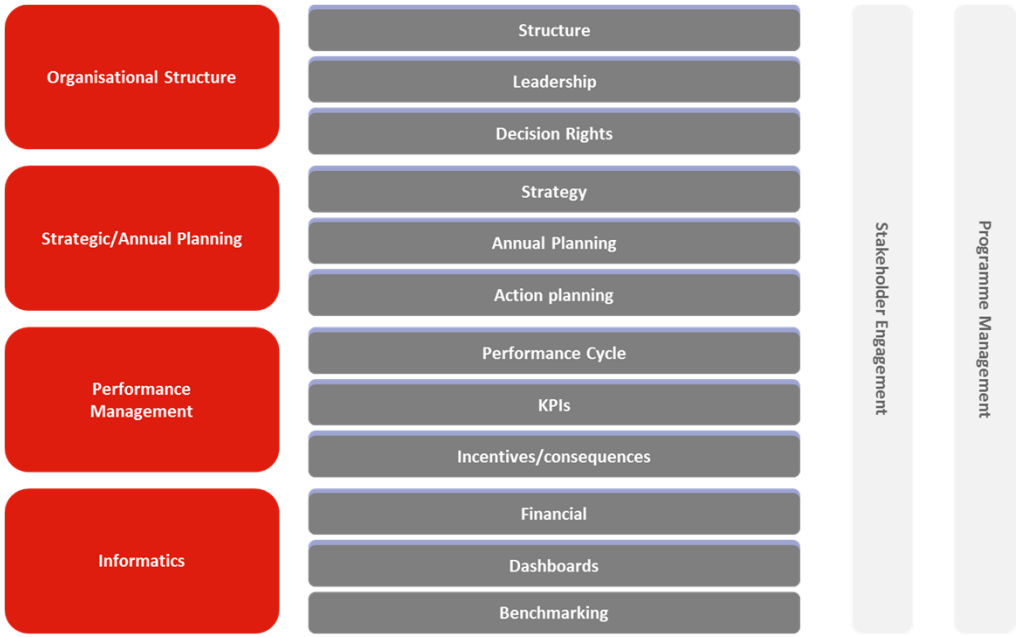
Implementing SLM will start a cycle of continuous improvement led by the local staff resulting in the service being locally adapted to the needs of the local service users and community.

Timely, accurate and useful information is the foundation of SLM. It provides the basis for Service Line Leaders and Managers to make informed decisions about the improvement of their service.

The reporting information required to support SLM can be defined into four distinct elements:

- Financial reporting – (Service Line Reporting)
- Activity
- Quality – including Patient Experience
- Staffing

An operating model to support SLM



Key Actions: financial management

Take control	Stabilise	Transform

• Produce a detailed system wide projected outturn, to include a reforecasting of cash requirements for the last quarter of the year. Use this outturn position to confirm the recovery plan to the end of the year and to establish cash limits which will be strongly enforced;
• Roll out template reports to monitor spend to date, produce outturns and track delivery of Cost Containment Plans consistently;
• Create dashboard for senior management at all levels on delivery against key metrics:
  • Pay: overtime, agency, absenteeism
  • Non pay: procurement targets
  • Income
• Develop an approach to the 2013 service planning process which ensures that a whole systems view is taken to support policy development and operational and financial management decision making;
• Implement savings plan sign off process covering RDO and hospital level.
• understand impact on service delivery arising from savings proposals.
	• Review progress being made in activity based costing initiatives underway;
	• Agree on standard process to adopt across all hospitals;
	• Implement consistently across all hospitals in the first instance;
	• Use to inform service planning and budgeting process in future years;
	• Develop an approach to Service Line Management and test its key operating principles within a hospital group.
		• Design new financial management processes aligned to new operating model;
		• Implement Service Line Management across the health sector on a phased basis across care groups, with acute sector in phase 1.

The Process applied in establishing the 2012 Budget (Sept-Dec)

Draft HSE Service Plan → Iterative Planning Process → **Final HSE Service Plan** → **Regional Service Plan**

Comprehensive Review of Expenditure in Health Sector

Submitted to DPER in September 2011

Extensive examination of all programmes operated by HSE

- Informed Draft Service Plan which was submitted following intensive discussions involving HSE, DH, DPER and Ministers

Estimates Process

Establishment of overall Government Budget

- HSE Vote determined in the context of overall government expenditure targets

Step 1 Identification of Allocation for the year

Vote at 31 Dec 2011

Less: one off adjustments and supplementary funding in year

Adjusted for: Recognised Additional Funding and Savings Specified in the Estimate

Vote at 1 Jan 2012

- Funding provided to address structural deficit in Child Welfare and Protection
- Acute sector budget set in the context of further roll out of clinical care programmes.

Step 2 Identification of the Financial Challenge

Savings specified in the Estimate

Additional Known Cost Pressures

- Nationally agreed savings targets based on priority areas of focus;
- previous years' pressures and structural deficits were addressed to the extent possible within the financial constraints imposed by the level of resources available.

Step 3 Allocation of Budget to Regions

Agreed Budget for 2011 used as a baseline

Budget adjustments made in establishing Vote allocation apportioned across relevant budget heads using methods agreed by National Directors of Finance and ISD

Allocations applied within Synergy system, and reconcile to Vote

- Issues from previous years not reflected unless recognised in Vote;
- Allocations incremental in nature and not reflective of cost pressures.

Step 4 Establishment of Regional Budget

Allocated in line with Agreed Budget for 2011

Cost Containment Plans established to adjust Budget for 2011 in line with Allocation for 2012

Service Plan developed to deliver targets within Budget for 2012

- Little recognition of cost of capacity within the system or impact of demand;
- Service Plan and Budget established without full understanding of cost to deliver;
- Cost Containment Plans whilst designed to address cost pressures are in the main tactical and defer cost rather than address underlying structural issues.

Step 5 Management of Budget in Year

Delivery of Cost Containment Plans:

Specific metrics measured

YTD Spend compared against YTD Budget

Comparisons made with previous year

- Formal projections on a monthly basis not reported;
- Cash implications not recognised.

Budgeting, Service Planning and Performance Management

Key challenges

Budgeting & Service Planning

- The "Top Down" approach to budgeting is based on arbitrary top slicing with no reflection of demand/need at a hospital level;
- This process perpetuates year on year inefficiency and drives a lack of ownership for financial performance;
- Service plans focus on priorities which do not align to the "Top Down" budget allocation approach – thereby creating a financial gap;
- Budgets at a local level are based on the prior year's budget, not prior year's actual – thereby not reflecting historic actual service demand/need and ignoring any annual growth in demand;
- There is little evidence to suggest that the budget reflects the activity presented in the agreed service plans at a regional level;
- There are deficiencies in regional financial control targets: Cost Containment Plans fail to address the entire financial challenge;
- Formal projections on a monthly basis are not reported consistently;
- Cash implications not recognised in monitoring and reporting.

Target Setting

- Lack of credibility surrounding the process of calculating and communicating realistic targets;
- Current cost reduction plans are tactical in nature and it is unclear how much of their nominal projected savings will translate into true reductions in expenditure or Vote.

KPIs

- Major disparity between the extent, quality and focus brought to financial and non-financial KPIs between the hospital and non-hospital sectors; consideration of the latter is outwith the scope of this report.
- Limited evidence of causal modelling and analysis to develop financial and operational plans which are mutually consistent and optimised within the hard constraints facing the HSE.

Performance Reporting

- The systems and processes used to establish the HSE have not created an integrated financial performance framework which operates consistently across all Regions – this creates inconsistencies in approaches to data collection, analysis and financial performance management;
- The Performance Report (PR) provides an overall analysis of key performance data from Finance, HR, Hospital and Primary & Community Services. The activity data reported is based on Performance Activity and Key Performance Indicators outlined in the National Service Plan 2012;
- National performance reporting at present measures activity against plan, headcount and financial performance, but not in a holistic way which enables interrelationships to be fully understood;
- The same Performance Report (PR) is used to report externally on performance and to manage the HSE operationally; the use of one document for multiple audiences does not lead to effective performance management;
- Link to personal objectives and implications for poor performance requires clarity;
- Need for more robust performance reporting from HSE to Department distinct from performance report which is externally focused;
- Need for more effective operational performance reporting which focuses on actions required at a local level to address areas of poor performance.

Budgeting, Service Planning and Performance Reporting

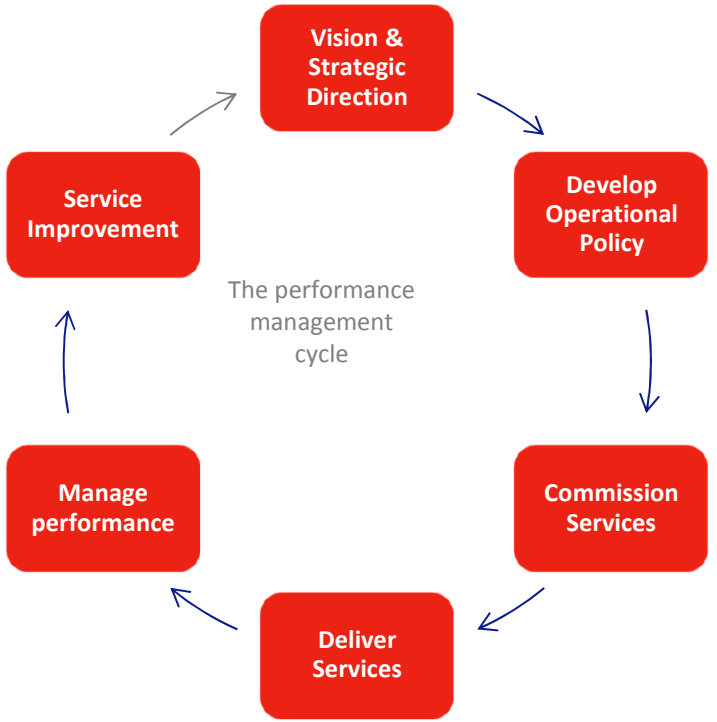
What good looks like

The Performance Management Cycle

The performance management cycle ensures that political imperatives are translated within operational policy and are reflected in how services are commissioned and delivered. Performance is managed against these imperatives and where poor performance occurs, service improvement action is taking to address failing services. Budgeting, Services Planning and Performance reporting are core processes which underpin the performance management cycle.

Attributes of leading practices include:

- Service Planning and Budgeting are fully aligned;
- Annual budgets reflecting the full cost of delivering planned activity levels, assessed with a view to maintaining patient safety;
- Budgets established from a zero base rather than incrementally to ensure that cost reductions can be aligned effectively to service delivery, and reflected appropriately in operational budgets;
- Services are commissioned through a service agreement which clearly links service requirements to the delivery of targets and budgets;
- Performance management framework in place which drives behaviour and links strategic operational and personal objectives;
- Performance measures consider all aspects of delivery with a strong focus on key priorities, and maintaining patient safety by considering key metrics around quality, access and finance;
- Clear ownership of the indicators and subsequent actions;
- Intervention mechanisms exist to enable poor performers to be supported through service improvement actions.



- Use of service line reporting by hospitals to enable service performance analysis;
- Active leadership promoting improvement, scrutiny, accountability, prioritisation, partnership and the challenge process;
- Enhanced data quality and analysis to ensure that the performance information facilitates concurrent control with as much real-time data as possible.

Budgeting Service Planning and Performance Reporting

Take control	Stabilise	Transform
• Prior to the 2013 service planning process, undertake a zero based budget exercise at hospital level to establish the link between service planning and financial planning. This exercise would be informed by the planned projected outturn exercise and would build on existing activity based costing exercises at a hospital level; • Improve the method of budget allocation nationally to better align with service outcomes and cost to deliver these outcomes; • Develop more robust performance reporting from HSE to Department distinct from the existing performance report which is externally focused.	• Undertake a zero based budget exercise in all other HSE care groups; • Identify systems to support budget management and forecasting at an activity and service line level; • Define new and consistent performance management arrangements across all aspects of the health system; • Improve operational performance reporting to focus on actions required at a local level to address areas of poor performance, aligned to principles of Service Line Management.	• Implement systems to support budget management and forecasting at an activity and service line level; • Implement new performance management arrangements.

Fit for purpose systems

Key challenges

- The systems and processes prevalent across the HSE do not support effective financial management and control with inconsistencies in approaches to data collection, analysis and financial performance management;
- The operating model remains tied to the previous Health Board structure and there are multiple legacy systems in use;
- Multiple instances of financial systems inhibits the move to shared services and the clear financial benefits that would generate;
- Multiple payroll systems and no link between HR and Payroll, means it is not possible to get full a picture of the cost of establishment or to drill down on pay elements to an individual level;
- Lack of organisation-wide procure to pay system hinders procurement transformation and the effective management of non-pay costs;
- There are deficiencies in consolidating reporting at a national level as reporting is based on regional extracts rather than being based on a comprehensive data set;
- Whilst there is a system to support the process of allocating Vote Expenditure to Regions and other Care Groups there is no budgeting and forecasting system in place which would support more effective budgetary control at an operational level;
- There is evidence of a significant amount of effort in identifying system requirements, and developing business cases to support investment but approvals to proceed have not been secured. This lack of progress severely inhibits the HSE's ability to meet the financial management needs of the organisation, both in managing its existing financial difficulties and in supporting the Reform agenda. It also prevents the release of cost savings through systems rationalisation, shared services and procurement.

What good looks like

- Common chart of accounts linked to a standard reporting framework;
- Integrated HR and Payroll system to support the entire organisation enabling a complete picture of the cost of the establishment and full visibility on cost over overtime, absence and temporary staff at a service line level;
- Integrated Procure to Pay system which will facilitate supplier management and rationalisation, category management and enforce more effective procurement practice through the use of catalogues;
- Integrated financial management and reporting system which supports financial management and control at all levels of the organisation:
  - Hospital and Local health organisations
  - Regional integrated service delivery
  - National care groups
  - National performance reporting
  - Statutory and external reporting
- Functionality should include:
  - Budget management and control
  - Outturn projections
  - Job costing
  - Activity based costing/service line reporting
  - Financial reporting, including Vote Accounting
- The implementation of multiple instances of a common system should be avoided through the use of shared hosting of a common system across the heath sector.

Key Actions: Fit for purpose systems

Take control	Stabilise	Transform

• Undertake a portfolio review of all planned system improvements, investments and replacements across the Health sector. This should be considered in the context of plans for shared services across Government being led by DPER. Consideration should also be given to planned system investment within hospitals and other LHOs both in the statutory and voluntary sector (e.g.planned investment in SAP at Tallaght) Report to include
  • Project overview
  • Outline of progress to date
  • Status of business case
  • Plan, resources and costs
  • Benefits
• Establish a Design Authority to govern all systems improvement and investment activity going forward.
	• Based on the Portfolio Review report, develop a Fit for Purpose Systems strategy and roadmap which will rationalise existing plans and develop a systems landscape for the future which will support a new operating model and the requirements of Future Care.	• Implement Fit for Purpose Systems strategy in line with agreed roadmap.

Skills and Capabilities

Key challenges

- Ogden identified insufficient levels of professionally qualified accountants within the organisation. Torpey also commented on this within his review. The moratorium on recruitment has prevented any action to resolve this issue;
- Whilst it is important that skilled and capable financial staff support the business, particularly in times of financial challenge, it is equally important to ensure that financially qualified staff are focused on added value activity and that a suitable mix of technical specialists and administrative support is deployed to facilitate operations excellence in financial management;
- Our engagement has highlighted that limited financial management capability exists within the system. Where this does exist it is under significant stress;
- The recent financial difficulties experienced by the HSE and the consequential scrutiny on finance issues from across government has had a negative impact on the perceived credibility of the finance function within the HSE;
- System limitations mean that finance staff focus significant effort in supporting the monthly reporting cycle, and are unable to devote more time to improving the quality of financial analysis and in supporting decision making at both a strategic and operational level.
- The importance of a strong cash management function within the HSE should not be underestimated in the context of the Vote transfer.
- To embed a cost conscious culture across the organisation, there needs to be a focus on the development of financial management capability, both within Finance and amongst operational managers and clinicians

What good looks like

A modern finance professional requires a broad mix of skills and capabilities, and the emphasis on these skills will vary depending on the specific demands of the role.

The Finance Director needs to ensure that there are sufficient skills and capabilities within the organisation to fulfil the following, quite different roles:

- Strategy & Policy Development;
- Financial control, risk management and assurance;
- Performance improvement;
- Finance operations (managing the engine room of payroll, payments, income collection and reporting);
- Business Intelligence – providing analysis and insight to support decision making;
- Business Partners: supporting operational decision making and financial management;
- In addition to the specialist roles of tax advisory, treasury management and pensions advisory, for example.

Typical skills and capabilities needed to support these roles are outlined in Appendix D, and illustrate the breadth of skills and capabilities required.

The focus need not be on recruiting qualified accountants, but on ensuring that you have the right people with the right skills in the right place to support the business. You may also decide that certain capability is not core, and decide to outsource this requirement rather than deliver directly.

Key Actions: Skills and Capabilities

Take control	Stabilise	Transform

• Identify accounting staff across the system, nationally, regionally and within each hospital;
• Undertake skills and capability analysis of existing staffing;
• Document job roles, responsibilities etc. currently undertaken and issues and challenges with existing staffing complement in place;
• Define a resource plan/workforce plan that will allow existing skills to be deployed against greatest need.
	• Design future job roles and person specifications as part of new operating model for finance design (page 30 refers);
	• Define skills and capability requirements;
	• Identify skills gaps and capability development needs.
		• Implement new finance operating model;
		• Appoint staff to new roles;
		• Develop a Financial management community of practice to develop leading practice;
		• Introduce a Financial management development programme:
		  ◦ For finance professionals;
		  ◦ For budget holders: clinicians and operational managers.
		• Continuing professional development:
		  ◦ Develop a Finance training scheme to develop the future leaders in finance;
		  ◦ Introduce learning and development requirements to ensure that staff remain at the top of their profession.

A “fit for purpose” Finance Organisation is essential to deliver Future Health

Future Health sets out the major healthcare reforms that will be introduced by 2015, prior to the launch of Universal Health Insurance (UHI) in 2016 and the abolition of Ireland’s unfair and inefficient two-tier healthcare system. These reforms will help to deliver on the overall objective of the health service which is to improve the health and well-being of the people of Ireland by:

- keeping people healthy;
- providing the healthcare people need;
- delivering high quality services; and
- getting best value from health system resources.

Future Health is built on four key inter-dependent pillars of reform :

- **Health and Wellbeing.** The role of the health service must be seen as helping people to stay healthy as opposed to just treating sick people;
- **Service Reform.** The current hospital-centric model of care has not delivered and cannot deliver the quality of care required by our citizens at a price which the country can afford. Primary care is an essential driver in developing a new Integrated Model of Care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible;
- **Financial Reform:** One of the key goals is to reduce costs by improving productivity, whilst also increasing quality and delivering a fairer system. In order to do this we need a new financial model to incentivise better outcomes for less money. Under “Money Follows The Patient” providers will be paid for the needs they address, the quantity and quality of the services they provide and the outcomes they deliver at a population level;
- **Structural Reform:** Future Health will replace the current over-centralised model of healthcare with a new system of earned autonomy. Under the new model healthcare professionals will be given much greater leadership roles, and providers will secure ever more operational freedom – provided that they in turn deliver on the budgetary, patient quality and access outcomes required.

The success of all of these reforms will depend on significant improvements in information and in the IT infrastructure to support the integrated and effective utilisation of that information. Improved leadership across the health system will also be a key prerequisite for successful reform.

From our experience in supporting Health system reconfiguration in the UK and Australia we have developed the ideal reconfiguration journey, with some key challenges at each stage to make sure that you keep on track. We have presented this at Appendix E for your information.

How Finance will support the change

Implementing major healthcare reform at a time of severe financial challenge will require a step change in the way financial management is delivered within the HSE.

To do this finance must:

- Be suitably resourced and with the right blend of qualified and experienced staff with the skills and capability to support the implementation of:
  - A commissioner led model of service delivery where money follows the patient;
  - Zero based budgeting, activity based costing, service line financial reporting and HRG based tariffs;
  - A national performance reporting system which consolidates finance, quality, staffing, access and patient experience measures to drive service improvement and effective cost management.
- Have access to integrated systems to support the delivery of effective financial management and control;
- Have access to appropriate skills development, training and CPD programmes to ensure that staff have skills to comply with international best practice and standards.

This will require a significant investment in Finance, in terms of people, process and technology across Health, at a time when HSE finances are severely constrained.

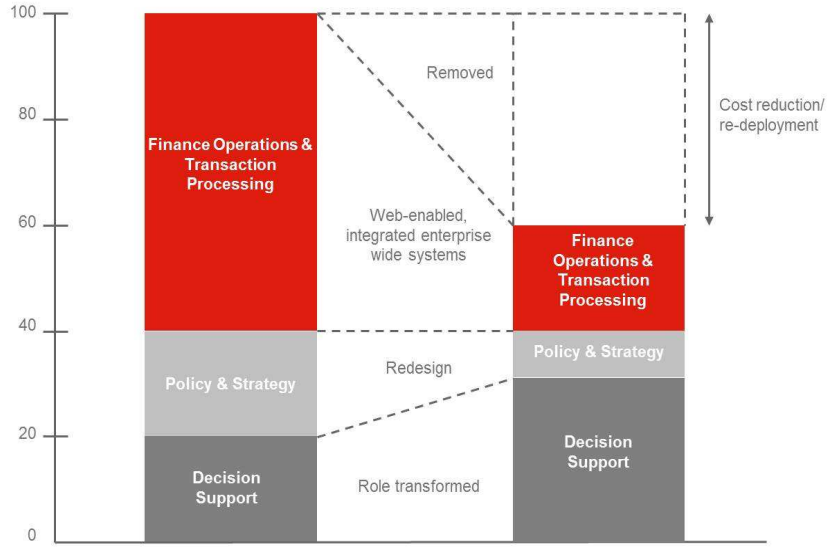
Failure to invest in Finance at this time however will place the success of Future Health at risk, and will prevent significant cost reduction opportunities from system rationalisation, back office reconfiguration and effective procurement and sourcing from being realised. Tackling these areas will protect frontline services wherever possible.

How Finance functions are transforming to meet new challenges

The figure below illustrates how leading organisations have transformed their Finance operations. The overall cost of the finance function can fall by as much as 40%. To achieve this the "engine room" needs to operate as efficiently as possible, transforming systems and processes supporting operations, allowing resources to be redeployed into decision support.

Steps have been taken to introduce shared services, and to transform procurement, but a lack of investment has prevented these initiatives from securing the full benefits potential.

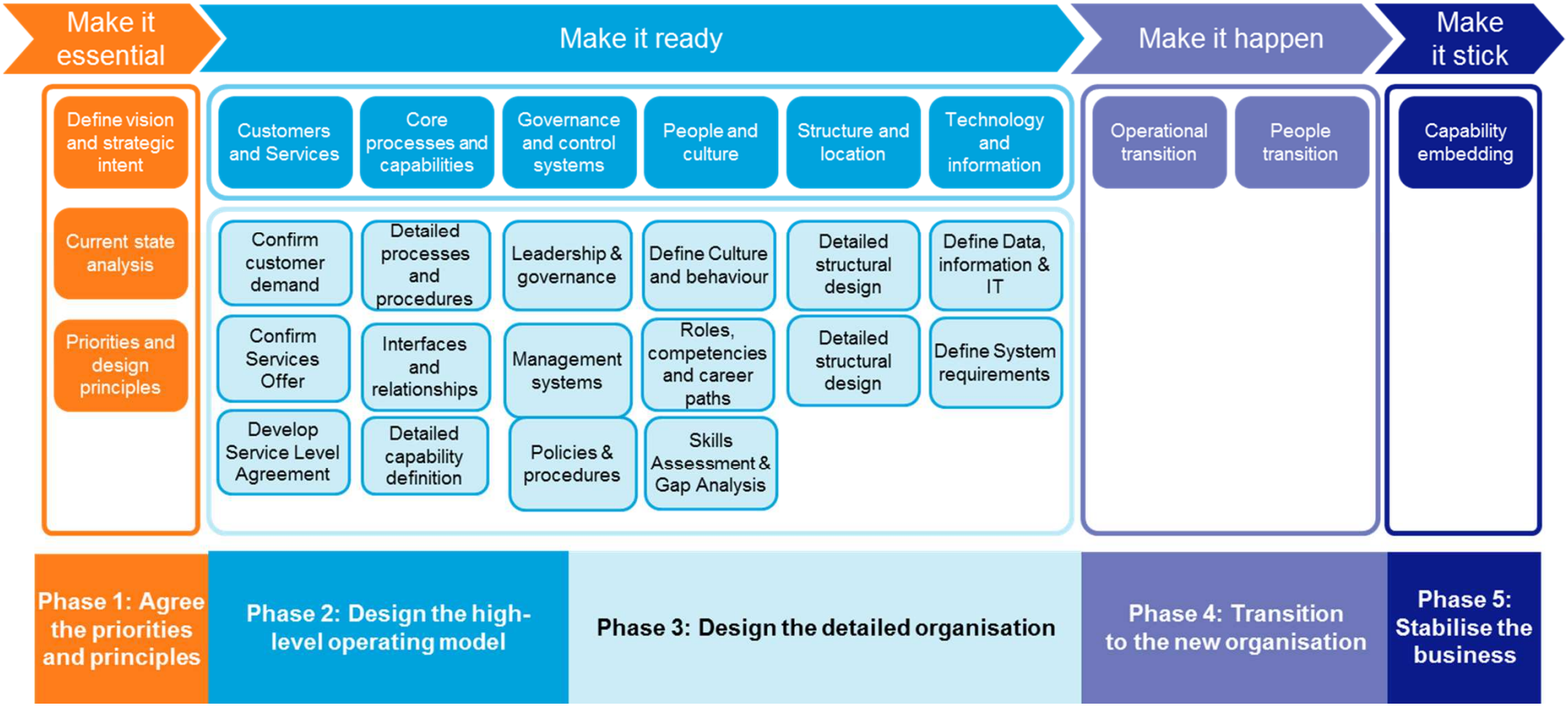
There is an opportunity now to redesign how finance is delivered, to address the weaknesses in financial management, systems and control identified whilst ensuring the future requirements needed to support Future Care can be delivered. The design of a new operating model will provide a framework to manage the change required to transform finance to be fit for purpose.



Key Actions: A new finance operating model

We have considered actions to address the individual elements which would be considered in developing a new Operating Model for Finance in our recommended actions for Governance and controls, Financial management, Budgeting service planning and performance management, Fit for purpose systems and Skills and capabilities.

The diagram below illustrates the key steps involved in designing and implementing an operating model. The design elements should run in parallel to the design of the Future Care operation, and we would suggest that this work is undertaken before March 2013. Priority areas for implementation should be planned for during 2013 with longer term structural elements following in the intervening years.



Source: PA Knowledge 2012

3 An assessment of Cost Containment Plans

The Approach to Cost Containment

Introduction

The HSE Service Plan for 2012 identified a financial challenge of some €750m to be delivered in year to ensure that the levels of activity proposed within the Service Plan could be delivered within the approved Vote allocation.

As part of the service planning process, each Region identified the cost containment actions required to deliver their service plans within allocated budget during 2012.

We were asked to stress test these plans to assess their effectiveness and the extent to which the cost containment identified would be delivered as planned.

In stress testing these plans we sought to:

- Understand the background and context in which the Cost Containment Plans had been set;
- Assess the approach taken to identify and quantify the impact of measures contained within each plan at a regional level;
- Identify and assess the effectiveness of the monitoring ,management and delivery against these plans in year;
- Take a view, based on the financial information made available, as to whether the plans were deliverable.

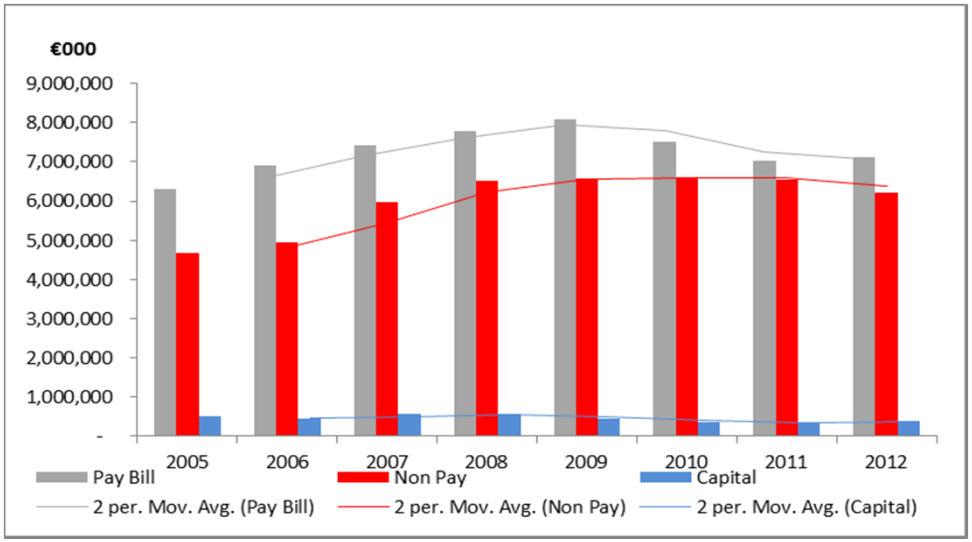
The Financial Challenge in Context

The health service budget has reduced by €2.5 billion over the last three years . Figure A below presents the Vote allocated to HSE since 2005, which clearly illustrates that pay costs in particular have fallen sharply from its peak in 2009, whilst non pay costs have remained relatively constant: improvements in procurement practice have contained the impact of the increasing cost of drugs and other demand led schemes.

Also of note is the declining investment in capital expenditure despite the need to support reform and finance advances in medical technology and infrastructure.

The focus of our review is the hospital sector which has borne the brunt of the cost reduction, with the budget falling by some 24% in the last 3 years.

Figure A: Estimates Summary Vote Trend



The Financial Challenge in context

The Cost Reduction Target for 2012

Table A outlines how the Vote for 2012 was determined. The Service Plan assumed gross reductions of €494m as part of the annual Estimates process. In addition, additional cost pressures which would not be funded, amounting to €256m were identified. This amounted to a Cost Reduction target of €750m. A detailed breakdown of these elements is presented in Table B.

Funding Grace Period Exits during 2012

Departmental savings specified in the estimate included an estimated €183m for pay and cost reduction measures, namely €160m for grace period exits and €23m for reductions in overtime. (Table A)

These amounts were removed from the budget nationally prior to allocation of the budgets regionally. This means that to achieve budget, a net saving of €160m would be required from staff exiting the service during 2012.

The Service Plan identified the cost of grace period exits as € 227m. The elements making up this cost is presented in Table C.

It was assumed that the additional costs arising would be funded from a combination of pay savings based on 3000 WTE leaving the service of the HSE (€160m) other pay savings (€23m) and additional funding from DPER to meet the cost of lump sums (€44m).

It would appear that as the pay and cost reduction measures are already assumed to be delivered within the base budget; and as such the costs incurred in delivering these savings have not been provided for. This would go some way to explaining in part the deficit in pay costs being experienced.

Table A: HSE Vote 2012

Derivation of HSE Vote 2012	€'million
Vote at 31/12/11	**13,565**
Less: Once off funding Fair Deal Withdrawn	-15
Less: 2011 Supplementary Funding	-148
Revised Opening position	**13,402**
Less: savings specified in the estimate 2012	
Pay and cost reduction measures	-183
Procurement	- 50
Care group reductions	-50
Community based drug schemes reductions	-124
Income - voluntary hospitals	- 64
Pay reductions: Student Nurses	-12
Long stay repayment scheme	-11
Other	-1
Add: additional funds set out in estimate 2012	
Nursing Home Support Scheme: As Fair Deal	55
Superannuation	147
Community based drug schemes	158
GP Cards	15
Mental Health investment	35
Vote at 1/1/12	**13,317**
Provided REV Transitional Care	15
Revised Vote at 1/1/12	**13,332**

Table B: Cost Reduction Target 2012

Cost Reduction Target 2012	€'million
Gross reductions	
Pay and cost reduction measures	183
Procurement	50
Care group reductions	50
Community based drug schemes reductions	124
Income – voluntary bodies	63
Pay reductions: Student nurses	12
Long stay repayment scheme	11
Other	1
Gross reductions total	**494**
Additional cost pressures not funded	
Annualised closing run rate deficit	130
EU Directive on agency staff	15
Increments	46
Renal Services	5
VAT – estimate	50
Removal of relief for pensions	10
Additional Costs not funded total	**256**
2012 Target	**750**

Table C: Additional Costs arising from Grace Period Exits

Additional Cost	€m
Additional Pensions	68
Lost pension income	19
Proritised recruitment	16
Additional lump sums	44
Other pay reductions	80
Total	**227**

Source: HSE National Service Plan 2012

Approach taken to assess Cost Containment Plans

Engagement with Regional Finance and Operations Teams

As an initial step to assessment, we scheduled conversations, either face to face or over the telephone, with Regional Directors of Operations and the Assistant National Director of Finance from each region to discuss the cost containment approach at regional level. This engagement resulted in detailed discussions that concentrated mainly on; areas of cost containment focus, process, monitoring and management of plans and expected realisation of cash benefit.

As a follow on to these discussions, we requested to review the mechanism used to monitor progress of cost containment initiatives at regional level. Our rationale for this request was to assess the control/governance and effectiveness of plans within each region. Whilst we didn't receive a comprehensive return from each Region, from material reviewed it became clear that an inconsistent approach to monitoring exists. Consequently further email/telephone conversations ensued with the Assistant National Directors of Finance to seek further clarification in respect of the processes followed and data received. On the basis of this engagement the table below summarises our assessment of the effectiveness of cost containment plans and their monitoring and control within in each region.

Practices adopted by the South Region were far more comprehensive than others, however there are still some deficiencies with the approach adopted.

Table A: Effectiveness of Current Cost Containment Plans

Effectiveness criteria (Low → Effectiveness of Approach → High)	DML	DNE	SOUTH	WEST
Plans in place to address entirety of financial challenge	◔	◔	◑	●
Plans supported by cost analysis at level of granularity necessary to support decision making	◑	◔	●	◔
Plans aligned to budget and reflected within GL	Not observed			
Plans profiled to indicate timing of cash realisation	◑	○	●	○
Plan realisation monitored at initiative level on a monthly basis	◑	○	●	○
Responsibility for key actions required to ensure delivery clearly understood	○	○	●	○
Key decisions tracked	◑	◑	●	◑
Cash realisation demonstrated through link to cash forecast and cash drawn	Not observed			

Processes in place to monitor the delivery of Cost Containment Plans

Our engagement with the finance teams in the regions identified, at a high level, the process in place within each region to monitor and manage the Cost Containment Plans. This is summarised below.

Summary of Regional Processes

South

Produce a detailed monitoring report that includes a cash profile on a monthly basis. Initiatives are categorised according to pay, non-pay and income. The report identifies whether initiatives are one-off or recurring benefits and are tracked against plan.

A summary of cost containment scenario plans is also produced. This sets out detail in relation to each CCP initiative proposed in HSE South in 2012 .It is against this master document that the monthly report is reviewed and monitored. The cost containment scenario plan appendices set out the following for each specific initiative:

- Initiative Summary
- Background and rationale for proposal
- Implications for clients and service
- Implications for staff
- Costing associated with proposal

Recommendation: Approach is be used as example of good practice and shared among regions

West

Each area within the West region are asked to set CCPs to meet their respective financial challenge. Some areas implement plans from the start of the year and are therefore included in the run rate while others identify specific cost containment plans to be implemented at different stages of the year. It has been necessary to adjust these plans at several stages due to service implications/increased cost pressures etc. The measurement of delivery of CCP's is based on the progress each area is making in meeting their challenge and their year-end forecast which is reviewed at the end of each month. A cash profile is produced on a monthly basis.

The plan for West has a strong focus on the management of absenteeism, overtime and agency use. They have undertaken a number of initiatives to reduce costs in these areas resulting in lower levels of spend compared to their peers.

Dublin Mid-Leinster

The HSE DML CCPs are reviewed on a regular basis with all key service providers that constitute DML. The HSE DML CCP has been profiled to identify planned delivery on a monthly basis. The profile takes account of timelines and key dependencies so that in most cases it is likely that there will be an increased delivery on a month by month basis as the year progresses. The detailed plans, in which each initiative is set out on a line by line basis, is assessed on a monthly basis as part of the overall performance management process in the region.

PA were unable to access an overall regional cost containment report which included financial targets for initiatives set. Managing CCPs within DML is challenging due to the proportion of service being supported by the voluntary sector, both in hospitals and mental health sector, due to a lack of visibility and ability to intervene.

Dublin North East

Monitoring/tracking at a line item level is not possible given systems and staff resource constraints within the region. There is a monthly process in place of projecting out a year end position for each agency and service area element. Relevant cost containment feedback received from areas/hospitals etc. is included. There is a dependence on areas/hospitals to update the balance of cost containment measures to be delivered. Delivery/performance against expectations is then discussed at Service Plan meetings. There is now an obligation on areas to provide a monthly breakdown of expected cost containment delivery. It should be noted that there is a heavy dependence on areas and hospitals to provide timely accurate returns.

As projections are done on Excel, many different layouts are received (despite requests to follow set format). There is an issue about getting a list of cost containment measures from areas/hospitals at the beginning of the year and how to monitor those measures in a fluid and dynamic environment. Process does not allow for the required level of granularity.

Effectiveness of Current Cost Containment Plans

Deficiencies in the on-going management of Cost Containment Measures

A Cost Containment Plan is designed to be the bridge between last year's and this year's budget. However measures contained within the HSE Regional plans predominantly drive efficiency not necessarily cost reduction, resulting in increased activity being supported at the same level of cost, rather than cash savings being realised.

From our review of plans submitted to the National Director for Integrated Service Delivery on 17th July 2012, delivery of Cost Containment Plans is monitored and controlled by considering performance against the following key measures:

a) Maintaining activity in line with Service Plans in the following areas:

- In-patient discharges;
- Day Case activity;
- Emergency Admissions.

b) Managing key financial targets:

- Reducing Agency Costs by 50%;
- Reducing Overtime by 10%;
- Reducing Travel and Subsistence.

(measured by comparing YTD spend with spend in the same period in the previous year)

The emphasis appears to be on short term, tactical measures focused on bed closures, staff costs and length of stay with limited reference to key measures such as demand management and patient need.

As the budget is based on an adjustment to the previous year's budget, comparing actual performance to the previous year's actual in the same time period does not take into consideration the recognised structural problems with the budgets, or the structural deficits included within the run rate.

Monitoring procedures do not explicitly demonstrate the impact Cost Containment Plans are having on the run-rate, by demonstrating a reducing requirement for cash drawn.

The delivery of these plans is largely influenced by the level of control the HSE has over the hospital. For example, there is an inherent risk in the delivery of CCPs within Voluntary hospitals due to lack of visibility, influence and management control by the HSE.

Our analysis of Cost Containment measures in place across each Region is presented in Appendix F.

The following two slides describe the effectiveness and impact of the key cost containment measures we reviewed under each of the five categories specified above

Effectiveness of Key Cost Containment Initiatives

Initiative	Cost Reducing Measure	Effective Management Tool	Impact / Consequence	Frequency of benefit
10% reduction in Overtime Costs				
NCHDs being reviewed and revised	YES; if feasible to implement reduced hours	YES; improves operational efficiency	Patient safety is a key consideration. Potential impact on access targets where NCHDs are delivering core service	On-going if feasible to implement
Close monitoring of Hospital Overtime spend	NO; unless action is taken to reduce overtime levels.	YES; improves operational efficiency	Maintains focus on Overtime as a controllable cost	On-going if actions resulting in direct cost savings are implemented
Reduction in levels of Absenteeism				
On-going monitoring and management as per attendance management policy. Specific attention to maternity related sick leave immediately pre maternity leave	NO; unless amendments to maternity leave policy are made	YES	Embeds a culture of good practice and conforming to policy	On-going
Absence Management audits / Back to Work interviews underway	NO	YES	Embeds a culture of good practice and conforming to policy	On-going
Management undergoing continual training on attendance policy	NO	YES	Embeds a culture of good practice and conforming to policy	On-going
Implementing disciplinary procedures where necessary	YES; if necessary to terminate contract of employment	YES	Demonstrates management ability to take action and intervene when necessary	On-going
Reduction in Travel & Subsistence Costs				
Maximise use of teleconferencing	YES	N/A	Positive financial impact – reduction in expense claims. Could be used to improve access to services where appropriately deployed, e.g. video-conferencing with GPs to prevent OPD attendance.	Recurring
Car pooling where appropriate	YES	N/A	Positive financial impact – reduction in expense claims	Recurring

Effectiveness of Key Cost Containment Initiatives

Initiative	Cost Reducing Measure	Effective Management Tool	Impact / Consequence	Frequency of benefit
Activity in line with Service Plan				
Bed closures	YES; If closure is long term, pay and non pay variable costs are saved, but fixed costs remain	Only drives efficiency if the same level of activity is delivered through reduced number of beds	Reduces available capacity and impacts on ability to deliver access targets and increased waiting lists may lead to increased ED attendance / admission	On-going for duration of closure
Implementation of Clinical Care Programmes focussing on admission avoidance strategies	YES; if effectively implemented, monitored and controlled	YES	Potential to reduce costs in the hospital sector whilst transferring costs to primary / community care	Continuous if effective
Reduced length of patient stay	NO; reducing length of stay within a fixed capacity will increase efficiency, but will not reduce cost	YES	Potential increase in ED attendance / re-admission. Patient safety is key consideration	Benefit received on a case by case basis
Seasonal closure of surgical wards	Yes ; but saving is marginal unless staff costs are avoided.	YES; efficiency savings during periods of reduced activity	Consideration to be given to increased demand in alternative hospitals. Surgical Ward closures also have the potential to impact negatively on delivery of access targets	Seasonal
50% Reduction in Agency Costs				
Conversion of Agency Nurses to WTEs	YES; measure strongly recommended in cases not restricted by Croke Park limitations	YES	Reduce cost premium staffing costs to normal levels.	Recurring
Efficiency projects to assess Staff V Productivity	NO	YES	Low level impact in financial terms	None
Implementing authorisation controls for expenditure	YES; potentially as operational efficiency improves resulting in reduced cost	YES	Maintains staff focus on agency spend	Recurring
Elimination of Admin/Mgt/Maintenance Agency	YES	YES	Feasibility of initiative to be assessed. WTE variance of -12.40% in this staff category since Mar 2009	Recurring
Efficiencies in Rostering/Staff Redeployment	YES ; if agency use is avoided as a direct result	YES ; improves operational efficiency	Patient safety is a key consideration. Need to consider staffing ratios and case mix.	On-going if effective
Reduction in use of Locums	YES	YES	Patient safety is a key consideration. Potential impact on access targets where locums are delivering core service, e.g. Letterkenny GI Scopes.	On-going if effective

Deliverability of Current Cost Containment Plans

Assessing deliverability of Cost Containment Plans

The lack of consistency in identifying, monitoring and controlling cost containment measures makes it impossible with the information provided, to confirm whether plans in place will enable the HSE to deliver an outturn financial position in line with the agreed budget position.

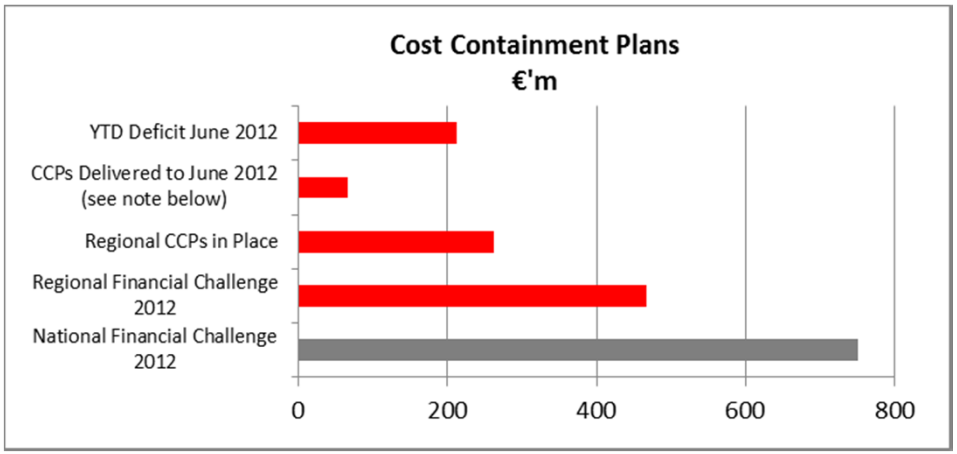
The graph on the right(Figure A) is a snapshot of current financial position of Cost Containment Plans by region, illustrating the deficiencies from our review:

- The HSE service plan identified a financial challenge of €750m whilst Regional Service Plans account for €466m. The balance is being sought from national programmes outwith the scope of this review.
- We were able to identify CCPs in place amounting to €262m, only 56% of the identified financial challenge in the Service Plans.
- In the July 17th return, two of the four Regions reported delivery against CCP achieved of €67m (DML 45% of plan; South 25% of plan)
- A deficit of €213m was reported regionally in June.
- This deficit will be a consequence of non-delivery of cost containment measures and the impact of additional cost pressures. These factors were not conclusively reported as part of the existing performance management and reporting arrangements.
- There was some evidence of additional measures being considered to address the challenging financial position, the most common to seek additional resources for “un-funded” activity.

We were unable to conclusively determine overall deliverability of these plans.

Consequently there is an urgent requirement to undertake a detailed projected outturn exercise across all areas of spend, to produce an accurate forecast of spend to the end of the year, based on a line by line assessment of each budget, assessing each line item in the context of performance v’s plan and likelihood of delivering. As part of this process a reforecast of cash requirements for the last quarter would be produced, enabling firm cash limits to be established, facilitating cost management at a cash level.

Figure A: Summary of Regional Financial Position



Note: CCPs delivered to June 2012 were not reported by Dublin North East or West. Therefore, above graph is exclusive of both these regions.

Key Actions: Cost Containment Plans

Take control	Stabilise	Transform

• As a matter of priority prepare a comprehensive Projected Outturn exercise which will review and challenge in detail spend levels projected until the year end which will:
  • Consider all areas of spend on a line by line basis, and forecast based on actual spend patterns rather than on a straight line basis;
  • Confirm the impact of existing Cost Containment Plans;
  • Identify contracted and committed spend until the end of the year (i.e. that element of cost that cannot be addressed by further cost containment measures);
  • Link spend projections to the application of a cash limit to minimise discretionary spend to the end of the year.
  • Monitor and intervene to take remedial action as required.
• Impose a standard methodology for the management of Cost Containment Plans to be applied across all HSE business operations which is based on a standard template which tracks delivery of plan on a projected outturn basis.
	• Review and revise the Cost Containment Approval process to ensure that impact on quality and access is properly considered;
	• Review the process for budget management and control with a view to simplifying and standardising across all aspects of HSE operations, ensuring effective alignment with demand forecasting, capacity planning and performance reporting;
	• Undertake a capacity planning exercise which will enable the cost of existing capacity to be fully understood and whole system implications to be assessed during service planning process;
	• Undertake a detailed zero based budgeting exercise within the hospital sector in the first instance, and then rolling out across all other care groups thereafter to inform the annual service planning process;
	• Ensure Cost Containment Plans are reflected within the budget at Cost Centre level to enable delivery of plans to be accurately measured and reflected in outturn forecasts.
		• Ensure that any new financial system incorporates functionality to manage budgets and outturn forecasting, including links to non financial performance metrics within its system requirements.

4 Alternative Areas for Cost Reduction

Considering an alternative approach to cost reduction

Tackling the Financial Challenge in 2012

Our earlier analysis has concluded that the HSE's Cost Containment Plans for 2012 focus on **short term** measures which do not consider the whole health system, and may have unforeseen consequences as a result. In particular some measures:

- are non-targeted, and are applied consistently across the HSE regardless of the impact on service delivery (e.g. workforce reductions through grace period early retirement);
- are short term in nature and not structural (agency and overtime reductions); and
- do not take into consideration impact on targets or patient safety, or factor in the costs of demand being diverted elsewhere in the system.

As a consequence there are inherent risks to patient safety, the quality of patient care, and operational and administrative efficiency in the current cost containment approach.

A structural, whole system approach is critical to ensure stability of the system. Such an approach would:

- achieve savings on a national scale rather than an inconsistent approach for each of four regions or 48 hospitals;
- provide a consistent, transparent assessment of the scale of savings across the regions, through to their impact on spend;
- include the non-acute / non-ISD elements of the HSE budget;
- assess the timeline for each CCP from idea to implementation and delivery of cash savings;
- assess any additional actions required to translate the CCP into a cash saving;
- Identify whether there might be any wider implications – which will need to be managed appropriately.

To demonstrate the need for an alternative approach, and to highlight some potential areas for focus, in this section we have:

- carried out an assessment of potential savings which might be sustainable from the current focus on pay costs – notably on headcount reduction, reducing expenditure on Agency staffing and Overtime, and the management of Absenteeism;
- assessed the cost drivers and issues in each of the three main elements of the HSE budget : Pay, Non-Pay, and Income; and
- identified alternative approaches which will help the HSE deliver within the financial constraints which it will face over the coming months and years.

The Pay Costs Challenge – Changes in Headcount

Changes in headcount

- As shown in Figures A and B below, the staff category most adversely affected by a reduction in headcount (as measured in WTE) is Nursing;
- Nursing levels have fallen by some c.3,900 since Q1 2009, including 1,000 in the current financial year.
- The only staff category to have increased in the period from Q1 2009 to date is Medical/Dental, which now accounts for 8,200 of total headcount. Even in this category there have been reductions since the start of 2012;
- Significant reductions have also been experienced across; Management/Admin, Support Staff, and Other Patient & Client Care;
- A reduction in staffing of 1,000 WTE will - if there is no consequential overtime or agency spend - reduce the payroll run rate by an estimated headline rate of €70m pa;
- The extent to which this sum is realised in full – in particular in the case of those leaving due to early retirement – varies significantly depending on circumstances, and this should be reflected in any cost containment assumptions.

Figure A: July WTE by staff category

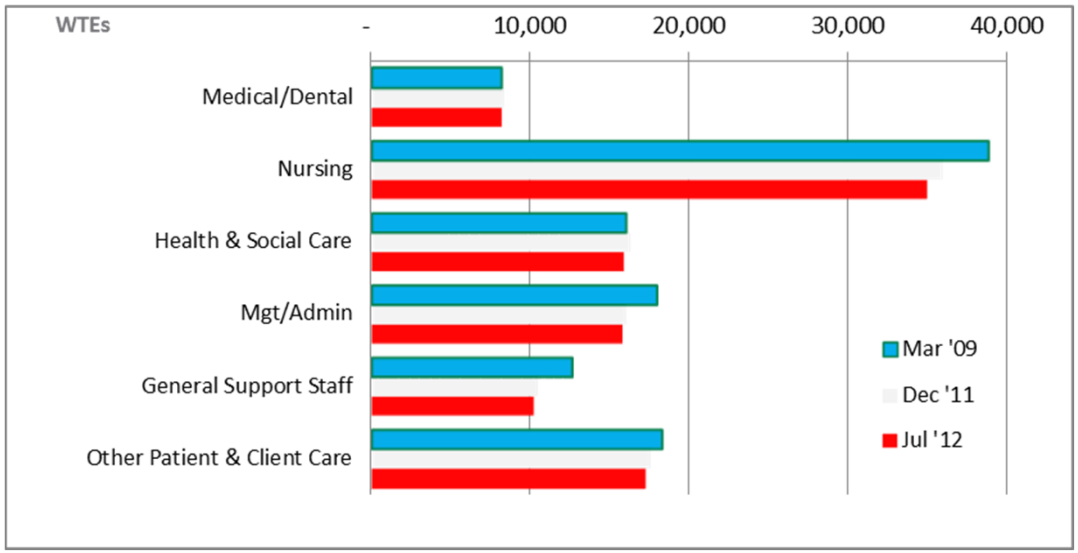
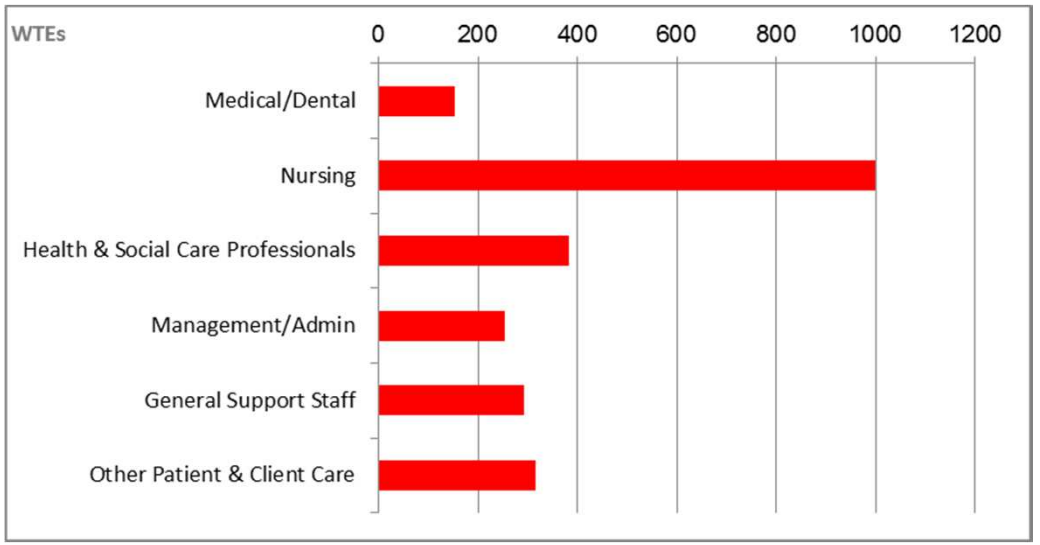


Figure B: Reduction in WTE by staff category, Dec 2011 - July 2012

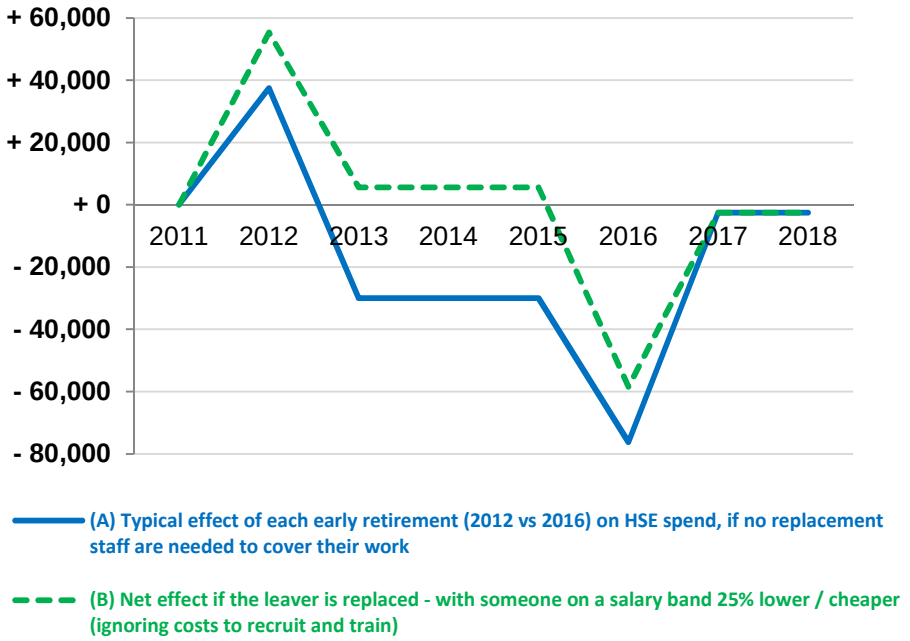


The Pay Costs Challenge – Impact of Early Retirement

Changes in headcount from early retirement

- Any headcount reductions achieved through voluntary severance or early retirement typically do **not** save the HSE any cash in the year of leaving, because the pension costs, pension lump sum, and severance costs are all funded out of the HSE budget;
- Cash savings typically take a year to start to flow through;
- Furthermore, in the case of retirements, the saving realised is less as the leaver draws a lump sum and (unabated) pension - which is met from the HSE budget – therefore the net saving is less than the headline figure;
- Figure A illustrates the impact of one simple example* early retirement: a leaver aged 56, with 28 years' service, earning €50,000 pa, who takes early retirement in mid 2012 instead of mid 2016, and whose role is then not covered;
- The blue line shows the effect of this on HSE expenditure. Spending is **higher** in 2012, due to the lump sum element of the pension;
- The dashed green line shows perhaps a more typical outcome, where a replacement has to be recruited, at a cost 25% lower – i.e. it is resource-neutral - ignoring any differences between the individuals, and ignoring all recruitment and training costs. **Spending is higher in 2012, and is also higher in 2013-15**, because the HSE is paying for both the new recruit and the retiree. From 2017 onwards, there is a small saving, this is simply due to the leaver drawing a smaller pension - 28/80ths of salary instead of 32/80ths - and would be reversed when the replacement reaches retirement.

Figure A: Timing of savings from early retirement (mid 2012)



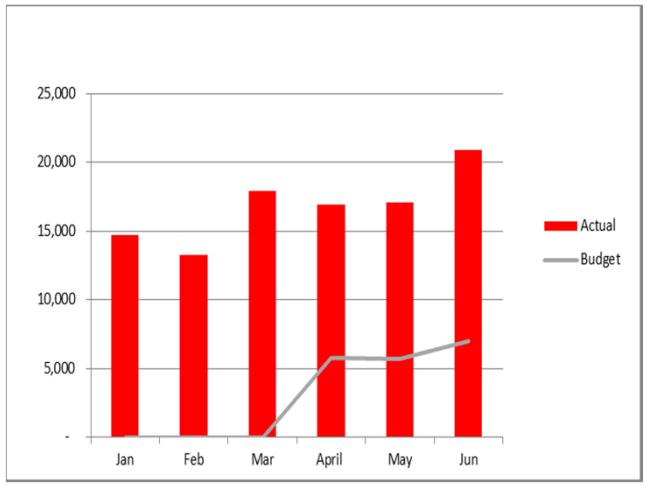
**The other main approximations and assumptions used were: normal retirement age = 60, accruing 1/80 of final salary for each year of service, take 3/80 of final salary as a lump sum, wage rates and pensions keep pace with inflation. Costs are calculated in 2012 money terms.*

The Pay Costs Challenge – Agency Costs

Understanding the Agency Cost Drivers within Health

- Agency staff costs currently stand at €128m pa or 3% of total pay (YTD). At 3% it appears plausible that cost containment measures in this regard are being managed quite effectively, and that large further savings in this area may be difficult to sustain;
- Figure A below indicates the significant variance in total agency spend per month against budget. As the control of agency costs has been prioritised within the Health sector, regions have been allocated a cost containment target of a 50% reduction in agency costs;
- The West region in particular have demonstrated their implementation of robust management controls in this area. Their efforts have been positively reflected in their figures for agency costs, as shown in Figure B below;
- Figure C confirms that the bulk of these costs arise amongst front line services - nurses, support services, and medical staff;
- Further reduction in agency spend needs to be considered with reference to patient safety. In many cases the best which can be achieved is a substitution from agency cost to employee cost – i.e. the agency premium is saved, but the basic costs (plus e.g. pensions) are still incurred.

Figure A: Agency Spend v Budget 2012, €000s

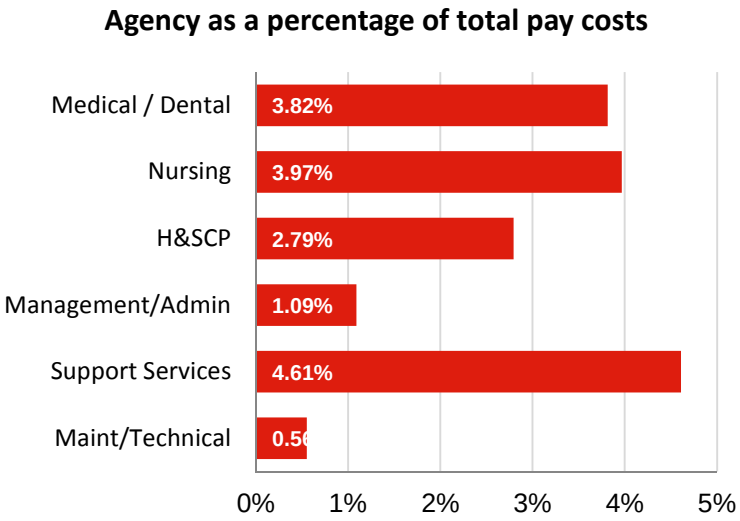


Source: HSE Performance Reports 2012

Figure B: Regional Agency Cost as % of Total Pay

Region	Agency Costs as a % of Total Pay July 2012
Dublin Mid -Leinster	4.10%
Dublin North East	4.65%
South	2.69%
West	1.18%

Figure C: Agency Cost as % of Total Pay – by skill group



The Pay Costs Challenge – Overtime

Understanding the Overtime Cost Drivers within Health

- Overtime costs currently stand at €155m pa (YTD at July);
- Medical/Dental headcount and Overtime costs are noteworthy. Staff numbers have reduced in 2012, but there has been a compensating increase in overtime costs, indicating a need to address staff cover requirements through overtime. Medical/Dental has the highest proportion of Overtime, at 14.5% of total pay;
- Despite nursing levels being severely impacted by headcount reduction, Overtime costs for this staff category stands at 2% of the total July 2012 paybill. This indicates that regional cost containment measures in place are being monitored and delivered effectively;
- Again, as a result of the emphasis placed on containing HR costs in the West, significantly lower overtime expenditure is incurred in this region in comparison to the other regions. This is demonstrated in figure B below;
- If this year's cost containment objective of achieving a 10% reduction in overtime were attained, potential savings of €15m would be realised. This is significantly less than the €23m target.

Figure A: Overtime Costs as % of Total Pay July 2012

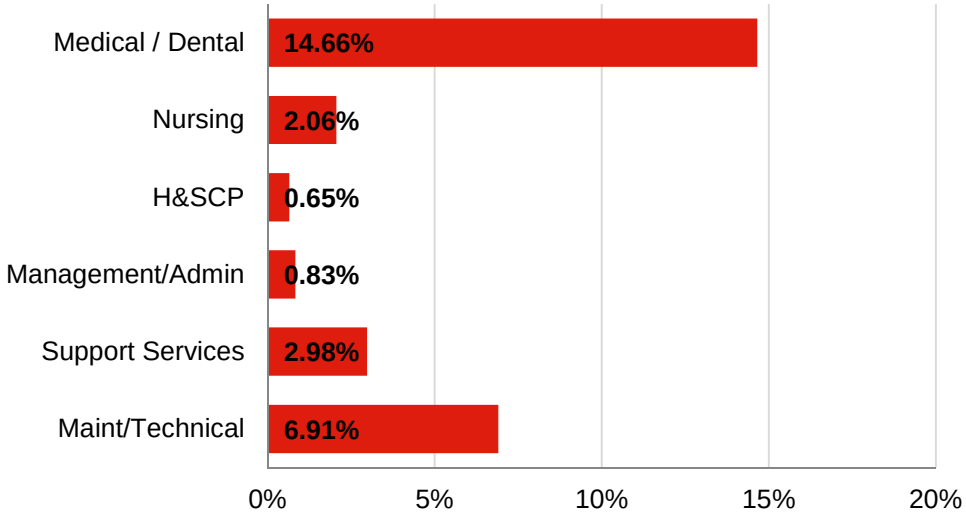


Figure B: Regional Overtime Cost as % of Total Pay

Region	Overtime Costs as a % of Total Pay July 2012
Dublin Mid -Leinster	4.10%
Dublin North East	4.41%
South	3.64%
West	2.78%

The Pay Costs Challenge – Absences

Understanding the Absenteeism Cost Drivers within Health

- Figure A below shows that absence rates at May 2012 (the latest available at the time of writing) at about 4.8% overall, varying between skill groups – 1-2% for medical staff and 5-6% for most other skill groups;
- If costed at the average rate of pay, the price tag for this amounts to some €300m - €350m pa;
- HSE aspires to reduce absence rates from 4.8% to 3.5%. Recent trend (in figure B) is downwards, generally in line with normal seasonal patterns;
- If achieved and sustained, and assuming that the corresponding pro-rata reductions could be made to headcount and/or agency/overtime, this would save some €100m pa. The proportion of this sum which is cashable is likely to be less than this figure, as in many instances, cover for leave is not provided for;
- The HSE current absenteeism rate is 4.8%. The target rate of 3.5% should be considered in the context of actual rates for Wales and England being 5.5% and 4.2% respectively;
- Levels of sickness in management and admin in particular should be particular areas for focus.

Figure A: Absenteeism rates by skill group by Hospital / LHO

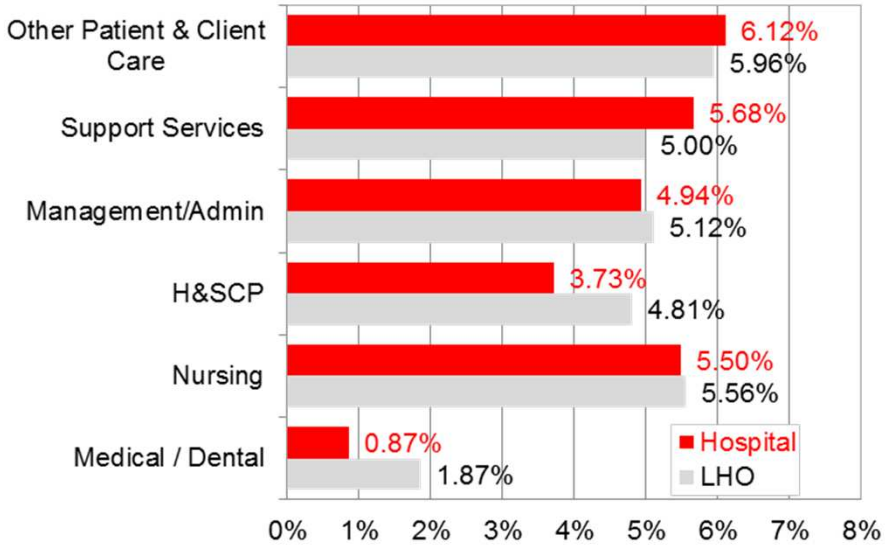
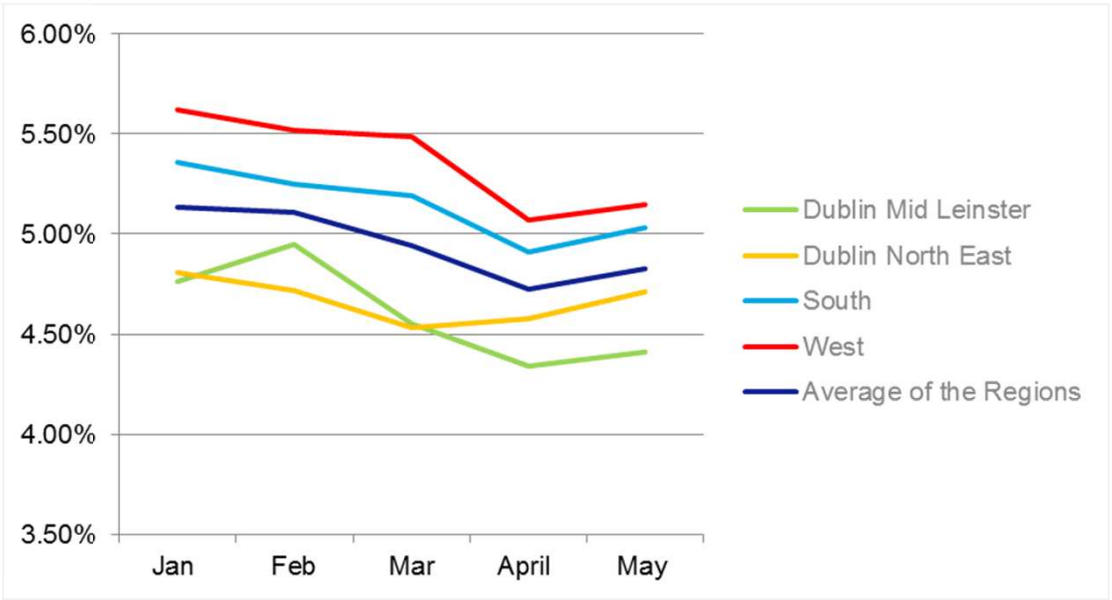


Figure B Absenteeism rates by month by Region



The Pay Costs Challenge – Summary

Headcount

- Nursing levels have fallen by c.3,900 since Q1 2009, including 1,000 in the current financial year.
- Significant reductions have also been experienced across all other categories;
- Caution is required in converting a reduction in WTEs into a cash saving – there is a risk of additional costs being incurred in agency or overtime to ensure adequate frontline cover. In the case of early retirement schemes, any cash saving is deferred by oneyear, and may prove difficult to deliver in the longer term.

Agency

- Agency staff costs currently stand at €128m YTD or 3% of pay, the majority providing cover for nurses, support services, and medical staff;
- Regions have a cost containment target to reduce agency costs by 50%, and the West region in particular have demonstrated their implementation of robust management controls in this area;
- Further reduction in agency spend should be considered with reference to patient safety. In many cases the best which can be achieved is a substitution from agency to employee cost – i.e. the agency premium is saved, but the basic costs are still incurred.

Overtime

- Overtime costs currently stand at €155m YTD and are (relatively) highest for Medical/Dental. For nursing it is 2% of the pay cost;
- The emphasis placed on containing HR costs in the West has resulted in significantly lower overtime expenditure – a potential saving of up to €20m pa if there is no corresponding uplift in headcount or WTEs, or perhaps more realistically/conservatively €5-7m pa if the workload is still covered but paid at basic rate.

Absence

- There are possible benefits of 1% of pay costs (€70m pa), but there are challenges in achieving and sustaining this. Savings are only realised if they flow through into reductions in headcount/WTEs and/or agency or overtime. The downstream reductions in WTEs / agency / overtime are a pre-requisite for reductions in absence to yield a cash saving – they are not an additional saving.

Conclusion : These approaches could deliver annual savings in the tens of millions – but there are risks regarding their sustainability and (most notably for reducing headcount via early retirement) the timing and scale of their impact on the rate of HSE expenditure

Understanding Cost Drivers within the Health System : Pay Costs

Pay Costs - Trends

- The long term trend in demand is upwards. Life expectancy is increasing by 2 years per decade; of these two years, one is typically in poor health. The combined effect translates into increases in demand of the order of 2% per annum;
- This increase in demand will make it difficult to reduce staffing numbers, and therefore pay costs significantly without system wide reform.
- Pensions costs are set to take a larger share of the HSE budget. The current round of early retirements has significantly increased the number of pensioners supported by the HSE. As the pensioner base continues to grow, in the context of increased life expectancy, the ratio of payroll costs to pension costs will continue to grow in the coming years.
- There is possible upwards pressure on pay, as and when the economy moves out of recession in 2014+.

Pay Costs Drivers – and how can they be managed effectively ?

- Nursing is the largest staff category. There is scope to change the staffing model, increasing the ratios of qualified staff to Health Care Assistants;
- Medical and dental is the second largest staff category . It is recognised that base salary costs are high relative to EU norms; addressing these will require the renegotiation of current terms and conditions of contract.
- Back office and admin costs whilst only a small proportion of the paybill offer the potential to deliver significant savings through improved delivery arrangements, shared services and outsourcing e.g. centralise and automate the Accounts Payable and Payroll functions;
- Retirement costs are set to grow – the main option for containing these is to make the scheme less generous – retire later, or with less pension. Another consideration would be to increase contribution levels.

Understanding Cost Drivers within the Health System : Non-Pay

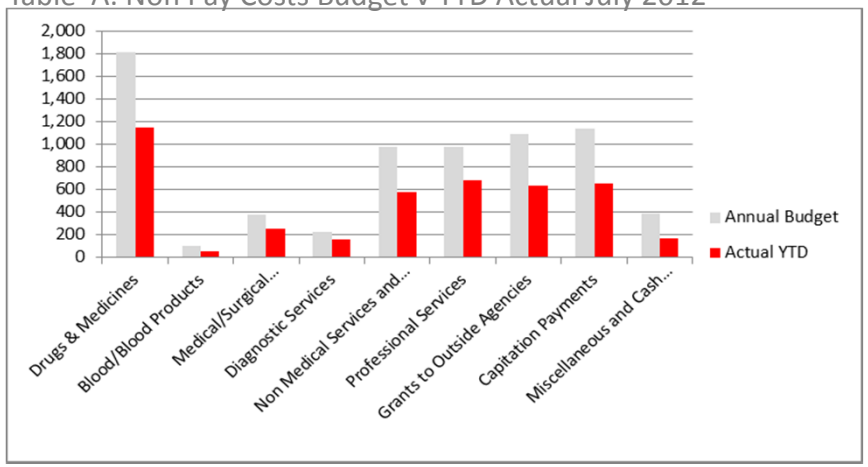
Non Pay Costs - Trends

- Trends indicate an increasing number of patients with chronic conditions, with a long term reliance on drugs;
- Unit prices for drugs are high relative to other EU states - in particular for off-patent items;
- Prescribing practice skews towards branded rather than generic with corresponding cost implications;
- Increasing medical card volumes drive a corresponding increase in fees and drugs costs;
- Significant levels of spot purchasing is prevalent, from over 60,000 registered suppliers.

Nature of Non Pay Costs

- Approximately 50% of non-pay costs are costs of services, and 40% are drugs and other clinical supplies;
- Drugs expenditure amounts to €2bn per annum – at a high unit cost relative to EU norms and subject to national price negotiations;
- Medical Supplies and diagnostics spend amounts to €0.7bn and Non-medical Services and utilities costs €1bn a year
- Improved procurement practices offer the potential to drive further savings in this area.

Table A: Non Pay Costs Budget v YTD Actual July 2012



Non Pay Costs – Drivers and how can they be managed effectively ?

- A key driver of costs through the PCRS scheme is medical card eligibility. Efforts to alter eligibility criteria have a corresponding impact on all aspects of the scheme;
- The GP contract is another key driver of costs through PCRS, and a potential inhibitor of reducing costs through transferring responsibility for care into the community. There is real scope to reduce costs through renegotiation of the GP contract;
- Drug pricing is subject to national negotiations. These talks have proved challenging in recent months but must continue with the aim of reducing pricing in line with other EU states. This will enable significant opportunity to reduce costs in this area;
- National Framework contracts for generics which include an option to source outwith Ireland, have the potential to reduce costs and simplify sourcing and logistics;
- A national approach / guidelines for prescribing and acceptable pricing levels – informed by evidence from outside the Republic e.g. WHO and UK (NICE) will support cost management in drugs expenditure;
- Investment in improved procurement and sourcing will extend the successes already achieved by Procurement in renegotiating contracts and in introducing improved inventory management arrangements at the point of delivery. This will drive more value from the supply chain and improving working capital by reducing stock levels;
- National contracts for medical supplies, professional services, and non medical supplies and utilities will improve pricing through volume discounts, and reduce administration at a local level.

Understanding Cost Drivers within the Health System : Income

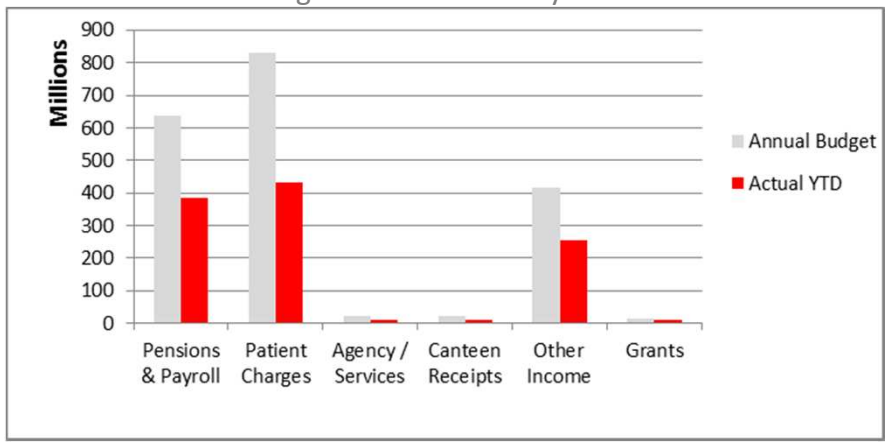
Income – Trends

- The two main income streams relate to pension contributions and other payroll recoveries and income from patient charges;
- The recession has had an impact on the volume of PHI cases, but high levels of ED admissions and the failure to legislate in respect of bed re-designation further contributes to a falling level of recovery;
- There is some upward pressure from new / innovative procedures and therapies.

Income – influencing factors

- Constraints in system;
  - high charges will increase the costs of Private Health Insurance, which in turn will drive up premiums, with a potential impact on the extent of private coverage, and increase demand in the state funded system.
  - Any increase in private charges needs to balance the potential impact on premiums, to ensure that additional revenue is secured.
- Poor systems and procedures;
- Bed re-designation;
- Impact of increasing activity levels and bed closures;
- Inability to recover full cost of procedures as prices are set with limited reference to cost.

Table A: Income Budget v YTD Actual July 2012



Income – How can it be managed more effectively

- Charging for private care is devolved to a hospital level. Prices are set by the Minister. Reviewing current pricing to ensure that all costs are being recovered will ensure that recoveries are optimised.
- Require private patients or their insurers to guarantee payment of charges incurred in advance of any non-emergency care provision (standard practice in much of the private sector e.g. hotels, airlines, car hire). This will create a significant one-off benefit to cash flow, plus smaller on-going savings from bad debt provisions and its management;
- Consider charging for some services that are currently free, and/or reduce access to free care via medical cards;
- Assess the level of health tourism / elective use of HSE by e.g. EU/other nationals - and if necessary take steps to manage down its costs;
- Carry out a review of fees and charges for other aspects of income generation across all four regions and introduce a national policy which optimises income generation potential;
- Manage recovery and debt collection as a shared service to ensure a consistent approach to debt management and reduce the cost of administration significantly;
- Finance Shared Services has acquired a system to manage patient charges, which enables electronic transfer to the key insurers. This application has been used successfully in St James. Plans to roll out its use to all statutory hospitals are underway, and it is anticipated that this should take 2 years. Approach to deployment should be reconsidered with a view to fast-tracking implementation.

Alternative measures to drive out costs

Short Term Solutions

There are a small number of alternative measures that could be used to target cost reduction or cash savings more strategically in the short term.

- The introduction of demand management through the introduction of Planned Procedures with Thresholds (PPWTs) in 8 key areas could result in reductions in scheduled care waiting times and also reduced spend to clear those waiting lists. This is explored further in the next slide;
- The current practice of invoicing 100% in arrears for private care increases the amount of money which the HSE is obliged to tie up in working capital, and creates additional costs in the form of bad debts (some €15m expected to be written off in 2012) and in the clerical costs of debtor management. A move to some form of payment pre-authorisation, or initial settlement with health insurers, could reduce the recurring and growing cost of bad debt, as well as provide a one-of cash saving from bringing forward 1-3 months' worth of income into the current calendar year;
- The historic system-wide staff WTE reduction and vacancy freeze has the unintended consequence of increasing overtime and agency/locum staff use in a number of hospitals. A partial relaxation of the moratorium where overtime, locum and agency use is the norm to deliver safe services could result in cost saving;
- Identify named members of hospital/LHO management who have overall accountability for the delivery of non pay cost reductions in hospitals / LHOs through improved procurement, supplies management and more effective use of supplies. This will improve the focus on non pay expenditure and help support the identification of procurement opportunities;

Towards financial stability in the medium term

In the medium term financial stability could be improved through a focus on strategic cost reduction initiatives which focus on resource utilisation, staff efficiency and effectiveness and demand management.

- The identification of hospital consultant, NCHD and nursing staffing levels should be determined in relation to hospital specialism and demand and not based upon historic staffing levels where there is no job planning to balance the need for medical staff to deliver clinical services, teach and research;
- Hospital management must be more proactive in the management of consultant medical staff leave, theatre allocation and utilisation and approvals of locum and agency use to ensure that maximum use is made of existing hospital capacity to meet demand within cash limits;
- Hospital management must set cash limits for sick leave/agency use and overtime which cannot be exceeded without formal review and approval from the hospitals Chief Executive or Director of Operations;
- There is some anecdotal evidence to suggest that premium rate payments which exceed PSA agreement (Croke Park) are paid locally. These matters, including the basis for calculating holiday pay (notional overtime) should be subject to renegotiation.
- The extension of PPWT to additional procedures could not only reduce demand for scheduled care but also reduce spend particularly where money follows the patients;
- The implementation of consultant level service line financial reporting benchmarking could deliver significant improvements in efficiency and cost when money follows the patient;
- The introduction of consultant job planning will not only improve efficiency and effectiveness but deliver significant cost reduction in consultant spend;
- The introduction of demand management processes within PCRS could significantly reduce overall drugs expenditure.

Demand management: Planned Procedures with thresholds (PPWTs)

The implementation of a process to manage demand for a number of planned procedures could have a significant impact on the costs of delivering elective treatment.

The implementation of PPWTs underpinned by approved clinical guidelines would also have a significant impact on the scheduled care waiting times.

The short term financial saving from the implementation of PPWTs would be a reduction in the current scheduled care waiting list, and a consequent reduction in the need for NTPF funding to clear those waiting lists.

The medium term financial gain would accrue from restricting service demand where money follows the patient – thereby reducing the total cost of treatment for a range of agreed PPWT procedures.

The table below highlights the total number of patients on the current waiting list, and those who have been on the list for more than six months for common PPWT procedures.

Table A: PPWT waiting lists

Example PPWT Procedure	Total Procedures on Current Waiting List	Procedures > 6 months
Adenoids	119	9
Tonsillectomy	1660	323
Myringotomy	357	27
Breast Reductions	88	36
Circumcisions	347	122
V Veins	1040	352
Dental extractions	1198	421
Exc of skin lesions	3698	557
Cataracts	4333	1343

The table below provides an analysis of the potential total cost saving that could accrue to the procedures highlighted. The analysis is based upon the following assumptions:

- Cost is estimated as NTPF case mix cost for each procedure;
- The inpatient /day case ratio is 25/75;
- Only 50% of the Current Waiting List meet the PPWT criteria;
- An additional sensitivity analysis is provided, showing what the savings would be if 30% of the waiting list meet the PPWT criteria.

Table B: Savings in annual run rate from introducing PPWTs for common procedures

Procedure	Removing 50% OR 30% of total current activity		
	Total inpatient cost (50% of patients breach PPWT)	Total day case cost (50% of patients breach PPWT)	Total (Day Case & Inpatient) €
Adenoids	43,063	75,416	118,479
Tonsillectomy	600,713	1,052,025	1,652,738
Myringotomy	120,354	144,585	264,939
Breast Reductions	45,749	0	45,749
Circumcisions	95,989	157842	253,831
V Veins	462,280	841620	1,303,900
Dental extractions	353,859	252928	606,787
Exc of skin lesions	1,001,696	431,279	1,432,975
Cataracts	2,046,801	1,996,971	4,043,772
TOTAL	**4,770,503**	**4,952,666**	**9,723,169**
If the assumption is changed that only 30% of the total waiting meet the PPWT criteria list breach PPWT			**5,833,902**

Demand management: Planned Procedures with thresholds (PPWTs)

The implementation of a PPWT Scheme within the Irish Health system will require a number of actions. In the first instance:

- Identify those procedures which would be best suited to PPWT threshold analysis;
- Identify the clinical protocols/thresholds that should be used to set the PPWT threshold – via the Clinical Programmes
- Make use of existing NTPF/Hospital resource to validate waiting list for those procedures selected against the waiting list;
- Remove those patients who do not meet PPWT thresholds from the waiting list.

Then in the medium term:

- Extend the application of thresholds to a further group of procedures
- Identify protocols to support clinical decision making;
- Establish review process to ensure that only appropriate cases are added to the waiting list.

Structural Reconfiguration and Transformation

Over the longer term, the implementation of Future Care and the resultant reconfiguration of the Health System has the greatest potential to drive costs out of the system.

An exercise to model the cost of current capacity in the system, and to develop scenarios of demand and how that can be managed across the whole system to optimise cost is an essential activity to shape strategy and long term decision making.

This exercise will also enable sustainable cost reduction targets to be established over the longer term whilst properly recognising the cost of care on a system wide basis.

A renewed focus on ensuring that the back office is as effective as it can be is essential to:

- Maximise resources being spent on the frontline; and
- Ensure a focus on core activity, and to use others where it is more cost effective to do so.

Existing efforts to improve financial management, deliver activity based costing, implement new systems and develop shared services are not progressing as quickly as they need to and renewed focus supported by dedicated resources is required. The payback potential is significant, and a failure to act now will place any financial recovery plan at risk.

5 Conclusions

Conclusions

The HSE is facing a crisis in its Financial Management which will only be addressed through targeted efforts to improve financial management practice and to drive out costs.

The financial management challenge is far reaching and severe

The financial issues being faced by the HSE are significant and require an immediate response to re-establish an effective financial management and control environment, demonstrate control of spending and to re-establish credibility in its financial and operational management practices across government.

Failings in financial management, most notably budget management and control require immediate intervention and investment;

- At HSE Finance level **to support the National Director of Finance** in addressing the immediate concerns highlighted and to deliver the step change in service required to support the changing nature of Health in Ireland, **recognising in particular that existing Finance staff are under-resourced and under stress in their efforts to manage business as usual.**
- At hospital level, where the scale of the financial deficit and other aspects of operational performance indicate that **focused operational and financial management support is necessary to safeguard service delivery.**
- Within the Department itself to provide **additional capability and capacity** to support the transition to the new operating model required under Future Care and the transfer of responsibility for the HSE Vote.

Our review focused on one aspect of the HSE budget, the hospital sector but a similar level of scrutiny must be given other care groups to ensure full disclosure of the financial challenge for the coming year.

Immediate first steps : to take control

- Undertake Projected Outturn and Cash forecast across the Health Sector;
- Develop a Revised Budget Process for 2013 based on activity based budgeting principles; and
- Commence targeted intervention in poorly performing hospitals to improve performance to inform the development of a new governance and intervention model.

By the Year End: to stabilise

- Develop a revised Financial Controls and Governance framework;
- Introduce standardised budgetary control processes and financial reporting based on dashboards;
- Introduce improved performance management arrangements;
- Undertake a portfolio review on systems and improvement projects including Shared Services and Procurement; and
- Undertake a skills and capabilities analysis of existing Finance staff supporting the health sector.

Existing Finance capacity and capability is limited, and investment in the development of that capability over the medium term is essential; not only to ensure that financial management activity to support current operations across the health sector improves, but to ensure that the transition to new structures and ways of working in both the HSE and the Department can be appropriately supported and managed effectively.

Conclusions

The development of excellence in Financial Management: Transform

The combined challenge of delivering far reaching and ambitious reform with fewer resources at a time of increasing demand places an increasing emphasis on the need for excellence in financial management.

Improving financial management practice, developing skills and capability and addressing the significant challenges arising from structural cost reduction in a time of significant change will require an investment both in terms of professional expertise and in systems and process to support delivery.

Addressing these challenges in an effective and sustainable way will require intervention over the medium term to;

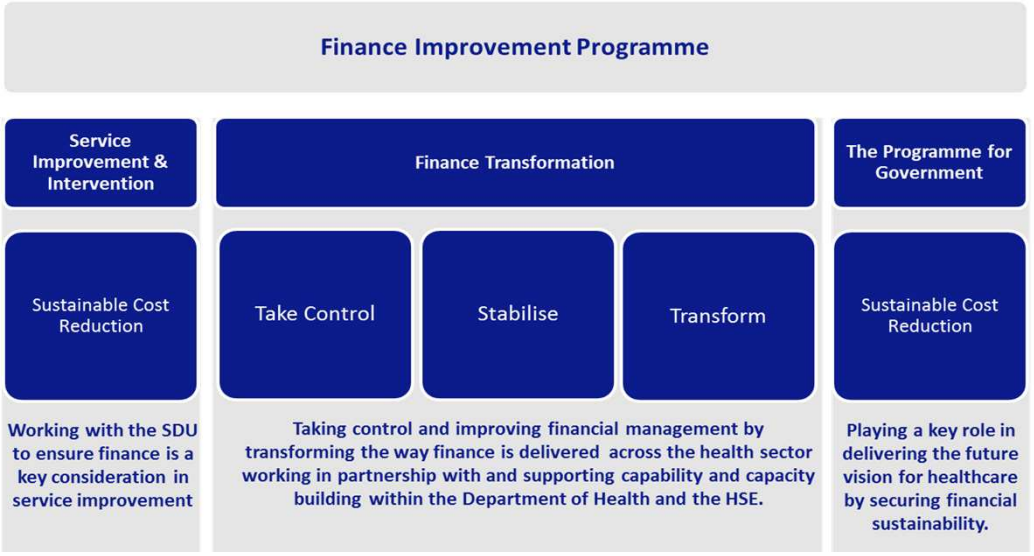
- demonstrate that the department has re-established control over spending;
- take action to stabilise the system through structural reform; and
- transforming financial management across the sector to support the vision of Future Health.

Tackling this is essential to re-establish credibility in financial management capability and to provide additional capacity to support existing finance professionals and improved capability and expertise across a broad spectrum of finance competency, including, but not restricted to:

- Operational and financial performance improvement and intervention
- Sustainable cost reduction
- Financial strategy governance and control
- Financial reporting and accounting
- Management accounting, budgeting and costing
- Finance function transformation
- Financial systems improvement
- Procurement and strategic sourcing
- Commissioning and demand management.

A programme management approach is essential to drive change

- Delivering sustainable cost reduction through service improvement and system wide change requires a systematic approach to fundamentally challenge the way services (both back office and frontline) are delivered.
- The establishment of a **Finance Improvement Programme (FIP)** will put the necessary infrastructure in place to support successful project delivery, the management of risks, issues and interdependencies and the tracking of financial and non financial benefits realisation.
- By investing in resources, both internal and external, the programme will provide additional capacity and build capability in Financial Management at all levels.
- FIP will improve financial management across the health sector by delivering projects to take control, stabilise and transform financial management practice.
- The programme will deliver sustainable cost reduction by playing a key role in operational service improvement and cross cutting Health Reform. The components of the programme are illustrated below.



Conclusions

FIP: Key roles and responsibilities

The potential roles and responsibilities of the key elements of the Finance Improvement Programme are outlined below. Each will have a key part to play in driving the required improvements in Financial Management skills, capabilities and ways of working.

The Finance Improvement Board: Senior Executive level steering group comprising Sec Gen DPER; Sec Gen DH; Deputy CE HSE ,Asst Sec Gen Finance and HSE CFO

Programme Director

Accountable to the Finance Improvement Board for the delivery of the programme and providing strategic advice and support to the Department and HSE on financial management issues. Leading the improvement programme and building credibility through effective stakeholder engagement across government.

Design Authority

Experts from across the health sector supported by external subject specialists, the design authority will develop financial management strategy and future direction and to provide insight and challenge in driving the improvement programme. Representatives from all service areas to ensure improvement plans are fit for purpose and deliverable.

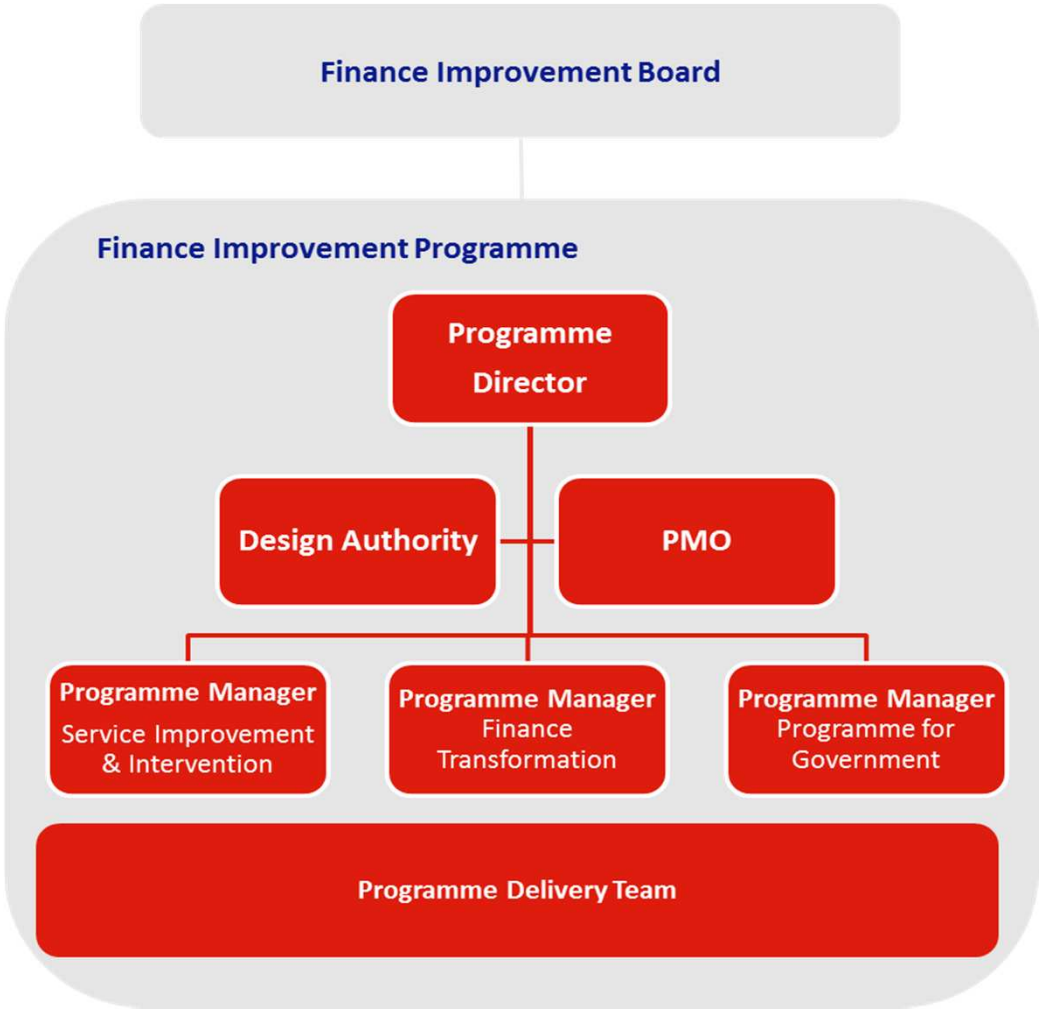
Programme Management Office (PMO) Supporting programme governance, reporting of progress against plan, risks and issues, managing dependencies and tracking delivery of benefits (including cash savings). Will be aligned to wider PMO supporting Programme for Government change programme.

Programme Managers

Accountable to the programme director for the management and delivery of projects within their work stream. Service Improvement and Intervention and Programme for Government work streams will also report into wider programmes and will ensure alignment with Finance Improvement objectives within these programmes.

Programme Delivery Team

Project based delivery teams, with health sector leads, resourced through a combination of internal, external and joint teams. Capability and capacity will be key criteria for project team resourcing and backfilling of substantive roles considered as part of the cost of implementation.



6 Recommended Actions

Action Plan: Immediate

Any short term actions to improve financial management performance must take account of levels of hospital demand - both scheduled and unscheduled care - staffing ratios and clinical outcome measures to ensure that they do not compromise the delivery of clinically safe and sustainable services. Immediate actions must have an initial focus on gaining a consistent view of financial performance and issues of cost control and income maximisation

	Sept 12	Oct 12	Nov 12	Dec 12
Take Control				
Governance & Control • Develop the model of intervention for all hospitals which will facilitate operational and financial improvement within hospitals which are failing • Provide clarity in the short term regarding roles, responsibilities and delegated authorities within existing organisation structures both at HSE and at a hospital level. • Ensure nationally managed programmes (SDU) are aligned with operational responsibility at a regional and local level • Ensure delegated decision making at a regional and local level is consistently applied, and reflects need to introduce spending controls in the short term • Ensure systems and processes are in place to measure effectiveness of delegated responsibility and accountability				
Financial Management • Produce a detailed system wide projected outturn, to include a reforecasting of cash requirements for the last quarter of the year. • Roll out template reports to monitor spend to date, produce outturns and track delivery of Cost Containment Plans consistently. • Create dashboard for senior management at all levels on delivery against key metrics: • Develop an approach to the 2013 service planning process which ensures that a whole systems view is taken to support policy development and operational and financial management decision making • Implement savings plan sign off process covering RDO and hospital level.				

Action Plan: Immediate

	Sept 12	Oct 12	Nov 12	Dec 12
Take Control				
Budgeting, Service Planning and Performance Reporting • Undertake a zero based budget exercise at hospital level to enable link between service planning financial planning to be established. • Improve the method of budget allocation nationally to better align with service outcomes and cost to deliver these outcomes. • Develop more robust performance reporting from HSE to Department distinct from performance report which is externally focused.				
Fit for Purpose Systems • Prepare a status report on all planned system improvements, investments and replacements across the Health sector.				
Skills and Capabilities • Identify accounting staff across the system, nationally, regionally and within each hospital • Determine the ratio of qualified to unqualified staff • document job roles, responsibilities etc. currently undertaken and issues and challenged with existing staffing complement in place. • Undertake skills and capability analysis of existing staffing				
Cost Containment Plans • As a matter of priority prepare a comprehensive Projected Outturn exercise • Impose a standard methodology for the management of Cost Containment Plans to be applied across all HSE business operations which is based on a standard template which tracks delivery of plan on a projected outturn basis				

Action Plan: Medium term

Actions to be undertaken in the next 12 months to introduce structural improvements to stabilise the health system. Financial stability will be improved through the implementation of consistent systems and controls and direct intervention where hospitals are found to be failing or at risk of failing, and a consistent approach to performance management and monitoring. Unless specifically referring to hospital sector, these actions should be implemented on a whole system basis.

Key Actions	Qtr4 2012	Qtr. 1 2013	Qtr. 2 2013	Qtr. 3 2013
Stabilise				
Governance & Control • Design a new system of governance for Voluntary providers using Monitor's regime for Foundation Trusts in England as an exemplar • Review current governance and controls framework and assess its effectiveness nationally, regionally and locally • Design a new governance and control environment for new organisation including appropriate incentives to drive cost conscious culture				
Financial Management • Review progress being made activity based costing initiatives underway, agree on standard process to adopt across all hospitals • Implement consistently across all hospitals in the first instance • Develop an approach to Service Line Management and test its key operating principles within a hospital group.				
Fit for Purpose Systems • Based on the status report, develop a Fit for Purpose Systems strategy and roadmap which will rationalise existing plans and develop a systems landscape for the future which will support a new operating model and the requirements of Future Care.				

Action Plan: Medium term

Key Actions	Qtr4 2012	Qtr. 1 2013	Qtr. 2 2013	Qtr. 3 2013
Stabilise				
Budgeting, Service Planning and Performance Reporting • Undertake a zero based budget exercise in all other HSE care groups • Identify systems to support budget management and forecasting at an activity and service line level • Define new and consistent performance management arrangements across all aspects of the health system • Improve operational performance reporting aligned to principles of Service Line Management.				
Skills and Capabilities • Design future job roles and person specifications as part of new operating model design • Define skills and capability requirements • Identify skills gaps and capability development needs				
Cost Containment Plans • Impose a standard methodology for the management of Cost Containment Plans to be applied across all HSE business operations • Review and revise the Cost Containment Approval process to ensure that impact on quality and access is properly considered. • Review the process for budget management and control with a view to simplifying and standardising across all aspects of HSE operations, • Undertake a capacity planning exercise which will enable the cost of existing capacity to be fully understood and whole system implications to be assessed during service planning process. • Undertake a detailed zero based budgeting exercise within the hospital sector in the first instance, and then rolling out across all other care groups thereafter to inform the annual service planning process. • Ensure Cost Containment Plans are reflected within the budget at Cost Centre level to enable delivery of plans to be accurately measured and reflected in outturn forecasts				

Action Plan: long term

Actions to be undertaken as part of a long term change programme to transform financial management within Health in Ireland

Key Actions	2012	2013	2014	2015	2016
Transform					
Future Care					
Develop a new Operating Model for Finance • Agree the priorities and principles • Design the high level operating model • Design the detailed organisation • Transition into the new organisation • Stabilise the business					
Governance & Control • Embed new environment within new operating model					
Financial Management • Design new financial management processes aligned to new operating model • Implement Service Line Management across the health sector on a phased basis across care groups, with acute sector in phase 1.					
Budgeting, Service Planning & Performance reporting • Implement systems to support budget management and forecasting at an activity and service line level • Implement new performance management arrangements					

Action Plan: long term

Actions to be undertaken as part of a long term change programme to transform financial management within Health in Ireland

Key Actions	2012	2013	2014	2015	2016
Fit for Purpose Systems • Implement Fit for Purpose Systems strategy in line with agreed roadmap.					
Skills & Capabilities • Appoint staff to new roles • Develop a Financial management community of practice to develop leading practice • Introduce a Financial management development programme: • Continuing professional development					
Cost Containment Plans • Ensure that any new financial system incorporates functionality to manage budgets and outturn forecasting, including links to non financial performance metrics within its system requirements					

A Stakeholder Engagement

Stakeholder Engagement

We are grateful to the following key individuals from the Department of Health and the Health Service Executive, who co-operated fully, and were most supportive in providing background information, insight and analysis to aid our understanding and inform the findings of this review.

Name	Role	Organisation
Damien Casey	Head of Shared Services	Health Service Executive
Kevin Cleary	Head of Business Unit, DML	Health Service Executive
Maureen Cronin	Assistant National Director of Finance	Health Service Executive
Kieren Doherty	Area Manager PCCC (West)	Health Service Executive
Mark Fagan	Assistant National Director of Finance (DNE)	Health Service Executive
Brian Fitzgerald	Director of Finance, St James' Hospital, Dublin	Health Service Executive
Donal Foran	General Manager V&T	Health Service Executive
Gerry Greville	Project Manager, Sustainability Project - DNE	Health Service Executive
Pat Healy	Regional Director of Operations (South)	Health Service Executive
John Hennessey	Regional Director of Operations (West)	Health Service Executive
Howard Kelly	Financial Analyst, Corporate Budgeting	Health Service Executive
Brian Long	Procurement	Health Service Executive
Declan Lyons	Assistant National Director of Finance (DML)	Health Service Executive
Colum Maddox	General Manager, Corporate Reporting	Health Service Executive
Paddy McDonald	Assistant National Director of Finance (Vote & Treasury)	Health Service Executive
Laverne McGuinness	National Director of ISD	Health Service Executive
Dr Ambrose McLoughlin	Secretary General	Department of Health
Liam Minihan	Assistant National Director of Finance (West)	Health Service Executive

Stakeholder Engagement

Name	Role	Organisation
Stephen Mulvany	Regional Director of Operations (DNE)	Health Service Executive
Sean Murphy	Chief Executive, Letterkenny Hospital	Health Service Executive
Bairbre Nic Aongusa	Assistant Secretary (Finance)	Department of Health
Tony O'Brien	Deputy Chief Executive and Acting Director General	Health Service Executive
Gerry O'Dwyer	Regional Director of Operations (DML)	Health Service Executive
Frank O'Leary	Assistant National Director of HR	Health Service Executive
Jim O'Sullivan	Programme Manager	Health Service Executive
Raymonde O'Sullivan	Assistant National Director of Finance (South)	Health Service Executive
Fiona Prendergast	Finance Unit	Department of Health
Dr James Reilly	Minister for Health	Department of Health
Francis Rogers	Asst National Director Human Resources (West)	Health Service Executive
Joe Sheeky	General Manager, Finance - DNE	Health Service Executive
Eoin Sheridan	Project Accountant, Finance – DNE	Health Service Executive
David Smith	Principal Officer, Finance Unit	Department of Health
Liam Woods	National Director of Finance	Health Service Executive

B Information provided to support our analysis

Supporting information provided

Name of file provided	Description of Content	Received from
Care Group Report PCCC June 2012	Actual & Budget Variances by LHO in South	Raymonde O'Sullivan
Cost Containment Scenario Planning	Cost containment scenario planning in South by LHO	Raymonde O'Sullivan
FW.msg	Cashflow June 2012 for South	Raymonde O'Sullivan
Cost Containment HSE South	Cost containment plan for South 2012 by LHO	Raymonde O'Sullivan
HSE South CCP Review Report	Review of performance against cost containment plan April 2012 South	Raymonde O' Sullivan
HSE South Decision Support Report June 2012 Results	• Outturn by service area • Variance Analysis Summary • Summary Position	Raymonde O'Sullivan
HSE South Finances	Proposed measures to address residual deficit	Raymonde O' Sullivan
HSE South Financial Position	• Review of performance against cost containment plan & measures to address the residual deficit June 2012 • Financial Summary Position of HSE South	Raymonde O' Sullivan
HSE South RSP	South Regional Service Plan 2012	Raymonde O'Sullivan
HSE South Scenario Service Planning	Hospital, area and regional summary of scenario plans	Raymonde O' Sullivan

Supporting information provided

Name of file provided	Description of Content	Received from
Message from KMBT	Performance Management HSE South – Slidepack on management structure, service plan and performance management process	Raymonde O'Sullivan
Performance Management Report	Performance Review report: Regional Performance report June 2012 Agenda Performance Review meeting 20th July 2012	Raymonde O'Sullivan
Untitled	Full year 2012 Cash Forecasting Report for South Cash Reconciliation report Jan – June 2012 for South	Raymonde O'Sullivan
Updated National Projections by Hospitals, LHOs & Care Groups	Income & Expenditure National projection June 2012 South	Raymonde O'Sullivan
WTE Analysis 2012	Full analysis for South 2012 including year-end projections and analysis on grace period retirements	Raymonde O' Sullivan
CCP PCCC excl Child Care April 2012	Cost containment plan South 2012 by LHO	Damian Casey on behalf of Liam Woods
HSE South Regional Service Plan 2012	Regional Service Plan 2012	Damian Casey on behalf of Liam Woods
HSE South Scenario Service Planning	Cost containment scenario plans 2012 South	Damian Casey on behalf of Liam Woods
NHO CCP April 2012	Cost Containment plans by LHO	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Performance review report April	Regional Management Performance report April 2012	Damian Casey on behalf of Liam Woods
SKMBT	Potential budget 2012 South	Damian Casey on behalf of Liam Woods
Decision Support Report South April 2012	Decision Support Regional Report	Damian Casey on behalf of Liam Woods
South Regional Service Plan 2012	South Service Planning 2012, cost containment scenario plan	Damian Casey on behalf of Liam Woods
Appendices for April 2012 Decision Support Report West	Broken down to Hospital level	Stephanie Lennon on behalf of Liam Minihan & Damian Casey
Cash Report April 2012 West	• YTD and year-end position • Current I&E forecast • National I&E Forecast Submitted • Cash Allocation Detail Vs Cash Forecast • Consolidated cash flow report	Stephanie Lennon on behalf of Liam Minihan & Damian Casey
HSE West Management Accounts April 2012	HSE West Management Accounts April 2012	Stephanie Lennon on behalf of Liam Minihan
LHO Sample Mid West Cost Containment Plan	Mid West PCCC cost containment plan Mar/April	Stephanie Lennon on behalf of Liam Minihan
Hospital Sample MGH Forecast	MGH Cost Containment plan 2012	Stephanie Lennon on behalf of Liam Minihan
ISA Forecast File	ISA forecast data by hospital	Stephanie Lennon on behalf of Liam Minihan

Supporting information provided

Name of file provided	Description of Content	Received from
Gross Debtors Reporting 2012 HSE West April 2012	Gross Debtors to hospital level	Stephanie Lennon on behalf of Liam Minihan
Pay Analysis 2012 West	ISA pay 2011 Vs 2012 to hospital level	Stephanie Lennon on behalf of Liam Minihan
Hospital Forecast	West North West and Mid West in isolation	Stephanie Lennon on behalf of Liam Minihan
LHO Sample Mid West	Area monthly management reports by county	Stephanie Lennon on behalf of Liam Minihan
Final PMR Report	Performance Management Report West June 2012	Stephanie Lennon on behalf of Liam Minihan
Decision Support Report DNE April 2012	Data broken down to Hospital level, excluding and including Childcare	Damian Casey on behalf of Liam Woods
IMR file including Fair Deal for Beaumont	Pay analysis for Beaumont Hospital April 2012	Damian Casey on behalf of Liam Woods
Master Unfunded capacity Beaumont	Additional/Unfunded capacity in use May 2012	Damian Casey on behalf of Liam Woods
Pensions / Cost pressures Mater	Pensions/lump sum status - Mater DNE	Damian Casey on behalf of Liam Woods
Dublin North City report	Finance, HR, Acute and Non-Acute Activity report	Damian Casey on behalf of Liam Woods
Dublin North East PCCC Cost Drivers report	Report for April broken down by LHO	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Additional Unfunded Capacity returns DNE	Description of additional capacity including summary, hours, costs	Damian Casey on behalf of Liam Woods
April 2012 HSE Debtors Performance Report	Gross Debtors Days for Acute Private Charges Debt < 12 months old	Damian Casey on behalf of Liam Woods
Decision Support DNE April 2012	Broken down to Hospital level, excluding and including Childcare	Damian Casey on behalf of Liam Woods
DNC Community Services Cost Measures	Dublin North Central Cost Measures	Damian Casey on behalf of Liam Woods
DNE Dublin North City Consolidated Trend Analysis April 2012	Deficit trend analysis and financial summary for DNE hospitals and LHOs	Damian Casey on behalf of Liam Woods
Draft Memo – Private Income April	Memo re private insurance income April 2012	Damian Casey on behalf of Liam Woods
HSE DNE Employment Monitoring Report	Details of WTE, Absenteeism, Agency Costs and OT	Damian Casey on behalf of Liam Woods
I&E Projection Jan to April base	Broken down to hospital level	Damian Casey on behalf of Liam Woods
IMR Commentary April Cav/Mon	Full financial info split by hospital	Damian Casey on behalf of Liam Woods
Income Debtors Template April 2012 DNE	Broken down by sector and by hospital	Damian Casey on behalf of Liam Woods
Potential Private Income Model April 2012 Draft	Jan – Apr Maximum potential private income Vs actual	Damian Casey on behalf of Liam Woods
Travel – Overtime- Agency Trend Analysis Jan to Dec 2012	Detailed trend analysis spreadsheet	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Weekly Agency and Overtime Reporting Cavan/Monaghan	Average Overtime and Agency from Jan – May 2012 for Cavan/Monaghan	Damian Casey on behalf of Liam Woods
Value of claims awaiting Consultant Action Trend	Includes Debtor Days and is broken down to hospital level	Damian Casey on behalf of Liam Woods
DNE Stability Report 2012 – 2014	Review of acute general hospital ward staffing levels and skills	Stephen Mulvany
General Surgical Ward Staffing DNE	Details of Ward staffing levels	Stephen Mulvany
Letter re Stability Plan from Stephen Mulvany	Letter to Hospital CEOs / General Managers DNE re acute general hospital ward staffing levels and skills	Stephen Mulvany
Letter to Director of Nursing & Midwifery DNE re Louth Meath Hospital Group re Cost Containment 2012	Letter re Financial Crisis – Recovery Plan - Agency and Overtime Ban – RDO Instruction	Stephen Mulvany
ISA by Operational Group	DML Regional Financial Performance including WTE by operation group - Report April 2012	Damian Casey on behalf of Liam Woods
ISA Care Group	DML Regional Financial Performance including WTE by care group - Report April 2012	Damian Casey on behalf of Liam Woods
ISA Pay Analysis	DML Regional Financial Performance in terms of pay costs- Report April 2012	Damian Casey on behalf of Liam Woods
ISA Volume – Stat – Split	Financial and WTE data for DML separated into Statutory and Agency	Damian Casey on behalf of Liam Woods
P7 LHO by Cost Centre	Breakdown of Finance and WTE by Cost Centre	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
All hospitals report – AFS	Financial data and WTE data by hospital	Damian Casey on behalf of Liam Woods
P7 LHO Care Group	Financial data and WTE data by care group	Damian Casey on behalf of Liam Woods
RDO by ISA	Financial data and WTE data by hospital	Damian Casey on behalf of Liam Woods
All hospitals pay analysis	Actual V's Budget: Broken down by type of pay i.e. OT etc.	Damian Casey on behalf of Liam Woods
All hospitals report	Financial data and WTE data by ISD	Damian Casey on behalf of Liam Woods
All hospitals report – AFS- Prior Year Comparison	DML Income and Expenditure report by hospital – April 2012	Damian Casey on behalf of Liam Woods
Property Purchase Deposits	National Financial Regulation on Property Purchase Deposits	Damian Casey on behalf of Liam Woods
Purchase to Pay	National Financial Regulation on Purchase to Pay	Damian Casey on behalf of Liam Woods
Payroll Overpayments and Underpayments	National Financial Regulation on Payroll Overpayments and Underpayments	Damian Casey on behalf of Liam Woods
Travel & Subsistence	National Financial Regulation on Travel & Subsistence	Damian Casey on behalf of Liam Woods
Fixed Assets and Capital Accounting	National Financial Regulation on Fixed Assets and Capital Accounting	Damian Casey on behalf of Liam Woods
Retention of Financial Records	National Financial Regulation on Retention of Financial Records	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Engagement and Management of Consultants	National Financial Regulation on Engagement and Management of Consultants	Damian Casey on behalf of Liam Woods
Credit Cards and Procurement Cards	National Financial Regulation on Credit Cards and Procurement Cards	Damian Casey on behalf of Liam Woods
Efficient Deployment of Resources	National Financial Regulation on Efficient Deployment of Resources	Damian Casey on behalf of Liam Woods
Cash and Bank	National Financial Regulation on Cash and Bank	Damian Casey on behalf of Liam Woods
Other staff costs	National Financial Regulation on other staff costs	Damian Casey on behalf of Liam Woods
Value Added Tax	National Financial Regulation on Value Added Tax	Damian Casey on behalf of Liam Woods
Voluntary Donations Gifts and Bequests	National Financial Regulation on Voluntary Donations, Gifts and Bequests	Damian Casey on behalf of Liam Woods
Protecting the HSE's Interest	National Financial Regulation on Protecting the HSE's Interest	Damian Casey on behalf of Liam Woods
Inventory Control	National Financial Regulation on Inventory control	Damian Casey on behalf of Liam Woods
Emergency Response	National Financial Regulation on Emergency Response	Damian Casey on behalf of Liam Woods
Patient Private Property	National Financial Regulation on Patient Private Property	Damian Casey on behalf of Liam Woods
Due Diligence Investigations	National Financial Regulation on Due Diligence Investigations	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Payroll Report	National Financial Regulation on Payroll Report	Damian Casey on behalf of Liam Woods
Financial Management Community Residence	National Financial Regulation on Financial Management Community Residence	Damian Casey on behalf of Liam Woods
Consultants' Private Practice	National Financial Regulation on Consultants' Private Practice	Damian Casey on behalf of Liam Woods
Funding & Approval	National Financial Regulation on Funding & Approval	Damian Casey on behalf of Liam Woods
Code of Governance	HSE Board Governance Part 1 & 2	Damian Casey on behalf of Liam Woods
Considine Report	A study of certain accounting issues related to HSE	Damian Casey on behalf of Liam Woods
Integrated Decision Support Function	Draft Decision Support Function February 2010	Damian Casey on behalf of Liam Woods
Implementation Resource Cost Estimate	Resourcing Requirements 2008 - 2010	Damian Casey on behalf of Liam Woods
Ongoing Support Resource Cost Estimate	Resourcing Requirements 2010 – 2012	Damian Casey on behalf of Liam Woods
NFPS Proposal & Business Case	93 page Proposal and Business Case for National Finance and Procurement System	Damian Casey on behalf of Liam Woods
Proposal & Business Case Appendices	Appendices to above	Damian Casey on behalf of Liam Woods
Torpey Report of Financial Control in the HSE	A review of finance controls in the HSE	Damian Casey on behalf of Liam Woods

Supporting information provided

Name of file provided	Description of Content	Received from
Management Controls Handbook	HSE Management Controls Handbook	Damian Casey on behalf of Liam Woods
Note for Sec General	An explanation of data regarding expenditure and levels of Sick Pay, overtime, agency / locum cover by region, service and grade;	Derek Finnegan, on behalf of the Secretary General
Combined Resource Report	Pay costs by pay element for Nursing and Medical/Dental for YTD May 2012	Derek Finnegan, on behalf of the Secretary General
Memo from ND ISD re Corrective Action	Letter from National Director ISD outlining areas for attention within HSE regions going forward	Derek Finnegan, on behalf of the Secretary General
Letter from Robert Watt to Ambrose McLoughlin re Health Sector Overrun	A request to submit a costed programme of structural measures by Aug 31st 2012	Derek Finnegan, on behalf of the Secretary General
Appendix1: Current Landscape & key challenges	2 page document on regional payroll systems	Damian Casey
Current System Landscape in Health	Graphical representation of Finance, Finance & Procurement and Hosting	Damian Casey
National AP Dashboard	Details of top 10 vendors used across Boards	Damian Casey
National Payroll Shared Services Transition	Draft business case for changes to the National Payroll system	Damian Casey
Overview	Breakdown of Finance Staff by Function/Breakdown of Finance Staff by Grade	Damian Casey
Health Sector Shared Service Plan – Finance	Shared Service Action Plan	Damian Casey

Supporting information provided

Name of file provided	Description of Content	Received from
Future Finance and procurement landscape	Graphical representation of Finance Customers, Finance Data Management, Finance & procurement process and Finance System logging	Damian Casey
HSE IE YTD July 2012	Excel spreadsheet detailing YTD allocation V's actual for income and expenditure	Maureen Cronin
HSE Employment report to CEO Jun 2012	Monthly employment monitoring summary by health service and by functions	Frank O' Leary
HSE Employment report to CEO July 2012	Monthly employment monitoring summary by health service and by functions	Frank O' Leary
July Board Report	Detailed Income & Expenditure report	Maureen Cronin
Hospitals Graph	Graph showing Hospital expenditure and budget 2007 – 2011	Colum Maddox
REV Build up 2007 - 2012	Vote build up from 2007 – 2012	Colum Maddox
2007 – 2012 Hospitals LHO's allocation spend	Allocation V's Expenditure for Hospitals and LHOs from 2007 - 2012	Colum Maddox
June Pay Analysis	Pay cost data YTD June 2012 by pay element and by staff category	Colum Maddox

Supporting information provided

Name of file provided	Description of Content	Received from
July Pay Analysis	Pay cost data YTD July 2012 by pay element and by staff category	Colum Maddox
Sample combined resource report Nursing Acutes – YTD July 2012	Pay costs by pay element for Nursing YTD July 2012	Howard Kelly
Sample combined resource report Med/Dent Acutes – YTD July 2012	Pay costs by pay element for Medical/Dental YTD July 2012	Howard Kelly
Detailed Income & Expenditure 2011	Income & Expenditure by Hospital within the West region	Helen Shaughnessy
Pay analysis by element as at June 2012	Pay data by pay element by Hospital within the West region as at June 2012	Helen Shaughnessy
Pay analysis by element 2011	Pay data by pay element by Hospital within the West region 2011	Helen Shaughnessy
2012 DML CCP Review Report June Actual 27th July FINAL	Review of performance against cost containment plan June 2012	Declan Lyons
2012 DML – Sup - Ver – 06 – Jun – Ver 1	DML Decision Support Report	Declan Lyons
Time phased projection for Cavan Monaghan	Projection of cost containment plans for Cavan Monaghan Hospital	Mark Fagan
Employment Report – Mid West Hospital Group Jun 2012	Monthly employment monitoring summary	Francis Rogers

Supporting information provided

Name of file provided	Description of Content	Received from
Employment Report – Galway Hospital Group Jun 2012	Monthly employment monitoring summary	Francis Rogers
Employment Report – HSE West Jun 2012	Monthly employment monitoring summary	Francis Rogers
I E projection Jan to June RDO update for Special Board Meetings	Detailed income and expenditure report for HSE Dublin North East	Mark Fagan
Cost Containment by month based on May actuals	Cost containment timelines for Dublin North PCS	Mark Fagan
As at 22nd June 2012 for period Jan to June	Details of costs containment for Connolly Hospital	Mark Fagan
Mayo June	Details of cost containment for Mayo Hospital	Tadhg Costello
1206 cost containment June combined Sligo Leitrim	Details of cost containment for Sligo Leitrim	Tadhg Costello
Cost containment template 2012 LGH	Details of cost containment plans for LGH	Tadhg Costello
PA Consulting Group – HOSPITALS – Pay, Non Pay Income 2001 V 2012	Income & Expenditure (pay broken down by element and by staff category)	Raymonde O'Sullivan
PA Consulting Group PCCC June 12	Income & Expenditure for LHO (pay broken down by element and by staff category)	Raymonde O'Sullivan

Supporting information provided

Name of file provided	Description of Content	Received from
PA Childcare Consulting Group June 12	Income & Expenditure for Childcare: South	Raymonde O'Sullivan
DNE Cavan Monaghan Area Consolidated Trend Analysis	Deficit trend analysis and financial summary for Cavan Monaghan	Mark Fagan
DNE Dublin North Consolidated Trend Analysis	Deficit trend analysis and financial summary for DNE Dublin North	Mark Fagan
DNE Dublin North City Consolidated Trend Analysis	Deficit trend analysis and financial summary for DNE Dublin North City	Mark Fagan
DNE Louth Meath Consolidated Trend Analysis June 2012	Deficit trend analysis and financial summary for Louth Meath	Mark Fagan
Presentation Version Final	Slidepack on performance management overview for HSE South	Annette Walsh on behalf of Pat Healy
Cash Forecasting Actual to June 2012	Cash forecasting report by area and by service	Donal Foran
Draft April 2012 Performance Report, National Service Plan 2012	Detailed HSE performance report by service area and by region	Laverne McGuinness
Regional Management Performance Reports April 2012	Detailed performance reports by region	Laverne McGuinness
Regional Decision Support Reports	Data and commentary on the financial position YTD April 2012 for each region	Laverne McGuinness

Supporting information provided

Name of file provided	Description of Content	Received from
Performance Review Meeting Agendas	Agenda for each of the four regions received	Laverne McGuinness
Analysis of Agency Costs	Analysis of change in agency costs between Qtr 1 2011 and Qtr 1 2012 – Individual report per region	Laverne McGuinness
ISD Performance Report	Regional Activity V's Target Difference Analysis	Laverne McGuinness
Review of Performance against Cost Containment Plan – April 2012 HSE Dublin Mid Leinster	Report assessing performance of Cost Containment Plans within HSE DML	Laverne McGuinness
Review of Performance against Cost Containment Plan – April 2012 HSE South	Report assessing performance of Cost Containment Plans within HSE South	Laverne McGuinness
Dublin North East Regional Service Plan 2012	Outline of funding position and service delivery for 2012	Laverne McGuinness
Financial Performance April 2012 – HSE West	Summary of financial performance across a range of measures Jan – April 2012	Laverne McGuinness
Important correspondence and other documentation	Series of letters from National Director ISD to regional representative regarding financial performance	Laverne McGuinness
Controls Assurance Statement for the year ended 31/12/2011	Signed copy of Controls Assurance Statement by National Director ISD	Laverne McGuinness

Supporting information provided

Name of file provided	Description of Content	Received from
Integrated Services Directorate Risk Register March 2012	Risk register outlining additional controls and actions required	Laverne McGuinness
PCRS Service Plan 2012	Outline of funding position and service delivery for PCRS for 2012	Laverne McGuinness
CAS 2011 L Woods	Internal memo from L Woods to C Magee re Controls assurance statement 2011	Damian Casey on behalf of Liam Woods
Consolidated Employment Monitoring Report to National Director, ISD	A monthly employment monitoring summary by health service and by function	Damian Casey on behalf of Liam Woods
Letter to CEO – April Employment Reports – 18th May 2012	Letter from Frank O'Leary to Cathal Magee re Employment Outturn as at end April 2012	Damian Casey on behalf of Liam Woods
Report for joint Employment Control Monitoring Group	Comprehensive overview of HSE employment situation - April 2012	Damian Casey on behalf of Liam Woods
The "Bible"	Cost of Catering, Cleaning, Portering, Linen per Hospital (HSE Overall)	Stephen Mulvany
National Absenteeism Report May 2012	Health Service Absenteeism by Grade Category	Derek Finnegan, on behalf of the Secretary General
Estimated Cost of Absenteeism 2011	Estimated cost of absenteeism across staff category for 2011	Derek Finnegan, on behalf of the Secretary General
Pay Costs Comparison	Pay cost data YTD May 2012 by pay element and by staff category	Derek Finnegan, on behalf of the Secretary General

C Monitor's Compliance Framework

Monitor's Compliance and Financial Risk framework

Monitor's compliance framework	
Finance	• Margin • Return on Assets • Liquidity • Delivery of plan • Return on income
Quality	• Service performance • Third party reports • Certification failures • Delivery of annual plan

Intervention is considered where:

- FRR <3;
- red-rated for governance;
- there are relevant third party concerns;
- or
- other major breaches of the Authorisation;

Monitor's financial risk ratings	
Financial Criteria	**Metric to be scored**
Achievement of plan	• EBITDA achieved (% of plan)
Underlying performance	• EBITDA margin (%)
Financial efficiency	• Return on capital employed (%) • I&E surplus margin net of dividend
Liquidity	• Liquidity ratio (days)

Indicators of forward financial Risk

- Unplanned decrease in EBITDA margin in two consecutive quarters
- Quarterly certification by trust that FRR may be less than 3 in the next 12 months
- FRR 2 for any one quarter
- Working capital facility used in previous quarter
- Debtors > 90 days past due account for more than 5% of total debtor balances
- Creditors > 90 days past due account for more than 5% of total creditor balances
- Two or more changes in Finance Director in a twelve month period
- Interim Finance Director in place over more than one quarter-end
- Quarter end cash balance <10 days of operating expenses or < £4 million
- Capital expenditure < 75% of plan for the year-to-date

D Skills and Capabilities in a leading Finance Department

Skills and Capabilities

Capabilities required of a leading finance professional

	Financial Management					Strategy & Governance	
	Finance Operations	Finance Specialists	Business Partnering	Business Intelligence	Procurement	Strategy, performance & Improvement	Risk management & Internal Audit
Operations Excellence							
Operations Management	●			●			
Process Improvement	●		○	●		●	○
Performance Improvement	●	○	○	○	○	●	○
Change Management	●	○	●	●	●	○	○
Information Management & Analysis							
Systems administration and data validation				●			
Trend and Variance Analysis	○		○	●			
Financial Modelling			○	●			
Investment Appraisal		○	●	●		○	
Business Analysis		○	●	●		○	
Benchmarking performance	○		○	●	○	○	
Financial Reporting			○	●			
Business Case development		○	●	●		○	
Governance & Assurance							
Strategy direction and horizon scanning		○	○	○		●	
Policy development		○	○		●	●	●
Performance Management		○	○	○		●	
Service Improvement		○	○	○		●	○
Risk assessment and management							●
Systems and process assurance							●
Fraud detection and investigation							●
Risk based planning							●

Skills and Capabilities

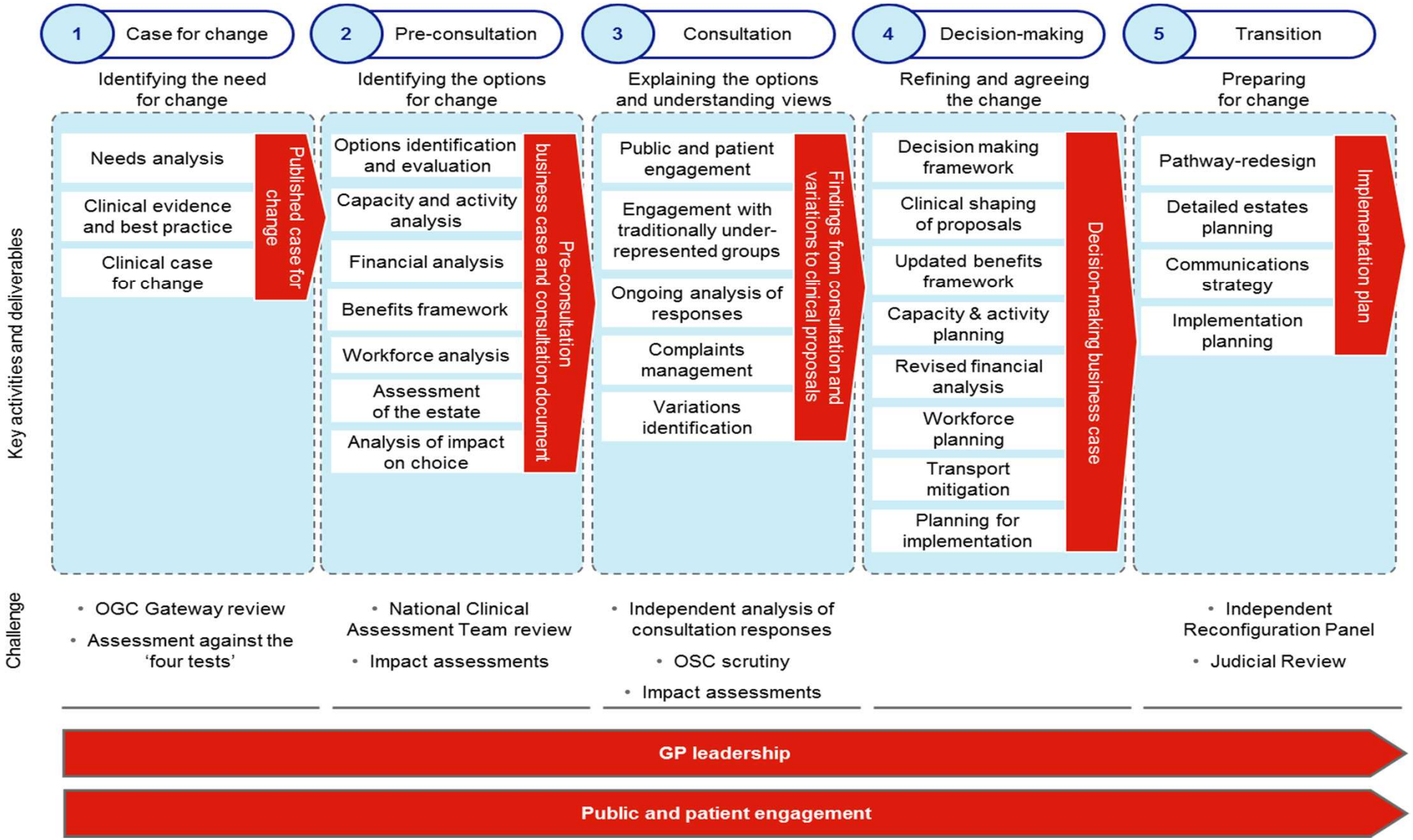
Capabilities required of a leading finance professional

	Finance Operations	Financial Management			Procurement	Strategy & Governance	
		Finance Specialists	Business Partnering	Business Intelligence		Strategy, performance & Improvement	Risk management & Internal Audit
Professional Advisory							
Financial Planning			●	●		●	
Financial & Technical Accounting			○	●		○	
Management Accounting			●	●		○	
Treasury and investment management		●					
Taxation		●					
Pensions Advisory		●					
Supplier engagement and market management					●		
Public Sector procurement					●		
Contract negotiation					●		
Contract management					●		
Service Insight							
Health sector trends and initiatives		○	●	○	○	●	○
Irish Public sector landscape		○	●	○	○	●	○
Alternative delivery models		○	●	○	○	●	○
Market awareness		○	●	○	○	●	○
Relationship Management							
Customer Service	●	●	●	●	●	●	●
Account Management			●				
Communications	○	○	●	●	○	○	○

Key	
Essential	●
Desirable	○

E The ideal reconfiguration journey

The ideal reconfiguration journey



Some questions to consider at each stage

1 Case for change

Identifying the need for change

- Is the case for change underpinned by multiple reasons for change, and hence able to withstand challenge and political change?
- Are both primary and secondary care clinicians clearly in the driving seat of the programme from the outset? Is this evidenced within the governance structure? Is their role recognised by the local NHS, the public and the local media?
- Does clinical evidence and best practice underpin the proposed changes? Is it clear that this evidence is applicable to the local context and widely supported by the local clinician community?

2 Pre-consultation

Identifying the options for change

- Do all stakeholders recognise the benefits framework and understand how it relates to improved patient outcomes and experience?
- Does the pre-consultation business case (PCBC) explain the options for change for consultation in a way members of the public will understand?
- Are you confident that your PCBC will still be relevant and robust during an IRP review in a year's time?
- Does your consultation document strike the right balance between being professional and comprehensive without being overly 'flashy' and expensive-looking?
- Is the consultation document written with its distribution strategy in mind? Do you know who will be reading it and is it pitched accordingly?

3 Consultation

Explaining the options and understanding views

- Is your target audience identified sufficiently and are engagement methods robust enough to justify the expense of the consultation?
- Will your analysis of consultation responses run concurrent with the consultation exercise, enabling real time consideration of issues raised?
- Have you identified the relevant traditionally under represented groups in your area, and know how best to engage individuals from these groups?
- Will your post consultation analysis provide you with a report that identifies the key areas of concern, and can directly support clinical working groups to review and revise their clinical proposals?

4 Decision-making

Refining and agreeing the change

- Is your target audience identified sufficiently and are engagement methods robust enough?
- Will your analysis of consultation responses run concurrent with the consultation exercise, enabling real time consideration of issues raised?
- Have you identified the relevant traditionally under represented groups in your area?
- Will your post consultation analysis provide you with a report that identifies the key areas of concern, and can directly support clinical working groups to review and revise their clinical proposals?

5 Transition

Preparing for change

- What will be the key mechanisms for engaging staff in transition planning?
- What are the key challenges in maintaining service quality through transition?
- How can the biggest risks to benefits be identified and mitigated?

If subject to an IRP review:

- Are you able to explain in detail how you will implement changes and what this will mean in terms of workforce, capital and estates?
- Do you understand what would happen if your plans were rejected?

F Analysis of Cost Containment initiatives

Summary of Cost Containment Initiatives

This appendix gives a high level summary of cost containment initiatives in place across the regions. The data has been collated from the regional plans submitted to the National Director of Integrated Services Directorate 17th July 2012 and additional files received directly from individual regions. Initiatives have been separated into both acute and non-acute services.

Acute	DML	DNE	SOUTH	WEST	Comments
Reducing activity levels in line with Service plan					
Inpatient discharges					
Medical / Surgical Bed Closures	✓	✓	✓	✓	Impact on access targets
Seasonal Closures	✓	✓	✓	✓	
Implementation of Clinical Care Programmes	✓		✓		
Reduced length of patient stay	✓		✓		Need immediate care if focused on LT patients. Need to also look at re-admission rates and risk management
Day case activity					
Develop private day case activity			✓		
Seasonal Closure of Surgical Wards	✓	✓	✓	✓	Access impact
Bed Closures	✓	✓	✓	✓	
Emergency Admissions					
Implementation of Clinical Care Programmes	✓		✓		
50% reduction in Agency Costs					
Significant reduction in Locum spend			✓		Impact on access where supporting core service delivery
Efficiency projects to assess staff v productivity		✓			
Reduction in agency costs due to seasonal closures	✓	✓	✓	✓	
Consultant cross cover for leave			✓		
Implementing authorisation controls for expenditure	✓			✓	
Elimination of Admin/Mgt/Maintenance Agency	✓				
Managers to pre-approve agency spend in Statutory Hospitals and monitor weekly	✓				
Efficiencies in Rostering/Staff Redeployment	✓	✓	✓		
Conversion of Agency Staff to WTEs	✓	✓		✓	

Summary of Cost Containment Initiatives

Acute	DML	DNE	SOUTH	WEST	Comments
10% reduction in Overtime Costs					
NCHDs being reviewed and revised/reduced	✓	✓	✓	✓	Access impact
Reduction in out-of-hours call outs budgets			✓		
Efficiencies in Rostering/Staff Redeployment	✓	✓	✓	✓	Potential to decrease Length of Stay
Close monitoring of Voluntary hospital OT costs	✓				
Managers to pre-approve agency spend in Statutory Hospitals and monitor weekly	✓				
Implementing clinical care programme efficiencies	✓				
Reduction in Absenteeism levels					
Local initiatives to manage sick leave in place	✓	✓	✓	✓	
On-going monitoring and management as per attendance management policy. Specific attention to maternity related sick leave immediately pre maternity leave		✓			
Absence Management audits underway		✓			
Peer Review Groups at service locations to review individual cases				✓	
Management undergoing continual training on attendance policy				✓	
Implementing disciplinary procedures where necessary				✓	
Back to work interviews being conducted				✓	
Reduction in Travel & Subsistence Costs					
Local initiatives in place to reduce spend	✓	✓	✓	✓	
Initiative to maximise use of teleconferencing		✓		✓	
Car pooling recommended				✓	
Pay initiatives					
Savings from Retirements, Resignations, Career Breaks, Unpaid leave	✓	✓	✓	✓	

Summary of Cost Containment Initiatives

Acute	DML	DNE	SOUTH	WEST	Comments
Non pay expenditure					
Established subset of Drug and therapeutic committee to reduce drug costs			✓		
Management of equipment and consumables	✓		✓	✓	
Implementation of non-pay initiatives such as Insurance premiums, pharmacy costs, contract renewal for MRI service	✓		✓		
Reduction in Budget allocation to particular areas across the system			✓		
Income					
Implement Car parking fee	✓		✓		
Maximise income opportunity for Orthopaedics/Pain/Plastics			✓		
Amendments to the provision of catering	✓	✓	✓		
Endoscopy/Minor Surgery waiting list initiative			✓		
Increase private bed occupancy	✓		✓		

Summary of Cost Containment Initiatives

Non Acute	DML	DNE	SOUTH	WEST	Comments
50% reduction in Agency Costs					
Significant reduction in Locum spend	✓	✓	✓		Access impact where supporting core delivery service
Efficiency projects to assess staff Vs. productivity		✓			
Ward closures		✓			Access impact
Implementing authorisation controls (i.e. pre-approval) for expenditure. Limits have been issued to certain areas	✓			✓	
Increasing Mental Health nursing posts	✓				
Efficiencies in rostering / staff redeployment / conversion of agency staff to WTEs	✓	✓	✓		
Reduction in supplementary payments to agencies for respite services			✓		
Reduce employment of Social Workers through agency			✓		
10% reduction in Overtime Costs					
Reduction in OT across all Mental Health disciplines			✓		
Efficiency projects to assess staff Vs. productivity		✓			
Ward closures		✓			
Elimination of Admin/Mgt/Clinical OT in certain areas		✓			
Implementing authorisation controls (i.e. pre-approval) for expenditure. Limits have been issued to certain areas				✓	
Efficiencies in rostering (in particular Mental Health Services) / staff redeployment	✓	✓	✓	✓	
Reduce Home Help hours in line with 2011 levels	✓				
Evening and Weekend Dental Clinics to cease in certain locations	✓				

Summary of Cost Containment Initiatives

Non Acute	DML	DNE	SOUTH	WEST	COMMENTS
Reduction in Absenteeism levels					
Local initiatives to manage sick leave in place			✓		
On-going monitoring and management as per attendance management policy.		✓			
Absence Management audits underway		✓		✓	
Management undergoing continual training on attendance policy				✓	
Implementing disciplinary procedures where necessary				✓	
Weekly Monitoring Reports implemented		✓		✓	
Statutory: Legal framework has been recirculated to all managers	✓				
Back to work interviews being conducted		✓		✓	
Reduction in Travel & Subsistence Costs					
Initiative to maximise use of teleconferencing		✓		✓	
Robust enforcement of restricted travel outside the ISA	✓				
Tight controls in place at local level: HSE travel policy being enforced		✓		✓	
Car pooling recommended				✓	
Non pay expenditure					
Limit foster care payments in respect of over 18's to €200 per week			✓		
Established subset of Drug and therapeutic committee to reduce drug costs/pharmacy costs			✓		
Reviewing expenditure relating to T&D			✓		
Reduction in grants to agencies	✓		✓	✓	
Ceasing of rental properties / reviewing rent/leases	✓	✓	✓		
Local initiatives in Children and Families in place			✓		
Income					
Implement car parking fee	✓		✓		

Summary of Cost Containment Initiatives

Non Acute	DML	DNE	SOUTH	WEST	COMMENTS
Amendments to the provision of catering	✓	✓	✓		
Endoscopy/Minor Surgery waiting list initiative			✓		
Increase private bed occupancy			✓		
Endoscopy/Minor Surgery waiting list initiative			✓		
Increase private bed occupancy	✓		✓		

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