Health Service Executive

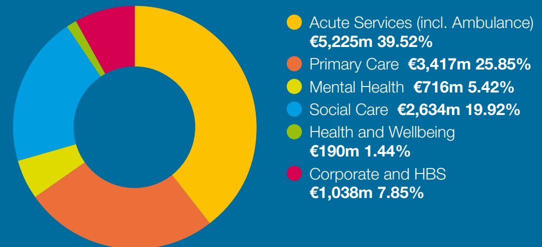
Annual Report and Financial Statements 2014

CARING AND PROVIDING FOR THE HEALTH OF OUR NATION

2014 Facts and Figures
Finance and Workforce

- Total HSE expenditure in 2014 was €13.22bn
- Gross expenditure on acute services was €5.2bn
- Gross expenditure on primary care services was €3.4bn
- Gross expenditure on social care services was €2.6bn
- Gross expenditure on mental health services was €716m

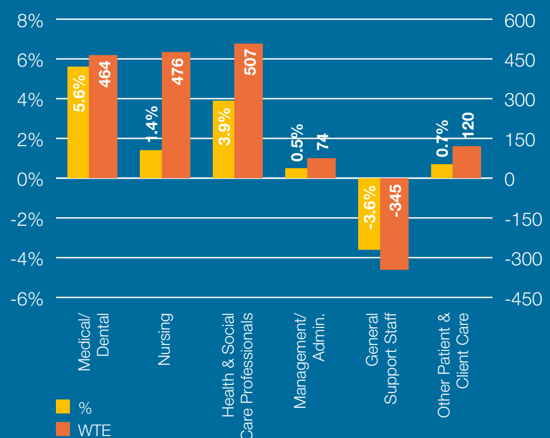
Breakdown of total expenditure 2014 (€m)



Data source: HSE Corporate Finance

- At the end of 2014 there were 97,791 WTEs employed
- Since 2007 there has been an overall reduction of 13% in staff numbers
- 50.8% of staff in 2014 worked in hospitals
- 43.7% of staff worked in community services
- Just 2.7% of staff worked in corporate services
- Absenteeism rates are continuing to improve , down from 5.76% in 2008 to 4.27% in 2014

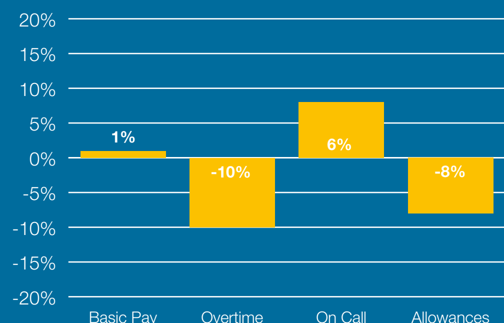
WTE and % change December 2013 - December 2014



Data source: Health Service Personnel Census

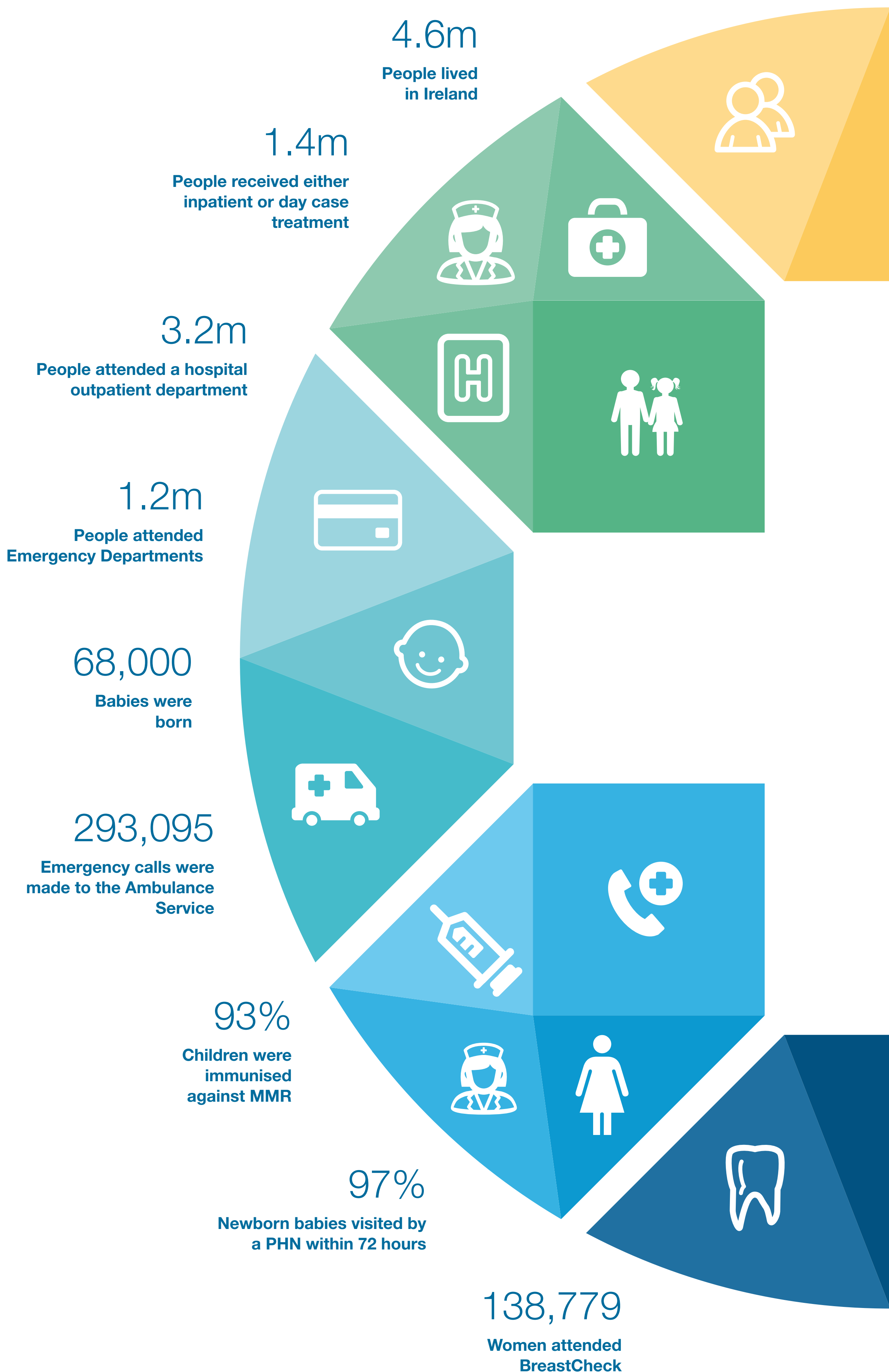
- In 2014, the overall pay bill, including voluntary service providers and excluding supperannuation, increased by €132.8m (2%)
- There was a 10% reduction in overtime payments (statutory and non-statutory)
- There was a 37% increase in agency expenditure
- Agency costs amounted to 4% of all pay costs

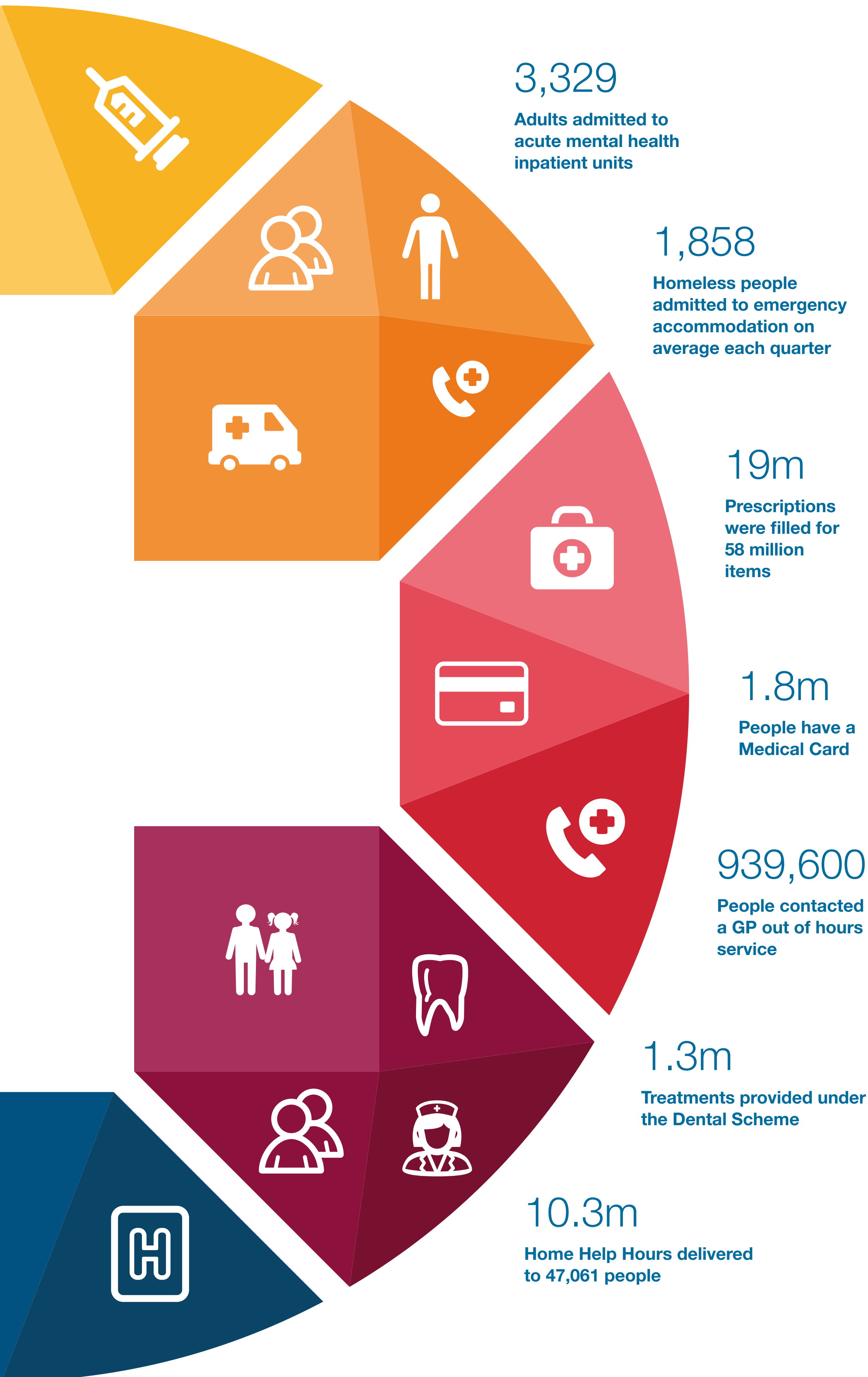
Pay cost change (statutory and non-statutory) excluding superannuation 2014



Data source: HSE Corporate Finance

2014 Facts and Figures





3,329

Adults admitted to acute mental health inpatient units

1,858

Homeless people admitted to emergency accommodation on average each quarter

19m

Prescriptions were filled for 58 million items

1.8m

People have a Medical Card

939,600

People contacted a GP out of hours service

1.3m

Treatments provided under the Dental Scheme

10.3m

Home Help Hours delivered to 47,061 people

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Statement from the Director General

Our health services have faced many challenges over recent years and 2014 was no different. Demand for services continues to increase year on year and this brings challenges for our staff in responding to these demands as speedily and as efficiently as we would like within the limited resources available. We are fortunate to have a committed and dedicated workforce that strives to deliver the best care they can to those who depend on our services.

While it remains the case that the majority of people who interact with our services have a positive experience, I am very much aware that there have also been instances of poor practice. Events at Áras Attracta and Portlaoise underline this reality. This is never acceptable and I am committed to ensuring that where there is poor practice it is remedied and that every person who interacts with our service receives a quality service and is treated with care, compassion and kindness. This requires a fair culture built on openness and transparency and our new Open Disclosure and Good Faith Reporting policies are very important in this regard. When we make mistakes we need to acknowledge them, apologise for them and learn from them. This will support a modern open approach to how we provide services.

Sometimes in the midst of challenges we overlook the many things we are improving. This includes advances in medical interventions, technology, models of care and the range and breadth of services we provide. This Annual Report sets out some of our successes and also some of our challenges during 2014.

Responding to our challenges

Legacy models of care are losing their relevance as advances in technologies are opening up new frontiers in diagnosis and treatment. Interventions in care and medicine, driven by evidence based policy, best practice, research and well trained and qualified staff, have enabled us to enjoy a longer life expectancy in Ireland – we are now above the EU average. However, our population is ageing. The increase in the number of people aged over 65 is approaching 20,000 per year. With increasing age, unfortunately, comes a prevalence of chronic illness. It is expected that chronic disease will increase by 20% by 2020, primarily related to our ageing population. Many chronic diseases are preventable and can be modified by how we live and by adopting healthier lifestyles. However they are also related to inequalities in society. Continuing to implement the *Healthy Ireland* framework will address some of these issues.

In recognition of service and demographic pressures, additional funding was made available by Government to progress specific initiatives across a range of areas including primary care, mental health, disability services, health and wellbeing and acute hospital services. Further details of this can be seen throughout this Annual Report.

Health Reform

During 2014 we continued to reform our health service to deliver better quality care for those who depend on us. Delivering cultural and structural change and reform is never easy and is not achieved without considerable challenge for everyone involved. The commitment shown and the appetite for change across the Health Service have been very encouraging.

We want our models of care to be the best they can be and to achieve this we are reorganising our services so that they are delivered in the most appropriate way.

- Clinical programmes and integrated care programmes are being implemented, delivering care that improves patient outcomes and satisfaction and focuses on patient centred care.
- Community Healthcare Organisations (CHOs) are being developed, ensuring that the provision of care is integrated by providing better and easier access to services for the public which are close to where people live. Chief Officers were appointed to seven of the nine CHOs before the end of 2014.
- Hospital Groups are being strengthened so that the services they provide are responsive and provide equitable access and better patient care. Six of the seven Hospital Group CEOs had taken up their appointment before the end of 2014.
- Health Business Services – our shared service organisation – has progressed on its journey towards a contemporary shared service platform for the entire health service providing for the most effective use of resources.
- Significant progress has been made in the reform of the operation of the medical card service.
- A Quality Enablement Programme was launched in the last quarter of 2014 with a focus on quality improvement on the one hand, and quality assurance and verification on the other. This will ensure a strengthened and more joined up approach to ensuring the embedding of quality and patient safety activities across all our services.

Leadership and Governance

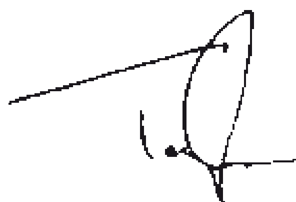
We sought to strengthen and improve our Leadership, Governance and Accountability arrangements in 2014 and we will continue on this journey in 2015. A new Accountability Framework is included in the 2015 Service Plan. The statutory governing body of the HSE, since the end of July 2013, is the Directorate and it has a legally prescribed list of reserved functions. The Directorate is a unique governance construct in that it is made up exclusively of a ministerial selected sub-set of members of a wider Leadership team of National Directors. The Directorate and Leadership Team meet together as the national forum within the HSE at which strategic, operational and quality and safety issues are considered and addressed. The creation of Hospital Groups and Community Healthcare Organisations has opened up a new era in the leadership of the Health Service and we will work with this wider leadership team to bring about improvements in health outcomes for individuals, communities and society as a whole.

Thank you

On behalf of the Directorate, I would like to thank Mr. Jim Breslin, Secretary General of the Department of Health and his predecessor Dr. Ambrose McLoughlin, together with their officials, for their support, encouragement and challenge during the year. Dr. McLoughlin was also Chairman of the former HSE Board until July 2013.

I acknowledge the leadership of the Minister for Health, Mr. Leo Varadkar TD, and his predecessor Dr. James Reilly TD, who along with the Minister of State for Primary and Social Care, Ms. Kathleen Lynch TD, and Mr. Alex White TD, formerly Minister of State for Primary Care, steered policy at Government level.

I also wish to thank all members of the Directorate and Leadership Team for their dedication and commitment throughout the year. I am profoundly grateful to all our staff members who have worked so hard to provide health and social care services for their commitment to providing the best services that they can. The outcomes detailed in this Annual Report are a record of their hard work and commitment.



Tony O'Brien
Director General
Health Service Executive

Our Organisation

Introduction

The core purpose of the Health Service is to provide safe, high quality health and personal social services to the population of Ireland.

This Annual Report describes what the Health Service did in 2014 to meet our objectives. It sets out progress against the HSE National Service Plan 2014 (NSP2014) and what we have achieved within the longer term agenda contained in our corporate and various strategic plans.

In line with our legislative requirements under the *Health Act 2004* (as amended), the Annual Report also reports progress against the HSE Capital Plan and provides detailed financial statements for the organisation.

Our Governance

The HSE Directorate was established in 2013, following the enactment of the *Health Service Executive (Governance) Act 2013* which abolished the HSE Board established under the *Health Act 2004*. The Board was replaced by a Directorate headed by the Director General as Chairperson, the other members of the Directorate being appointed by the Minister from persons employed as HSE National Directors.

The Directorate has collective responsibility as the governing authority for the HSE and the authority to perform the HSE's functions and is the ultimate decision-making level within the HSE under legislation. The Directorate is accountable to the Minister for the performance of the HSE's functions and its own functions as the governing authority of the HSE. The Director General as Chairman of the Directorate accounts on behalf of the Directorate to the Minister and is responsible for carrying on and managing and controlling generally the administration and business of the HSE. This is done on an operational basis through the Leadership Team and their supporting structures within the organisation. See also the Directorate Members' Report in the Annual Financial Statements of this Report and also an organisational chart as at 31.12.14 in Appendix 2.

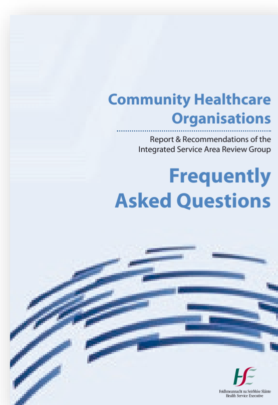
Health Reform

During 2014 we have continued to implement our key reform programmes. These include:

- The development of community healthcare and Community Healthcare Organisations (CHOs)
- Hospital Groups
- Patient centred care
- Enabling our support services.

Community Healthcare Organisations

The report *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group 2014* was published following a wide consultation. It provides a framework for new governance and organisational structures for community healthcare services. These will facilitate a move towards a more integrated health care system, improving services for the public by providing better and easier access to services, services that are close to where people live, more local decision making and services in which people can have confidence. Nine CHOs have been established. A national steering group has been established to oversee implementation of the report's recommendations and a high level implementation plan will be developed.



Hospital Groups

Seven Hospital Groups are now established and will drive the development of acute service provision over the coming years. These Hospital Groups will deliver more responsive and equitable access, deliver better patient care more efficiently and will ensure that smaller hospitals continue to play a key role in the delivery of health services.

Patient Centred Care

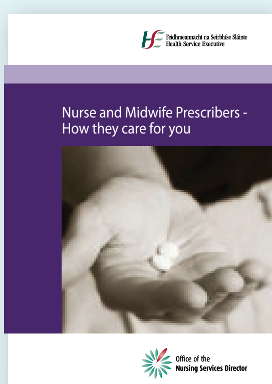
Delivery of care in a way which is integrated around the individual user is fundamental to improved ways of working and improving patient outcomes. National Clinical Programmes are central to the reform underway within our health services providing a strategic approach to the reform of a broad range of services in the acute, community and social care sectors. They are modernising the way services are provided through standardising delivery of high quality, safe and efficient services and ensuring that care is delivered in an integrated way for patients and service users. A number of Integrated Care Programmes have been developed spanning acute, mental health, primary care, social care and health and wellbeing services. The programmes are being implemented on a phased basis in the areas of patient flow, children, maternity, older people and prevention and management of chronic disease and represent a new phase in health care reform looking at where programmes need to be joined up to provide a more effective end-to-end patient journey, particularly where patient needs are complex and involve multiple encounters across a range of providers.

Nursing and Midwifery Services

In February, at the second Medicinal Product Prescribing Conference in Dublin, a number of documents including a toolkit were launched to support services introducing nurse and midwife medicinal product prescribing in Ireland.

Since primary legislation was introduced seven years ago, 668 nurses and midwives throughout the country are registered as nurse prescribers. These nurse prescribers work across 177 health service providers and within 102 clinical specialities.

Public Health Nurse of the Year, Bernie Long



Enabling support services

Critical to reform are the corporate enabling services such as ICT, Finance, HR and Health Business Services. Each of these services are evolving and reforming to ensure they are best positioned to fully support our health system into the future.

Further detail of these reform programmes can be seen throughout this Report.

Our Workforce

Our staff are the heart of our health system – doctors, nurses, health and social care professionals and all other healthcare providers working in our hospitals and communities.

During 2014, for the first time since the downturn of our economy, a growth in staff numbers was evident.

Building a sustainable workforce for our future we continue to invest in and promote a workforce that is dedicated to excellence, welcomes change and innovation, embraces leadership and teamwork, and maintains continuous professional development and learning. Additional information on Human Resources can be read on page 50.

Employment Control Framework

At the end of December 2014, the health sector employed 97,791 WTEs. This figure excludes approximately 3,204 WTE staff that transferred at the start of the year to Tusla, the Child and Family Agency and also excludes those employed as part of the Graduate Nurse Programme and Support Staff Intern Scheme.

Of the 97,791:

- 61,973 are employed with the HSE
- 22,267 are in the voluntary hospital sector, and
- 13,551 are in the voluntary non-acute sector.

Compared to the downwards trend in previous years' employment, in 2014 the health service saw growth in the numbers of staff employed across all grade categories other than General Support Staff which had a decrease of 3.6%.

The increase in employment levels is reflected as follows:

- 5.6% in medical/dental
- 3.9% in health and social care professionals
- 1.4% in nursing

- Nurse Graduate Programme and Support Staff Intern Scheme:

  As at the end of December 2014, a total of 1,536 employees were participating in the Nurse Graduate Programme and Support Staff Intern schemes (an increase of 1,034 whole time equivalents (WTEs) compared to 2013) as follows:
  - 298 WTEs in Graduate Nurse Scheme
  - 116 WTEs in General Support Intern
  - 1,122 WTEs in Other Care Interns.

Key messages from 2014:

- The primary driver of growth in the number of staff employed was in the acute hospital sector (up 1,361 WTEs compared to 2013).
- Consultant appointments since 2008 have increased from just over 2% to 2.7% of the overall health sector employment numbers.
- Employment overall has reduced by 14,980 WTEs or just over 13% since its peak in September 2007.
- The numbers employed in the management/ administration category are down nearly 18% since peak employment in 2007.
- 836 new development posts were filled (from 2013 and 2014 service plans).
- 3,582 WTEs above employment ceiling of 94,209.

Table 1: Health Service Personnel 2014 by Staff Grouping

Division	WTE Dec. 2013	WTE Dec. 2014
Consultants	2,555	2,635
NCHDs	4,919	5,302
Other Medical and Dental	879	881
CNSs, ANPs, Nurse Managers	7,468	7,934
Staff Nursing	24,130	24,125
Other Nursing	2,137	2,152
Therapists (Physio, OT, SLT)	3,594	3,764
Other Health and Social Care	9,483	9,819
Management and Admin.	15,038	15,112
Ambulance	1,546	1,556
Care Staff	15,096	15,208
Support Services	9,648	9,303
Total Health Service*	**96,494**	**97,791**
Graduate Nurses, Support and Care Interns	502	1,536
Total Employment (excl. Home Helps)	**96,995**	**99,327**

Data source: Health Service Personnel Census

* Employment Control Framework (ECF) basis (excluding Graduate Nurses, Home Helps, Support and Care Interns)

Table 2: Health Service Personnel by Division

Division	WTE Dec. 2013	WTE Dec. 2014
Acute	48,270	49,631
Mental Health	8,916	8,967
Primary Care	9,417	9,485
Social Care	24,391	24,252
National Ambulance Service	1,615	1,623
Health and Wellbeing	1,266	1,233
Corporate and HBS	2,619	2,599
Total Health Service*	**96,494**	**97,791**
Graduate Nurses, Support and Care Interns	502	1,536
Total Employment (excl. Home Helps)	**96,995**	**99,327**

Data source: Health Service Personnel Census

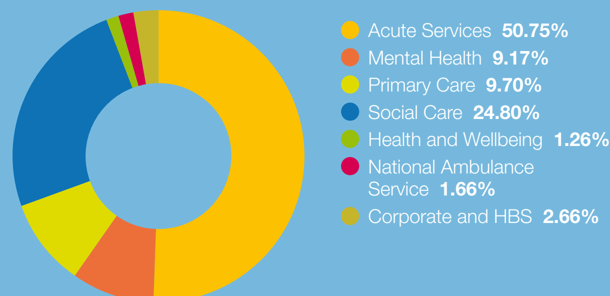
* Employment Control Framework (ECF) basis (excluding Graduate Nurses, Home Helps, Support and Care Interns)

Employment growth seen in 2014 led to significant employment control and cost challenges. Challenges have been experienced in meeting the employment and cost reduction targets originally set for 2014. This was further compounded by the significant increase in agency expenditure during the year.

National Doctors Training and Planning

Work continued with all stakeholders in implementing the recommendations of the *Strategic Review of Medical Training and Career Structure (MacCraith Report)* to optimise retention of our medical graduates.

Figure 1: Staff distribution December 2014



Data source: Health Service Personnel Census

- To respond to the increased number of European Economic Area (EEA) graduates from the six Irish medical schools, 44 additional intern posts were created in July, bringing the total number of posts to 684.
- Additional training posts were created for specialist training by converting suitable service-grade NCHD posts into basic and higher specialist training posts. The number of doctors in specialist training in 2014 was 2,943.

European Working Time Directive

Non-consultant hospital doctors (NCHDs) play a very important and fundamental role in our hospitals. In 2014, a focus was maintained on compliance with the European Working Time Directive (EWTD) amongst hospital NCHDs, in line with the implementation plan submitted to the European Commission in 2012. Data collated at the end of December indicated that in relation to 5,302 NCHDs (including 674 interns, 1,594 Senior House Officers, 2,034 Registrars and 1,000 Specialist/Senior Registrars):

- 67% were compliant with the 48 hour average working week.
- 94% did not work more than 24 hours on-site on call.
- 99% received documented daily breaks.
- 95% received 11 hour daily rest breaks or equivalent compensatory rest.
- 98% received weekly/fortnightly rest or equivalent compensatory rest.
- There is partial adherence with the requirement that EWTD compliance is specified as a key performance indicator for managers.

Full compliance with EWTD remains a significant challenge for the Health Service.

Absence Rate

The annual absence rate in 2014 was 4.3%, which showed a significant reduction on the 2013 absence rate of 4.7%. 90.4% of all absence was medically certified. The downward trend seen in recent years has been as a direct result of the continued management focus on managing absence. The accelerated decline in 2014 can also be attributed to the impact of changes to the paid sick leave scheme which came into effect on the 31st March 2014.

- New public sector sick leave arrangements:

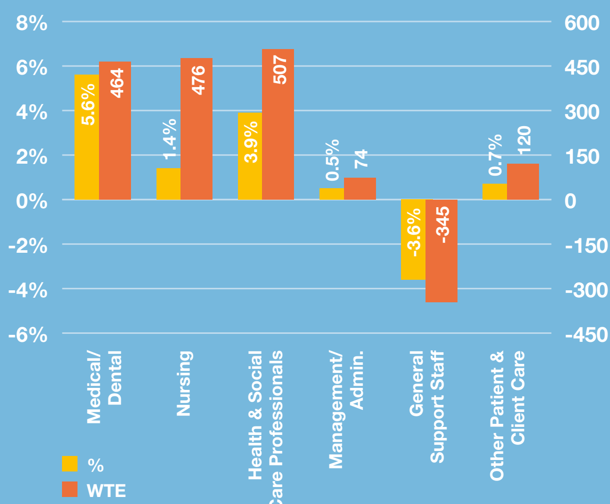
  Following the introduction of the new public service sick leave scheme in the health sector in March 2014, an information pack on the revised arrangements was issued to health service employers. The rationale for the new scheme is to increase productivity and lower the cost of sick leave, by reducing the periods during which paid sick leave will be available and capping the period during which 'temporary rehabilitation remuneration', formerly 'pension rate of pay', may be paid.

Table 3: Absence rate by staff category 2013-2014

Division	2013	2014	Change
Medical/Dental	1.30%	1.18%	-9.2%
Nursing	5.28%	4.62%	-12.5%
Health & Social Care Professionals	3.99%	3.53%	-11.5%
Management/Admin.	4.64%	4.35%	-6.3%
General Support Staff	5.37%	4.76%	-11.4%
Other Patient and Client Care	5.33%	5.19%	-2.6%
Total	**4.73%**	**4.27%**	**-9.7%**
Certified	*90.35%*	*90.42%*	*+0.1%*

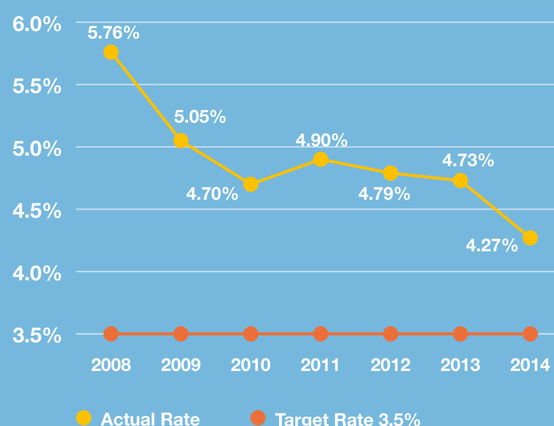
Data source: HSE HR – Management information

Figure 2: WTE and % change December 2013 - December 2014



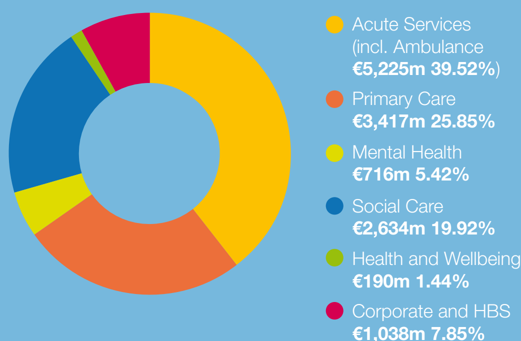
Data source: Health Service Personnel Census

Figure 3: Absence rate 2008-2014



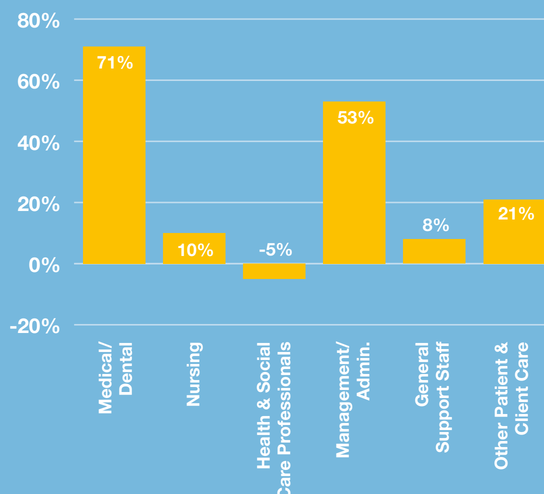
Data source: Health Service Personnel Census

Figure 4: Breakdown of total expenditure 2014 (€m)



Data source: HSE Corporate Finance

Figure 5: Variance in agency costs 2013-2014



Data source: HSE Corporate Finance

Finance

The total HSE expenditure in 2014 was €13.220 billion (bn) for the delivery and contracting of health and personal social services. A supplementary estimate of €680m was voted by Government to the HSE at the end of the year to provide for increased levels of medical activity, drugs and therapies, medical appliances, cost of State claims and frontline staff. The supplementary was included in the 2015 base budget.

The main areas of expenditure are set out in Figure 4.

In progressing the HSE Capital Plan 2014, the total capital expenditure was €357m, which included capital grants to voluntary agencies of €53m. Further information on capital and ICT infrastructure developments can be found on pages 52-53.

Comprehensive financial information can be found in the Annual Financial Statements in the second part of this Annual Report.

Payroll (Statutory and Non-Statutory)

Payroll savings of €268m were required in the 2014 National Service Plan. This included €140m to be facilitated by the *Haddington Road Agreement*, €108m in unspecified pay savings and €20m in respect of the Employment Control Framework (ECF).

The overall pay bill of the Health Service, including voluntary service providers and excluding superannuation, increased by €132.8m (2%) in 2014. Basic pay increased by €56.16m (1%), overtime payments reduced by €21.57m (-10%), on call increased by €4.54m (6%), and allowances reduced by €12.12m (-8%). However, there was a 37% increase in agency expenditure compared to 2013. The acute sector accounted for a 40% increase with a 21% increase in the non-acute sector. The greatest increase in the acute hospital sector, when compared to 2013, was in relation to the medical/dental pay category at nearly 81%. This increase has been driven by difficulties in recruitment of NCHDs in some hospitals.

- Overtime amounted to 6% of all pay costs (excluding superannuation).
- Agency costs amounted to 4% of all pay costs (excluding superannuation).

Governance Arrangements with the Non-Statutory Sector

The HSE provided funding of €3.425bn to non-statutory agencies to deliver health and personal social services:

- Acute voluntary hospitals €1.822bn (53%)
- Non-acute agencies €1.603bn (47%).

Over 1,900 agencies were funded, with over 3,000 separate funding arrangements in place. Nine agencies accounted for over 51% of the funding and ninety agencies accounted for over 90% of the funding.

The HSE has sought to enhance its governance arrangements with Section 38 agencies and also to strengthen the direct relationship between the HSE and the Boards of each of these Agencies. In particular:

- A formal engagement process was established with the Chairs of Section 38 Boards, including formal meetings twice a year.
- A new Compliance Statement was introduced whereby the Chair and another Director of the Board signs and confirms on behalf of the Board that the Agency had complied in full or in part with eight key areas under their Service Arrangement.
- Best practice requirements for Boards and Corporate Governance arrangements were defined.

In addition:

- A Compliance Unit was established in October to further support a strong culture of compliance across all Section 38 and 39 Agencies funded by the HSE. It will seek to ensure that all Section 38 and 39 Providers are compliant with the guidelines and regulations covered by Service Arrangements.

The requirement for an Annual Compliance Statement came into effect on 1st January 2014, applicable to each agency's 2013 Annual Financial Statements with a requirement for agencies to have a plan in place to achieve compliance in respect of 2014.

The Annual Compliance Statement process has resulted in many Boards of Provider Agencies undertaking projects to enhance their Board's governance, including the development of Corporate Governance Manuals, updating their Code of Governance and carrying out Audits of existing governance arrangements.

All Section 38 agencies have signed the Annual Compliance Statement in respect of 2013. There is a good level of compliance with HSE requirements with the exception of a number of identified areas for which a plan to reach compliance is being put in place by the relevant agencies.

Listening to our Service Users

Introduction

Ensuring involvement within the health service of patients, service users, their carers and their families is central to how healthcare services are designed, delivered and evaluated. The National Healthcare Charter *You and Your Health Service* describes key principles in relation to the provision of healthcare in Ireland with a focus on patients' and service users' rights, expectations and responsibilities. It promotes the partnership approach between everyone – healthcare providers and patients, service users, families and carers. The Charter continues to be reviewed and updated to reflect best practice.

A number of priority areas were progressed during the year, facilitated by the National Advocacy Unit, to promote patient and service user involvement across the health service. Some of these are set out below:

Advocacy

- We have invested in a Volunteer Advocacy Programme for older people through Third Age (Sage), a support and advocacy service for older people, making independent advocacy available in a number of settings including acute hospitals, long stay residential units, primary care centres and in the community. This is being carried out in conjunction with Atlantic Philanthropies.
- Listening sessions to gain qualitative feedback were undertaken with older people in a number of counties including Galway, Kilkenny, Meath, Kildare and Dublin City North West as part of Age Friendly Counties, which builds on the valuable role that older people can and should play in shaping their communities for the better.

Patients for Patient Safety Ireland

- Work continued on facilitating and supporting the work of Patients for Patient Safety Ireland, a national network of patient safety champions, including conducting a patient survey and having representation on the National Office of Clinical Audit Governance Committee and National Clinical Effectiveness Committee.

The Director General of the HSE, Tony O'Brien, has appointed Leigh Gath, a well-known disability advocate, as a 'Confidential Recipient', independent of the HSE, to whom anyone can make a complaint or raise concerns about the care and treatment of any vulnerable person receiving residential care in a HSE or HSE funded facility

Accessibility

- The *National Guidelines on Accessible Health and Social Care Services* were completed.
- Nationwide Access Officer training commenced in a number of locations with 70 Access Officers trained during the year.
- Draft model of care on transgender health was developed and consultation process commenced.

Open Disclosure

- Our open disclosure policy fosters a fair and just culture within healthcare and its implementation is a key priority for us. A number of initiatives were progressed during the year:
  - Train the trainer programme was developed and piloted.
  - The independent evaluation of the pilot sites commenced.
  - One day workshop was developed and delivered in the Royal College of Surgeons in Ireland (RCSI).
  - Work commenced with the Royal College of Physicians of Ireland (RCPI) quality assurance programme.
  - Workshops were delivered to graduate nursing students from St. Angela's College in Sligo and Letterkenny Institute of Technology.

Compliments and Complaints

Health Service Executive

(Excluding Voluntary Hospitals and Agencies)

The comments, compliments and complaints of service users and their families are welcomed and valued, as they allow us to continually improve our services.

In 2014, there were 6,179 compliments recorded, although many go unrecorded. Work is ongoing to encourage all staff to record compliments as they allow us to capture data on the positive aspects of our services and learn from what is working well.

There were 8,375 complaints recorded and examined by complaints officers, an increase of 22.8% on the number received in 2013. Of the total number of complaints received, 5,704 or 68% were dealt with within 30 working days.

Table 4: HSE complaints received and % dealt with within 30 working days

	No. of complaints received	No. and % dealt with within 30 working days
2014	8,375	5,704 (68%)
2013	6,823	4,651 (68%)
2012	6,813	4,664 (69%)
2011	7,449	5,623 (75%)

Data source: HSE Quality Improvement Division

Table 5: Complaints received by category 2013-2014

Category	2013	2014
Access	1,622	2,130
Dignity and Respect	720	868
Safe and Effective Care	1,631	2,520
Communication and Information	1,046	3,517
Participation	60	58
Privacy	68	141
Improving Health	84	124
Accountability	217	307
Other	1,512	460
Clinical Judgment	113	116
Vexatious Complaints	20	11
Nursing Homes/residential care for older people (65 and over)	30	56
Nursing Homes/residential care (aged 64 and under)	2	5
Pre-School inspection services	162	49
Trust in Care	29	22
Children First	34	8

Data source: HSE Quality Improvement Division

Note: Some complaints contain multiple issues and therefore fall under more than one category

Voluntary Hospitals and Agencies

In 2014, there were 12,639 compliments recorded, although many go unrecorded.

There were 10,752 complaints recorded and examined by complaints officers, an increase of 93% on the number received in 2013. Of the total number of complaints received this year, 9,794 or 91% were dealt with within 30 working days.

Table 6: Complaints received by category (voluntary hospitals and agencies) 2013-2014

Category	2013	2014
Access	1,410	2,838
Dignity and Respect	441	1,103
Safe and Effective Care	1,505	3,032
Communication and Information	1,622	2,979
Participation	47	102
Privacy	83	125
Improving Health	88	164
Accountability	71	398
Other	1,320	525
Clinical Judgment	–	168
Vexatious Complaints	–	19
Nursing Homes/residential care for older people (65 and over)	–	7
Nursing Homes/residential care (aged 64 and under)	–	89
Pre-School inspection services	–	0
Trust in Care	–	690
Children First	–	140

Data source: HSE Quality Improvement Division

Note: Some complaints contain multiple issues and therefore fall under more than one category

Complaints reporting in respect of outsourced health and personal social services has been strengthened under the HSE Governance Framework.

A national register of funded agencies was established enabling comprehensive compliance reporting. This was further enhanced by the introduction of Service Provider Governance (SPG) OnLine which furthers compliance with good governance by means of an on-line comprehensive control environment.

Complaints under Parts 2 and 3 of the *Disability Act 2005*

399 complaints were received under Part 2 of the *Disability Act 2005* in relation to a child's assessment of need for disability services. Two complaints were received under Part 3 of the *Disability Act 2005*, access to buildings and services for people with disabilities.

How to give a compliment, make a comment or complaint

- Talk to any member of HSE staff, service manager or Complaints Officer
- Email yoursay@hse.ie with your feedback
- Send a letter or fax to any HSE location
- Ring the HSE on 1850 24 1850
- Use the HSE website form at *www.hse.ie/eng/services/yourhealthservice/focus/ysys.html*

Reviews

There were 216 requests for review received. This represents an increase of 2.86% in the number of review requests received and examined since the previous year. A review can be requested under Part 9 of the *Health Act 2004* when a complainant is dissatisfied with the recommendations made following the investigation of their complaint. A review was requested in 2.5% of complaints that were made.

National Information Line

A total number of 105,205 calls were received by the National Information Line in 2014. This represents a decrease of 9,596 calls or 8.36% compared with 2013. Limerick Customer Service Centre, which is part of the National Information Line and provides a walk-in service, received 5,540 visitors and 1,910 postal queries.

Our Population

Our Population

- 4.609 million (m) people live in Ireland, a slight increase of 0.8% since the 2011 Census but an 8% increase since the 2006 Census.
    - While there is minimal growth in the overall population, the numbers and proportion of those in the older age groups is increasing rapidly.
    - The increase in the number of people over 65 is approaching 20,000 per year.

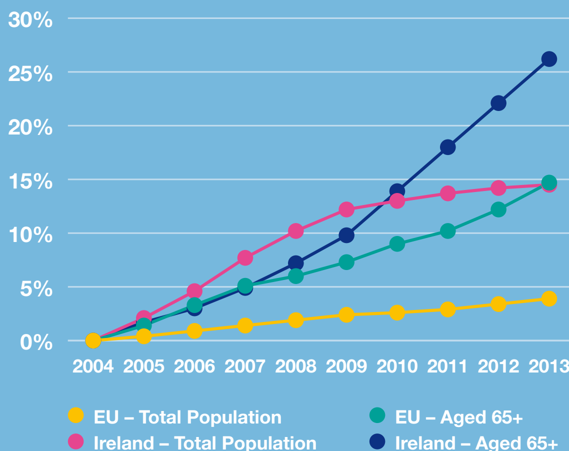
In Addition

- Ireland has the highest fertility rate among EU countries but the birth rate has fallen to its lowest since 2005.
- 22,033 marriages were registered. Of these, 6,167 were civil marriages, 32% of which were conducted outside a registration office.
- 392 civil partnerships were registered. Of these, 24% were conducted outside a registration office.

Life Expectancy and Mortality Rates

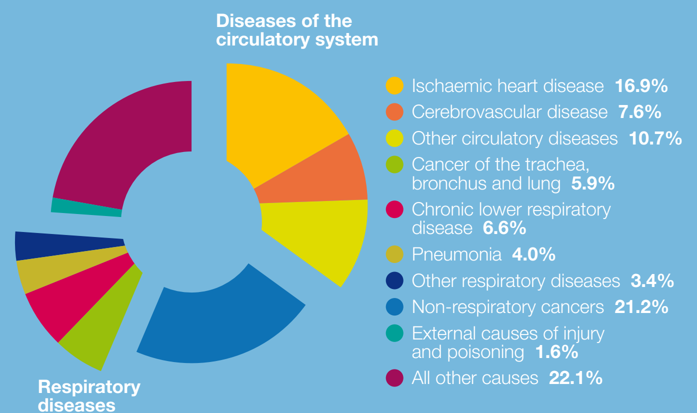
- Life expectancy in Ireland has increased by almost three years since 2003 and is now above the EU average.
- Although women have a higher life expectancy than men (women 83.2 years and men 78.7 years) when life expectancy is expressed as years lived in good health (or healthy life years) at age 65, the difference between women and men is less significant, indicating that women live longer but with more health problems.
- Three quarters of deaths in Ireland are due to three chronic diseases – cancer, cardiovascular disease (coronary heart disease and stroke) and respiratory diseases (including Chronic Obstructive Pulmonary Disease or COPD). These are largely preventable by modifying lifestyle risk factors such as obesity, smoking and alcohol.
- The cause of death for those aged over 65 years is very different to those aged 64 years and under
    - For those aged over 65 years, mortality is attributable to circulatory system diseases and cancer.
    - For those aged 64 years and under, heart disease and cancer remain significant causes; deaths from injury and poisoning are much more prominent, accounting for 18% of all premature deaths (compared to less than 2% in those aged 65 years and over).
- Mortality rates from diseases of the circulatory system remain the major cause of death (32%) but have declined over the last decade, by 30% since 2004. Cancer death rates decreased by 10%. Overall mortality rates in Ireland are nearly 4% lower than in the EU.
- Survival rates for breast and colorectal cancer show significant improvement over the past 15 years, though the 5-year survival remains just below the EU average. Survival from cervical cancer is showing a marginal decline over the same period.
- Prevalence of chronic disease is expected to increase by 20% by 2020 primarily driven by the ageing population.

Figure 6: Cumulative % increase in population 2004-2013



Data source: Eurostat

Figure 7: Deaths by principal causes, % distribution 2013, ages 65 and over



Data source: Central Statistics Office

Healthy Ireland

Many diseases and premature deaths are preventable. Increased morbidity and mortality are strongly related to lifestyle-based health determinants such as smoking, alcohol consumption, exercise and obesity. They are also related to inequalities in our society. The *Healthy Ireland* framework sets out a comprehensive and co-ordinated plan to improve health and wellbeing over the coming years. This is being actively implemented across all areas of the HSE.

Former Minister for Health, Dr. James Reilly TD, and An Taoiseach Enda Kenny TD at the publication of the Healthy Ireland framework at Government Buildings (Photograph courtesy of the Department of Health)

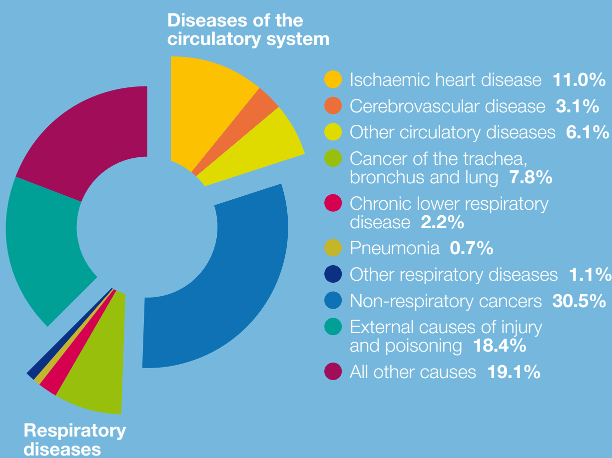
Health Inequalities

Although the health of Ireland's population has improved over the last decade, this has not been the case for everyone, and significant health inequalities remain which are largely avoidable.

- Life expectancy is greater in more affluent areas compared to deprived areas.
- Adults living in more deprived areas are more likely to be living with a chronic condition.
- Life expectancy is greater for professional workers compared to the unskilled. This pattern has increased since the 1990s.
- Death rates are two times higher for those who only received primary education compared to those with third level education.
- If economic mortality differentials were eliminated, it would mean 13.5 million extra years of life for Irish people.
- A larger proportion of people from lower socio-economic groups have high blood pressure, raised cholesterol and are obese. In addition, they report lower levels of physical activity, have a poorer diet, and are more likely to smoke and binge drink.
- There are significant health inequalities among marginalised and disadvantaged groups. Travellers for example have higher mortality rates and lower life expectancy than the general population.

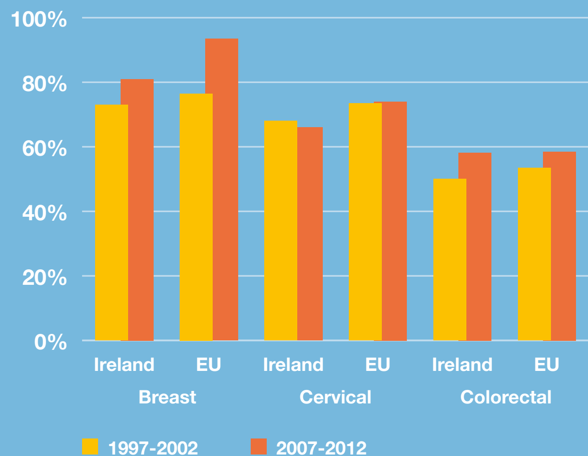
In addition, approximately 12% of our population are born outside Ireland. We have increased ethnic and cultural diversity. We must ensure that our service delivery models are responsive to meet the needs of all our service users.

Figure 8: Deaths by principal causes, % distribution 2013, ages 0-64



Data source: Central Statistics Office

Figure 9: 5-year survival rates from selected cancers, 1997-2002 to 2007-2012, Ireland and selected EU countries



Data source: Health Care Quality Indicators, OECD

Health and Wellbeing

FACTS AND FIGURES IN 2014

- 96% uptake in 6 in 1 childhood vaccination at 24 months
- 93% uptake in MMR vaccine at 24 months
- 138,779 women attended for breast screening
- 35,020 planned, and planned surveillance inspections of food business undertaken
- 18,227 tobacco control inspections carried out
- 84% uptake of 3rd dose of HPV vaccine among 1st year girls
- 97% newborn babies visited by PHN within 72 hours of hospital discharge
- 92% children reaching 10 months of age have had their child development screening before reaching 10 months of age
- 16,000 people were provided with support to quit smoking from a cessation specialist or by signing up to an online QUIT plan

Introduction

Supporting people to live healthier and more fulfilled lives is a key priority for us. Health and Wellbeing services cover the areas of public health, health protection, child health, national screening programmes, health promotion and improvement, environmental health, emergency management and health intelligence.

Key priorities for 2014 included:

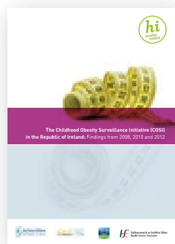
- Immunisation, child health screening
- Chronic disease prevention addressing tobacco use, diet, physical inactivity, alcohol misuse and mental wellbeing
- Enforcement of legislation to protect health and wellbeing
- Response to infectious diseases, environmental health threats and emergency management
- Implementation of the *Healthy Ireland* framework.

Progressing our Strategic Priorities

Child Health

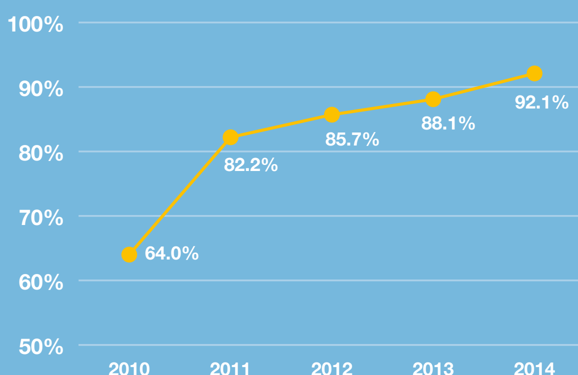
- 62,605 children or 92% of children received child developmental health screening within the target time. This has increased by 4.5% on 2013.
- 54,007 newborns or 86% of newborns were visited within 48 hours of hospital discharge against a target of 95%, and 97% were visited within 72 hours of discharge.
- Childhood immunisation rates in Ireland are at the highest levels ever recorded with 96% uptake in the 6-in-1 at 24 months and 93% uptake in MMR at 24 months.

Obesity



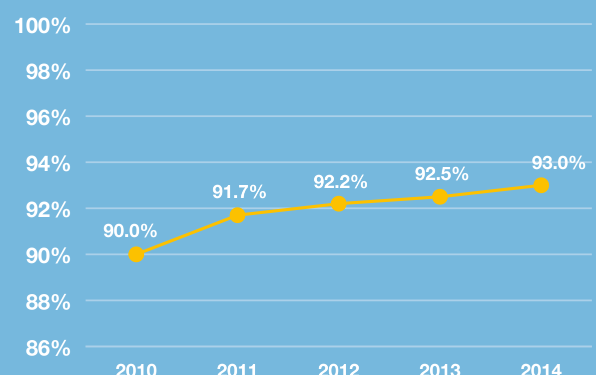
- The third set of results from the European Childhood Obesity Surveillance Initiative (COSI) was published. COSI monitors childhood obesity levels by measuring children in sample schools all over Europe. This data involves a nationally representative sample of seven, nine and eleven year old children from a mix of urban, rural and disadvantaged (DEIS) schools. The results have shown that rates of overweight and obesity have shown decreases at age seven and stabilisation at age nine while the overall incidence remains of concern.

Figure 10: % of children reaching 10 months who have had their child development health screening before 10 months



Data source: HSE Performance Reports

Figure 11: Uptake in MMR vaccination at 24 months 2010-2014



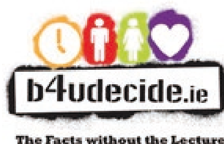
Data source: HSE Performance Reports

- A package of obesity reduction programmes are being supported including the Healthy Ireland Smart Start Programme. This is being rolled out to pre-school management and staff across all counties. Additional funding of €0.1m is supporting these programmes.
- The HSE-ICGP (Irish College of General Practitioners) Weight Management Treatment Algorithm for Children was distributed to 3,500 GPs supported through online training.
- 2,700 GPs accessed the physical activity module of the e-learning Brief Intervention Training.
- A new policy for Healthy Vending (cold soft drinks, confectionery and snack vending machines) was approved and is being implemented across the organisation. This aims to promote easy access to healthy foods for people visiting and using our services and for staff also. Under this policy, all vending machines will stock, as a minimum, 60% healthier options and 40% other products.

Healthy Ireland

- 465 schools nationally (12%) participated in the Health Promoting School model in 2014.
- The National Healthy Cities of Ireland Network received accreditation to the European Network of Healthy Cities Networks in Phase VI (2014-2018) in October. A Clinical Lead for Health and Wellbeing was appointed, playing a key leadership role in embedding prevention, early detection and self care within the five integrated care programmes.

Sexual Health



- The B4uDecide education programme which provides online relationship and sexual information to young people, launched its new website. On surveying 15-18 year olds recently they stated that what they wanted were the 'facts without the lecture' with faster downloads, more interactivity and personal stories. This new website provides this as well as resource materials for teachers and youth workers.
- Through the Think Contraception 'Johnny's got you covered' campaign, approximately 100,000 protection packs (containing sexual health information and a condom) were distributed nationwide at over 43 public events and festivals.

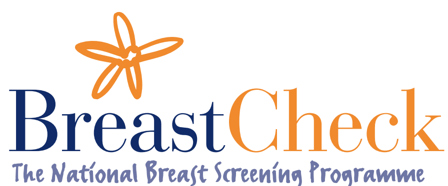
Healthy Ireland

A cross divisional steering group was established in 2014 to progress the *Healthy Ireland Implementation Plan* for the health services. The first site-specific hospital group Healthy Ireland implementation plan was also developed. A dedicated programme lead for *Healthy Ireland* is in place.

Health Protection

- In response to the increase in the number of cases of Verocytotoxigenic E.Coli (VTEC) in recent years, the HSE and Environmental Protection Agency launched an information campaign, including printed infographics for GP surgeries and pharmacies, posters and an online app for private well owners aimed at increasing awareness of the risk of VTEC infection, particularly to children, and how to test water.
- 437 outbreaks of infectious diseases were notified under the National Infectious Disease reporting schedule
    - 328 cases of tuberculosis (a rate of 7.1 per 100,000, the lowest ever rate in Ireland)
    - 718 cases of VTEC
    - 1,190 cases of Hepatitis.
- The winter 2014 'flu campaign was launched in October with a special emphasis on encouraging healthcare workers to avail of the vaccine. 750,000 doses of the vaccine were purchased in preparation for the 'flu season.

Mr. Tony O'Brien, HSE Director General, receiving the 'flu vaccine from Bríd O'Malley, Clinical Nurse Manager



The National Breast Screening Programme offers women aged 50-64 a free mammogram every 2 years

- 138,779 women attended for breast screening in 2014 in line with screening round (two-year) target
- From Q4 2015 the programme will be expanded over a number of screening rounds to all women aged 65-69 years

The National Cervical Screening Programme offers free smear tests to women aged 25-60 years

- 266,801 women attended for screening in a primary care setting
- This was 15.4% less than 2013 which is reflective of fewer eligible women due to:
  - Shift in demographics (ageing population)
  - Commencement of move to 5 (previously 3) year screening round for women aged 45-60
- Guidelines for *Quality Assurance in Cervical Screening (Second Edition)* was published

The National Diabetic Retinal Screening Programme offers screening aimed at reducing the risk of sight loss amongst people with diabetes aged 12 and upwards

- €4.5m was made available in 2014 to deliver screening and treatment for Diabetic RetinaScreen
- 115,907 people were invited to participate in Diabetic RetinaScreen programme in 2014
- 2014 saw the completion of the first round of screening
- From 2015 screening will be offered on an annual basis
- The increase in the prevalence of diabetes in the population will present a year on year increase in the numbers eligible for the programme.
- *Clinical Practice Guidelines for Treatment Clinics (First Edition)*, developed by Diabetic RetinaScreen, was endorsed by the Irish College of Ophthalmologists

The National Bowel Screening Programme screens for the early detection of bowel cancer in men and women aged 60-69 years (Phase 1)

- €2m was made available in 2014 to continue the roll out of the first round of BowelScreen
- 500,000 people are eligible within the 60-69 years age group
- 212,141 were invited to participate
- The first round of screening is planned to be completed by the end of 2015
- From 2016 onwards screening will be offered at a two year interval

Ebola Preparedness

- The National Public Health Emergency Team on Ebola met on a frequent basis to update the level of preparation of the health system in the event of a case of Ebola in Ireland. A range of useful information about Ebola was brought together and is available on www.hse.ie including key facts, frequently asked questions, video interviews and useful links.
- The HSE's Emerging Viral Threats group continued their intensive efforts ensuring that appropriate guidance, procedures and equipment was in place to manage any case of Ebola in Ireland which may arise. Training and interagency exercises for staff were held in three centres: Dublin, Galway and Cork.

Tobacco Control

We strive to continue to improve the effectiveness of our smoking cessation services. Additional funding of €0.1m was made available in 2014 to establish a new, integrated QUIT smoking support service, moving from a phone service to a multimedia, patient centred service that can be accessed through a wide range of channels.

- 9,309 smokers received intensive cessation support from a cessation counsellor, 7,500 were provided with online cessation support and 1,303 health care professionals have been trained in brief intervention in smoking cessation. An evaluation of this training was completed, with preliminary findings indicating positive impact of training on long term skills and changes in practice.
- 100% of hospital campuses are complying with tobacco-free policy; 69% of primary care campuses were tobacco free against a target of 70%.
- At any given time, 7 out of every 10 smokers want to quit and the evidence is that getting help and support with a quit attempt, doubles their chances of success. The HSE's QUIT campaign prompted an estimated 150,000 quit attempts in 2014, and the prevalence of smoking in the population aged over 15 decreased by 2 percentage points, or by 70,000 smokers. The QUIT campaign won two awards at the Institute of Advertising Practitioners in Ireland Advertising Effectiveness Awards in 2014. These awards are given to advertising campaigns that deliver real results and acknowledge the powerful impact made by recent QUIT campaign adverts featuring the late Gerry Collins, his family and their experience of his smoking-related lung cancer.
- The new integrated, interactive HSE QUIT service went live providing access and support for smokers across phone, text, social media and online channels, and smokers who choose not to engage with the QUIT team can avail of an enhanced self-help service by signing up to the QUIT plan.

For more support, contact the **Quit Team**, Monday to Friday 10am-7pm and Saturday 10am-1pm.

CALL 1800 201 203

EMAIL *support@quit.ie*

TEXT Freetext QUIT to 50100

TWEET *@HSEQuitTeam*

FACEBOOK *facebook.com/HSEQuit*

Environmental Health Protection

- 35,020 planned, and planned surveillance inspections of food business were undertaken, 6% ahead of target.
- 8,398 microbiological food samples were taken, and 3,980 chemical food samples were taken and assessed.
- 2,746 drinking water samples were assessed for compliance with fluoridation of drinking water supply requirements.
- 18,227 tobacco control inspections were carried out, including 482 test purchase (sales to minors) inspections conducted, 105 of which were non-compliant.
- Overall compliance with the *Public Health (Tobacco) Act* has been high. Convictions for tobacco-related offences were published for the first time in 2014 as a means of raising awareness of the legislation. There were 41 convictions in 2014.
- 124 Environmental Impact Assessment consultation requests were responded to and reports completed.
- 394 cosmetic product samples were taken and analysed, of which 21 had unsatisfactory results.

HPV Vaccine

This free vaccination programme involves the administration of 3 doses of HPV vaccine scheduled at 0, 2 and 6 months helping more than 42,000 girls from developing cervical cancer.

A report was published on the uptake rates for the 2012/2013 nationwide HPV vaccination campaign. The routine programme for 1st year girls during 2012/2013 was well received with an uptake rate of 84% for the 3 vaccine doses, well above the target of 80% uptake rate.

Most of the vaccinations were administered in schools by HSE immunisation teams with some girls being invited to HSE clinics for their vaccine.

The 2014/2015 school programme provides routine HPV vaccination for all 1st year girls as the catch-up programme was completed at the end of 2013/2014.

In addition a Men C booster was introduced for 1st year girls and boys. This vaccine is routinely given to babies but the immunity reduces over time so a booster is recommended for teenagers to provide additional protection.

Clodagh Armitage, Dr. Cate Hartigan and Dr. Nazih Eldin, Health Promotion and Improvement, HSE, with participants and former participant Bressie (Niall Breslin) at the opening of the Community Games

Community Games Festival

No matter what activity or sport you do with HSE Community Games, being healthy and active is the ultimate end goal… no Gold Medal can compare with creating lifelong healthy habits.

- The HSE Community Games Festival teamed up with *Healthy Ireland*, the new national initiative that is promoting health and wellbeing throughout the country. A particular focus was on healthy eating with a decision to remove the temptation of having burgers and chips at the event as a step in the right direction towards a healthy Ireland. As well as healthy eating, the focus was on participation and every child proudly went home with their own Participation Pin.
- The National Festival is held over two weekends every year in August attracting over 7,000 visitors. Almost 3,000 children took part in more than 40 different events over the course of the festival.

Participants and Bressie (Niall Breslin) fitness ambassador, at the Community Games.

Improving Quality and Delivering Safe Services

Introduction

Underpinning the delivery of all our services is the commitment to ensuring high quality and safety. This remained an important focus in 2014, in particular:

- Ensuring that each Director and the managers and clinicians within their areas of service are responsible and accountable for ensuring the provision of safe, quality services
- Supporting quality improvement initiatives across the health services that aim to enhance patient safety
- Improving the experience of patients and service users within the health services
- Ensuring that standards, policies and guidelines are understood and appropriately implemented by health service staff
- Putting in place a comprehensive set of quality and safety indicators to measure the quality and safety of our services.

Our ethos is to ensure that all health service staff, individually and collectively, have a responsibility for the quality of the services they deliver to the patients and service users in their care, and integrate a commitment to quality and safety into their core work and practice.

In 2014, additional investment of €0.86m was allocated to support us in progressing quality and safety priorities.

Quality Enablement Programme

Towards the end of 2014, a Quality Enablement Programme was established to support quality and safe care that is consistently person centred. Quality improvement and assurance underpin this approach, led by both the Quality Improvement Division and the Quality Assurance and Verification Division.

The four key objectives of the programme are that:

1. Services must subscribe to a set of clear quality standards that are based on international best practice
2. Services must be safe with a robust level of both quality improvement and quality assurance
3. Services must be relevant to the needs of the population
4. Patients and service users must be appropriately empowered to interact with the service delivery system.

By a combination of clinical leadership, strong management and clear accountability for quality and safety across all services, we are committed to ensuring that learning and continuous quality improvement remains at the heart of health service delivery. 2015 will see the first full year's implementation of this programme.

Progressing our Strategic Priorities

- The *Quality Enablement Programme* was established.
- 47 acute hospitals and five community areas implemented the *Open Disclosure* programme with a number of national staff briefings, workshops and trainer programmes delivered.
- During the year to help support sustainable quality improvement capacity and capability building in the organisation:
  - 50 participants undertook the Diploma in Leadership and Quality.
  - Regional training was delivered by the National Leadership and Innovation Centre for Nursing and Midwifery to reduce rate of harm from falls for patients in various institutions.
  - A second cross border patient safety programme, in collaboration with the RCPI, Health and Social Care Safety Forum in Northern Ireland and Co-operation And Working Together, commenced in Q1.
- An updated Safety *Incident Management Policy* was published in May.
- A *HSE Corporate Safety Statement 2014*, agreed with the staff panel of Trade Unions and ratified at the National Joint Council, was developed which sets out how health, safety and welfare at work for its employees and others are managed in the HSE. Complying with legislation, it is based on the identification of hazards and assessment of risk.
- As part of patient advocacy the work of Patients for Patient Safety Ireland was facilitated.
- Following development and testing, additional new quality indicators were ready for public reporting. These included indicators on Medication Management and Implementation of the National Early Warning Score (NEWS).
- Implementation of the *Protection of Life During Pregnancy Act 2014* was supported.

Preventing Harm and Improving Quality of Care

- Healthcare associated infections and antibiotic resistance are serious threats to the quality of care provided. Good prevention practices are being pursued across all services. While MRSA rates in Ireland remain high compared to many countries, surveillance of MRSA and *C. difficile* infection levels (commenced in 2006 and 2008 respectively) of both have fallen, with a 62% reduction in MRSA bloodstream infections and a 14% reduction in *C. difficile* over the period to end 2013.
- The *Clean Hands Save Lives* campaign was launched aimed at healthcare workers and the public, which coincided with the WHO World Hand Hygiene Day in May. Latest compliance rates are 87.2%, an improvement on the 86.2% for Q4 2013. New materials have been developed including a video for hand hygiene best practice in primary care.
- The health service also commenced monthly hand hygiene, *S. aureus* and *C. difficile* reporting for acute hospitals in April.
- Antibiotic resistance is a global health threat and antibiotics need to be preserved for when they are really needed. The *Under the Weather* campaign and online support was launched during the year. This was developed by the HSE in partnership with GPs and pharmacists, offering straightforward advice on how to get through common illness without antibiotics. There has been an overall decrease in antibiotic use in the community, and evidence to suggest more appropriate prescribing (in line with primary care prescribing guidelines).

Tony O'Brien, Director General HSE, and Minister for Health, Leo Varadkar TD with some younger colleagues at the launch of the new *Under The Weather* website www.undertheweather.ie

Serious Reportable Events (SREs)

The HSE's Safety Incident Management Policy requires the management, reporting and investigation of all incidents that result in serious harm or death. In 2014 a subset of these incidents were designated as Serious Reportable Events (SREs) by the HSE and are subject to mandatory reporting.

All SREs must be reported to the Senior Accountable Officer. It is mandatory that investigations are undertaken in all cases and that these investigations are completed within four months of commencing.

Pressure Ulcers to Zero

An innovative healthcare initiative aimed at reducing and ultimately preventing pressure ulcers in patients was developed as part of the National Quality Improvement Programme, a joint programme between the HSE and the RCPI.

The initiative consisted of 21 teams from different healthcare settings in Dublin North East including hospitals, maternity services, primary care, public and private nursing and residential units, and disability services. These teams were made up of tissue viability nurses, healthcare assistants, household staff, nurses and midwives, physiotherapists, occupational therapists and dieticians.

Their aim was to reduce the number of avoidable pressure ulcers by 50% over a six month period. They successfully delivered a 73% reduction. Using an internationally recognised health improvement model, the teams used the SSKIN Bundle of Care to target pressure ulcers, an acronym for Skin inspection/Surface/Keep moving/Incontinence management/Nutrition. Taking a proactive approach, those at risk are identified early and interventions are targeted in the most appropriate way which can be a very clinically effective and cost efficient way of providing patient care.

It is anticipated that the lessons learned from the pressure ulcer collaborative can now be used right across the health service to implement change in other areas.

National Quality Assurance Programmes

The aim of the National Quality Assurance Programmes in Radiology, Histopathology and GI Endoscopy is to provide a framework that ensures patient safety and enhancement of patient care with improved accuracy, timeliness, completeness of reporting for diagnoses and consistent and accurate endoscopy services. The framework facilitates each participating unit to routinely review their own performance and drive improvement in key quality activities against the national aggregate performance and intelligently set targets.

The National Quality Assurance Programme in Radiology went live for quality assurance data collection in its first site, University Hospital Waterford, in June. The programme continued its roll out for data collection and data reporting (using the National Quality Assurance Intelligence System (NQAIS)) to all public hospitals by the end of the year.

Clinical Governance Development Initiative – Sharing Our Learning

Clinical governance is the system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they have delivered. The clinical governance development initiative involved:

1. Developing resources for practice – eight resource documents were developed for use. A wide range of advice was also provided to services, associations and interest groups on including the principles for quality and safety within structures, process, policies, procedures and guidelines.
2. Implementation in practice – five hospital action projects and two primary care teams. Detailed support was provided in these demonstration sites to embed the governance of care quality and patient safety in their management processes.
3. Evaluation and sharing learning – a thematic analysis of the data gathered for the evaluation was used to identify the learning and inform the development of key recommendations.

The four year initiative concluded in May with the publication of the *Report of the Quality and Safety Clinical Governance Development Initiative – Sharing Our Learning*. The main purpose of the report is to consolidate the learning and make core recommendations for health service providers, policy makers and commissioners to inform their own specific action plans. A suite of resource documents for clinical governance can be found at www.hse.ie/go/clinicalgovernance.

National Ambulance Service

Introduction

Throughout 2014 the National Ambulance Service (NAS) continued with its programme to develop a modern, quality service that is safe, responsive and fit for purpose while in the background pivotal, exciting and indeed challenging changes, both locally and nationally, thrived.

NAS continued to deliver a significant reform agenda mirroring many of the strategic changes underway in ambulance services internationally as they strive for high performance, efficiency and cope with a continuously increasing demand on services. Central to this reform is service improvement, quality and patient care with the NAS continuously striving to ensure that each patient's experience is not only safe and of a high quality but also caring and compassionate.

Progressing our Strategic Priorities

- The National Retrieval Service continued its work with:
  - 72 adult transplant patient transfers
  - 13 paediatric retrieval transfers, and
  - 513 neonatal retrieval transfers – this part of the service became fully operational in mid October.
- An Intermediate Care Service was established to assist with the timely transfer for non-emergency patients when transferring between hospitals within the healthcare system or moving to step down facilities in the community. This initiative to date has had a positive impact on the availability of emergency ambulances for pre-hospital care and facilitates emergency ambulance personnel to focus on the core function of the delivery of pre-hospital care.
- In improving quality, the Advanced Quality Assurance Audit process has enabled the NAS to audit the emergency calls received at all the emergency call centres. This computer based system enables the NAS to monitor and audit the calls effectively and efficiently ensuring that compliance levels are maintained at Accreditation – Centre of Excellence standards.
- Any delay in ambulance turnaround times at hospitals is inefficient. Supported by the evaluation from the Emergency Medicine Programme initiative, work commenced on a national framework document on the transfer of care of patients to the Emergency Department which will establish clear lines of responsibilities and the standards expected. A formal escalation process will be used by the NAS to alert the required levels of management both within the NAS and the wider healthcare system about delays in the release of ambulance resources.

FACTS AND FIGURES IN 2014

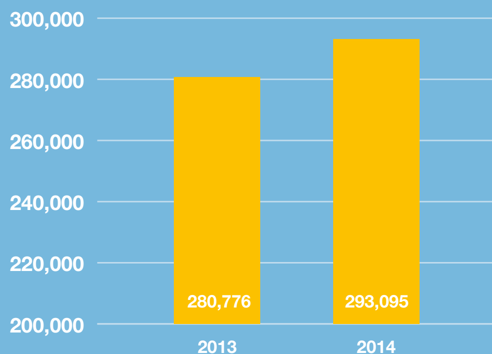
- NAS responded to 341,647 calls of which:
  - 293,095 were AS1 calls (emergency and urgent calls) and AS2 (urgent calls received from a GP or other medical source), a 4% overall increase on 2013
  - 48,552 calls were inter hospital patient transfer calls
- 11% (9,328) increase in DELTA calls (life-threatening illness or injury, other than cardiac or respiratory arrest)
- 7% (212) increase in ECHO calls (life-threatening cardiac or respiratory arrest)
- 76% ECHO and 65% DELTA incidents responded to within the timeframe of 18 minutes and 59 seconds
- 76% (37,000) of all inter hospital transfers were carried out by the Intermediate Care Service
- 309 Emergency Aero Medical Services calls completed
- 109 Air Ambulance calls and 342 Irish Coast Guard calls completed

Minister for Health, Leo Varadkar TD, being shown around one of the critical care ambulances used by the Paediatric Retrieval Service

- The 'Treat and Discharge Pilot Scheme' was piloted in Waterford. The Pre-Hospital Emergency Care Council developed clinical practice guidelines, permitting paramedics and advanced paramedics to assess, treat and discharge patients under approved protocols. The pilot will be evaluated in early 2015.
- Major reviews of the service were undertaken or commissioned during 2014 with three reports to be completed in 2015:
  - HIQA Report (2014) published in December
  - The National Ambulance Service Capacity Review (2014)
  - The Provision of Emergency Ambulance Service in Dublin City and County (2015)
  - Management Structural Review (2015)
  - Fleet Management (2015)

The outputs of these important reviews will inform a co-ordinated strategic planning process to shape and develop ambulance services in the coming years.

Figure 12: No. of AS1 calls (emergency and urgent calls) and AS2 calls (urgent calls received from a GP or other medical source) 2013-2014



Data source: National Ambulance Service

National Control Centre Project

The move to a modern single National Control Centre for the National Ambulance Service continued during the year, with additional funding of €3.6m allocated for 2014. This significant reform project will deliver a modern National Emergency Control Centre across two sites, Rivers Building Tallaght (hub site) and Ballyshannon (resilience site) using a single computer based platform.

This project exemplifies how teamwork, professionalism and dedication ensure that safe, patient focused improvements in service delivery are achievable. At the end of 2014, four of the original nine sites remained in operation – Townsend Street, Dublin; Wexford; Tullamore and Ballyshannon.

The fit out of the single National Control Centre in Tallaght is complete and migration to the Rivers Building will be completed by early 2015.

Members of the Lismore Community First Responder Group in training

Improving Outcomes for Cardiac Arrest

- The NAS continued to play an active role in supporting community engagement on the development of Community First Responder (CFR) schemes. In 2014 there were 105 CFR Groups. The contribution that these voluntary schemes make is greatly valued; they complement the ambulance services and ensure that life saving emergency treatment can begin as soon as possible. NAS is proud to have worked with existing CFR schemes and looks forward to supporting CFR Ireland in significantly expanding the number of schemes.
- Another important initiative in this area is the National Out-Of-Hospital Cardiac Arrest Register (OHCAR). Funded by NAS, this is hosted by the Department of Public Health Medicine in the HSE West and administered by the Discipline of General Practice, NUI Galway.
- The ONE LIFE Project is an initiative to increase out of hospital cardiac arrest (OHCA) survival rates in Ireland. The primary focus is on improving how OHCA is recognised, treated and measured. The project will be formally launched in 2015 with the reporting of OHCA outcomes also due in 2015.

Acute Hospital Services

Introduction

Our aim is to provide a model of care which treats patients at the lowest level of complexity in a safe, timely and efficient way, providing services as close to home as possible. Our reform programme is working towards moving away from a hospital focused model of care towards this new model of integrated care.

Key priorities for 2014 included quality and safety, improved access to services, the provision of integrated care through strategic reform and strengthening financial and human resource planning.

Progressing our Strategic Priorities

A number of services were supported through the provision of additional funding:

- A service to carry out sequential and simultaneous bilateral cochlear implants commenced during the year at Beaumont Hospital and Children's University Hospital Temple Street. €3.22m was made available to provide this service in 2014. 75 children have already benefitted with 33 sequential, 16 simultaneous and 26 unilateral cochlear implants fitted during the year. 56 adults received unilateral cochlear implants.
- Children's needs in respect of narcolepsy were addressed through the provision of €0.57m.
- Implementation of recommendations from the HSE and Galway HIQA reports on maternity services was progressed. Microbial pharmacists are being recruited in six Hospital Groups, National Clinical Guideline No. 6 on sepsis was launched, and a Maternal and Newborn Clinical Management System is being developed. Additional clinical staff are being appointed. The Irish Maternity Early Warning Score is being implemented in all 19 maternity units. €1.48m was allocated to support these developments.
- Recruitment is underway to support the organ donation and transplant services and to increase transplant rates by 7% as well as targeting the reduction of waiting times for transplant recipients. Additional funding of €2.92m was made available to the National Organ Donation and Transplantation Office.

Scheduled Care

- Inpatient activity rates are broadly in line with 2013 with 591,725 people receiving inpatient treatment in 2014.
- 860,763 people received day case treatment, a 2.9% increase on 2013.
- There was a 4.6% decrease in elective admissions compared to 2013. Part of this decrease can be accounted for by increased emergency admission demand and an increase in delayed discharges which constrained availability of capacity.

FACTS AND FIGURES IN 2014

Acute service activity:

- 1.4m people received either inpatient or day case treatment
- Over 3.2m attended at hospital outpatient departments
- Over 1.18m people attended Emergency Departments
- 67,395 births in 19 maternity units

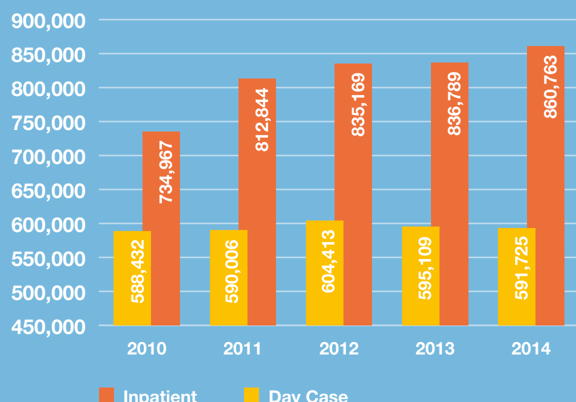
Cancer services:

- Overall in 2014, 94% of all urgent breast cancer service attendances were seen within 2 weeks of referral (target 95%)
- 88% of patients attending rapid access lung cancer clinic were offered an appointment within 10 working days (target 95%)
- 51% of patients attending rapid access prostate cancer clinic were offered an appointment within 20 working days (target 90%)
- 88% of patients undergoing radical radiotherapy treatment commenced treatment within 15 working days of being deemed ready to treat (target 90%)

- Adult waiting lists indicated that 77% (43,934) of adults were waiting less than eight months for a planned procedure at end 2014. There were 13,415 people waiting over eight months.
- 60% (3,474) of all children waiting on the elective waiting list were waiting less than twenty weeks. There were 2,282 waiting over 20 weeks.
- 63% of patients on the gastrointestinal endoscopy waiting list were waiting less than thirteen weeks by end 2014. By end 2014 there were 4,850 waiting over 13 weeks. A targeted initiative to address patients waiting over 13 weeks is underway.
- Our target is that urgent colonoscopies are completed within four weeks of referral. At the end of December, 21 patients were waiting longer than four weeks – all of whom were scheduled immediate appointments.

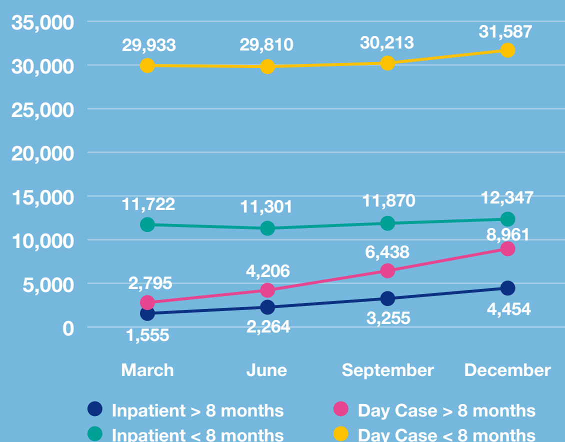
Minister for Health, Leo Varadkar TD with 100 year old Kathleen Madden at University Hospital Limerick

Figure 13: Inpatient and day case activity 2010-2014



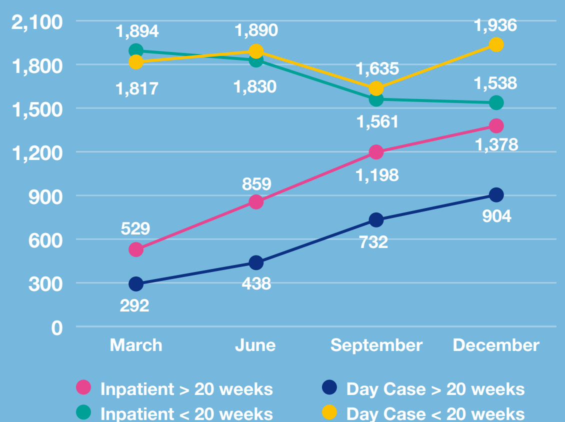
Data source: HSE Performance Reports

Figure 14: Adult waiting lists 2014



Data source: HSE Performance Reports

Figure 15: Child waiting lists 2014



Data source: HSE Performance Reports

Outpatients

- Over 3.2m people attended an outpatient department. This is an additional 92,261 people attending or a 3% increase on final 2013 figures.
- 324,381 people (84%) were waiting less than 52 weeks for an outpatient appointment at the end of December. There were 61,400 (16%) waiting over 52 weeks.
- The Outpatient Improvement Project is targeting capacity and business process improvements across all hospitals. However, despite this, outpatient waiting numbers are continuing to increase due to higher demand and referral rates. The number of people waiting less than one month at year end was 55,452 which equates to 14% of total patients waiting.

Delayed Discharges

- Due to the increase in the number of delayed discharges, hospitals have opened additional beds to address capacity issues. An additional €25m was secured to address these pressures during 2015 and €3m of this funding was allocated during December 2014 to immediately put in place additional long term care beds and a range of community supports including transitional, community and home care services. These measures will improve patient flow within hospitals by reducing the number of delayed discharges and the volume of patients waiting on trolleys in emergency departments for admission to an inpatient bed.

Unscheduled Care

- Over 1.18m people attended emergency departments. There was a 3.1% increase in new attendances since 2013.
- 68% of patients attending emergency departments were discharged home or admitted within six hours (target 95%).
- 81% of patients attending emergency departments were discharged home or admitted within nine hours (target 100%).
- There was a 1.7% increase in emergency admissions during the year which accounts for some of the continued pressure on inpatient capacity.
- The most significant rise in emergency admissions has been in Medical Assessment Unit related admissions. These Units ensure appropriate streaming of patients and the overall increase is as a result both of increased referrals by General Practitioners and an increase in the number of medical assessment units opened.

Other Areas of Performance

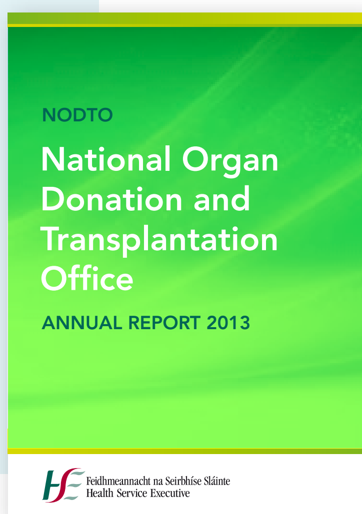
- 98% of hospitals fully implemented the National Early Warning Score in all clinical areas of acute hospitals and single specialty hospitals.
- There was 94% compliance with the requirement that NCHDs not be rostered/work >24 hour shifts and a 67% compliance with an average 48 hour working week.
- 82% of emergency hip fracture surgery was carried out within 48 hours (target 95%).
- 65% of surgical inpatients had principal procedure conducted on day of admission, an improvement against 62% in 2013 but further improvement is still required.
- The average length of stay was 5.3 days which was a slight improvement on 5.4 days in 2013 and is an improvement against the target of 5.6 days.
- 68% of acute stroke patients spent all or some of their hospital stay in an acute or combined stroke unit (target 50%).
- 12% of patients with confirmed acute ischaemic stroke, in whom thrombolysis is not contraindicated, received thrombolysis (target 9%).
- 84% of patients with myocardial infarction (STEMI), without contraindication to reperfusion therapy, received coronary angioplasty (primary percutaneous coronary intervention) (target of 70%).

2014 was the first full year in which Dublin Maternity Hospital campuses were smoke free

Organ Donation and Transplantation

The National Organ Donation and Transplantation Office launched its Annual Report for 2013. This was a record year for organ transplantation in Ireland with 294 transplants carried out in Irish hospitals compared to the previous record of 275 in 2011.

- A record 32 lung transplants, 11 heart transplants, 55 liver transplants, 11 pancreas and 185 kidney transplants were carried out in 2013. These procedures were carried out in the Mater, St. Vincent's and Beaumont Hospitals.
- 246 people received organs thanks to the generosity of the 86 families of deceased donors who agreed to donate their loved ones' organs. A record 20% (38 in total) of all kidney transplants in 2013 were made possible by living donors who donated a kidney. 147 kidney transplants from deceased donors were carried out, 11 of which were combined kidney and pancreas transplants.



National Clinical Programmes

Some of the key achievements of the National Clinical Programmes in 2014 include:

Acute Medicine

- Successful implementation and training in the use of the National Early Warning Score, Irish Maternity Early Warning Score (including Sepsis-Six box) and the newly developed Paediatric Early Warning Score across the hospital system.

Anaesthesia

- Pre-admission model of care was developed for all acute hospitals.

Critical Care

- Critical care model of care and implementation roadmap was developed for all acute hospitals.

Obstetrics and Gynaecology

- *Guidelines for the Critically Ill Woman in Obstetrics*, a joint guideline between the Anaesthesia and Obstetrics and Gynaecology Programmes, was published.

Outpatient Antimicrobial Therapy (OPAT)

- Successful roll out to acute hospitals of national OPAT standards, protocols, guidelines and standard operating procedures.

Orthopaedics

- Best practice guidelines were implemented in all trauma and orthopaedic units for fracture neck of femur patients using the Integrated Care Pathway.
- In conjunction with the Rheumatology Programme, 45,500 patients were removed from the outpatient orthopaedic waiting lists as a result of the successful implementation of the Musculoskeletal Physiotherapy Initiative.

Palliative Care

- A review of Palliative Care support beds for acute hospital services was completed and recommendations are being implemented.

Renal

- Commissioning of four contracted Satellite Haemodialysis Units around Dublin with an appropriate and robust Clinical Governance Model was completed.
- Continued successful implementation of the Telemedicine Rapid Access for Stroke and Neurological Assessment (TRASNA) service.

Surgery

- Clinical coding and guidelines for the management of day cases, minor operations and outpatient procedures was completed.
- Continued roll-out of NQAIS 2 (National Quality Assurance Intelligence System) nationally.

Transport Medicine

- Commencement of five day Paediatric Retrieval Service.
- Neonatal and Paediatric teams now have standardised equipment for use in the transport environment.
- Paediatric Retrieval team training programme was completed.
- Two critical care ambulances have been commissioned in partnership with the National Ambulance Service.

Some of the nursing staff from the Adams McConnell ward, which was chosen as the pilot ward for the Productive Ward programme in Beaumont Hospital

Stroke Rehabilitation Unit

A new exercise garden was opened at the Stroke Rehabilitation Unit in St. Finbarr's Hospital, Cork greatly enhancing the rehabilitation and recovery of patients, who as a result of stroke, frequently experience muscular weakness, impaired dexterity, unco-ordinated movement and decreased function and mobility.

With 72 rehabilitation beds (12 stroke specific) St. Finbarr's Hospital has the largest dedicated rehabilitation service for older persons in the country.

Claire Meade, physiotherapist, assisting a patient in the exercise garden

Prevention of Chronic Disease Programme

The Prevention of Chronic Disease Programme was established in 2012 with the goal of developing strategies to prevent the development and progression of chronic diseases in the well population, in those with risk factors and in people with established disease.

The report *Preventing Chronic Disease: Defining the Problem* was published in 2014 by the Prevention of Chronic Disease Programme and sets out a clear picture of the burden of chronic disease and known risk factors along with the impact of those risk factors on our health.

As indicated earlier in this Annual Report, three quarters of deaths in Ireland are due to three chronic diseases: cancer, cardiovascular and respiratory diseases – 27,122 deaths in 2010 alone – most of which are preventable. These chronic diseases, in addition to diabetes, account for 60% of all deaths worldwide and 76% of deaths in Ireland. Chronic disease is a major driver of healthcare costs.

The trend in death rates over time for cancer, cardiovascular disease (CVD) and respiratory disease indicate a sizeable decline for CVD from the mid-1980s; for cancer and respiratory diseases, the rates have been stable until the last decade when the rates started to decline.

Healthy Ireland recognises the importance of improving health and wellbeing in Irish society in the coming years and the prevention of chronic disease is a key priority in addressing the broad determinants of health as well as reducing risk factors for preventable chronic diseases.

National Cancer Control Programme

Key priorities for 2014 included implementation of the national medical and haemato-oncology programmes, supporting the hereditary cancer programme, supporting the designated cancer centres and continuing to address quality and safety standards.

- To support hospitals address the growth in demand for oncology drugs and to support the national cancer molecular testing in Beaumont/RCSI and St. James's Hospital, €3.8m was made available.
- 21,429 patients attended rapid access clinics:
  - 15,804 attendances at breast clinics of whom 14% had a primary cancer diagnosed.
  - 3,054 attendances at lung clinics of whom 30% had a primary lung cancer diagnosed.
  - 2,571 attendances at prostate clinics of whom 40% had a cancer diagnosis. 50% of patients attending rapid access prostate cancer clinics were offered an appointment within 20 working days against a target of 90%. Mechanisms are being put in place to improve performance including the recruitment of additional/replacement staff.
- A total of 4,125 patients have completed their radical radiotherapy treatment. A total of 88% of all radiotherapy patients commenced treatment within 15 working days of being deemed ready to treat (target 90%).
- Several initiatives of the national medical oncology and haemato-oncology programmes were implemented including:
  - Significant progress on implementation of the Oncology Medication Safety Review, with 66% of recommendations implemented and several national policies in development.
  - 41 national indication-specific cancer drug protocols were developed and are available on the National Cancer Control Programme website.
  - Completion of a business case for the development of a national Medical Oncology Clinical Information System – a key safety and quality priority.
- Under the auspices of the National Cancer Drug Management Programme:
  - Six newly-approved high-cost hospital-based chemotherapy drugs were included in the Oncology Drugs Management System and funded on a 'money follows the patient' approach.
  - Hospitals were supported to address the rising cost of existing cancer drugs.
- The Hereditary Cancer Programme provides ongoing support for clinics and St. James's and the Mater Hospitals, Dublin together with associated testing. Approval was received and recruitment is underway for a national lead in Cancer Genetics/Consultant Medical Oncologist.
- National guidelines were developed for the diagnosis, staging and treatment of patients with breast cancer and of patients with prostate cancer.
- A new Extracranial Stereotactic Radiation Oncology service commenced at St. Luke's Radiation Oncology Unit at St. James's Hospital, Dublin. The initial focus of the service is on treating early stage non-s30mall cell lung cancers with curative intent. This service will be gradually extended with the result that patients no longer have to travel abroad under the HSE Treatment Abroad Scheme or depend upon the service being contracted from the private sector.

St. Luke's Hospital, Rathgar

As part of the National Cancer Control Programme (NCCP), cancer services are developed nationally to ensure that patients are provided with prompt and timely access to quality assured services. The NCCP is equally committed to supporting patients to quit smoking and is directly involved with the Tobacco Control Framework and the Tobacco Free Campuses Policy, with the ICGP providing e-learning for GPs, and with staff through brief intervention training, motivational interviewing and e-learning for nurses.

St. Luke's Hospital, Rathgar, part of St. Luke's Radiation Oncology Network, became a tobacco free zone. Patients are informed of the new policy in advance of attendance and admission to hospital and, when admitted, patients who smoke are offered free nicotine replacement therapy during their hospital stay.

St. Luke's Hospital, Rathgar

Pictured at the launch of the St. Luke's Rathgar Tobacco Free Campus are Dr. Susan O'Reilly, former Director NCCP and former Minister of State for Primary Care, Mr. Alex White TD

Ireland East Hospital Group

Mater Misericordiae University Hospital • Cappagh National Orthopaedic Hospital • Midland Regional Hospital, Mullingar • National Maternity Hospital • Our Lady's Hospital, Navan • Royal Victoria Eye and Ear Hospital • St. Colmcilles Hospital • St. Lukes Hospital, Kilkenny • St. Vincent's University Hospital • Wexford General Hospital

Academic Partner: University College Dublin

Some highlights...

- The new €7m ED opened at Wexford General Hospital providing 17 treatment spaces and two resuscitation rooms (an increase of 13 treatment spaces and one resuscitation room), leading to improved admission times for patients and providing a more enhanced environment for patients and staff.
- The National Maternity Hospital, Dublin was awarded the Maternity Hospital of the Year at the Irish Healthcare Awards

RCSI Hospital Group

Beaumont Hospital • Cavan General Hospital • Connolly Hospital • Louth County Hospital • Monaghan Hospital • Our Lady of Lourdes Hospital, Drogheda • Rotunda Hospital

Academic Partner: RCSI

Some highlights...

- The new €1m eight bed MRI and Acute Medical Assessment Unit in Connolly Hospital officially opened providing rapid assessment, diagnosis and early management based on patient needs.

Irish Healthcare Award winners 2014 included:

- Our Lady of Lourdes Hospital Drogheda – Public Hospital of the Year Award
- Our Lady of Lourdes Hospital, Drogheda – Large/Teaching Hospital, Department Initiative of the Year Performance Improvement Projects
- Louth Meath Endoscopy Service – General Hospital Department Initiative of the Year

UL Hospitals

University Hospital Limerick • University Maternity Hospital Limerick • Ennis Hospital • Nenagh Hospital • Croom Hospital • St. John's Hospital

Academic Partner: University of Limerick

Some highlights...

- UL Hospitals launched their three year Strategic Plan 2014-2016
- First Annual Report for UL Hospitals published
- Irish Cancer Society Daffodil Centre opened

Oispidéil OL/UL Hospitals

Minister for Health, Leo Varadkar TD, at the opening of the new Critical Care Block at University Hospital Limerick with Josie Dillon, Ciara Cahill and Clair Barry

RCSI Hospital Group

Fatima Asif who recently received a second cochlear implant at Beaumont Hospital

Saolta

University Hospital Galway • Letterkenny General Hospital • Merlin Park University Hospital • Sligo Regional Hospital • Mayo General Hospital • Portiuncula Hospital • Roscommon Hospital

Academic Partner: National University of Ireland, Galway

Some highlights...

- The first meeting of the Patient Council for Saolta took place in late 2014 – a total of 16 members of the public were appointed to the inaugural Council.
- Following the flooding at Letterkenny General Hospital in 2013:
  - The ED/Acute Medical Assessment Unit re-opened. This unit fully restores all ED facilities along with the 11 bed acute medical assessment unit lost in the flood which damaged 40% of the hospital's ground floor space, affecting 70% of services.
  - A new pharmacy department was opened delivering a modern, purpose built department to support the hospital.
- First annual CEO Awards Ceremony took place in November.

Children's Hospital Group

Children's University Hospital (Temple Street) • Our Lady's Children's Hospital (Crumlin) • Tallaght Hospital (Paediatric)

Academic Partners: University College Dublin/RCSI/Trinity College Dublin

Some highlights...

- The design team for the new children's hospital was announced, an important step in the journey to integrate the three children's hospitals in the Children's Hospital Group.
- This is the largest, most complex and significant capital investment project ever undertaken in healthcare in Ireland and will bring together the three existing children's hospitals to be tri-located on one campus with St. James's Hospital and a planned maternity hospital.
- This tri-location will ensure best outcomes for children, young people, mothers and infants. It will be the regional hospital for children from the greater Dublin area and will also be the national hospital for children who need specialist tertiary care.

Saolta

Promoting Safe Care for Mother and Baby was the theme of National Midwives Week in Portiuncula Hospital

Ireland East Hospital Group

Stroke Information Day at St. Columcille's Hospital, Loughlinstown with Fiona Craven, Speech and Language Therapist (Left) and Nicola Schofield, Stroke Nurse

Children's Hospital Group

Minister for Health Leo Varadkar TD with members of the Youth Advisory Council for the design team for the new children's hospital

South/South West Hospital Group

Dr. James Reilly TD, former Minister for Health, opens the new endoscopy unit at Kerry General Hospital

South/South West Hospital Group

Cork University Hospital • University Hospital Waterford • Kerry General Hospital • Mercy University Hospital • South Tipperary General Hospital • South Infirmary Victoria University Hospital • Bantry General Hospital • Mallow General Hospital • Lourdes Orthopaedic Hospital, Kilcreene

Academic Partner: University College Cork

Some highlights...

- A new Endoscopy Unit serving a population of 140,000 opened at Kerry General Hospital (KGH). This redevelopment is a progression of KGH selection as a National Screening Service site for colorectal screening.
- Cork University Hospital became the first teaching hospital in the world to achieve a Green-Campus award from An Taisce. CUH is the largest teaching hospital in the country and UCC is its academic partner. The Green-Campus Programme encourages a partnership approach to environmental education, management and action in third level institutions.

Dublin Midlands Hospital Group

Coombe Women's and Infants University Hospital • Midland Regional Hospital, Portlaoise • Midland Regional Hospital, Tullamore • Naas General Hospital • St. James's Hospital • St. Luke's Hospital • Tallaght Hospital

Academic Partner: Trinity College Dublin

Some highlights...

- Hospital Pharmacists at Naas General Hospital received a commendation at the Excellence in Irish Healthcare Awards for their project entitled *Innovative Team-Based Model of Clinical Pharmacist Services*. The project highlighted how hospital pharmacists became integrated into medical teams improving the quality of prescribing and resolving medication issues, achieving significant improvement in patient care, reducing admissions and enabling financial savings estimated at €2.2m

Primary Care

Introduction

Our aim is that the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings ensuring that services are:

- Safe and of the highest quality
- Responsive and accessible
- Highly efficient and represent good value for money
- Well integrated and aligned with relevant specialist services.

Primary care priorities in 2014 included the delivery of primary healthcare through primary care teams and health and social care networks, providing additional services in the community and aligning and integrating national clinical programmes within primary care services.

Social inclusion priorities included improving health outcomes for people with addiction issues, implementation of the recommendations of the *Hepatitis C Strategy*, implementing health aspects of a housing-led approach to homelessness and improving access to services for ethnic and culturally diverse groups.

The provision of community schemes in an efficient and integrated way is a key priority for us. This is managed through our **Primary Care Reimbursement Service**. Our priorities included efficient provision and probity for medical cards, implementation of guideline changes for medical cards and GP visit cards for persons aged 70 and over and those returning to work, together with drug reference pricing and generic drug substitution.

FACTS AND FIGURES IN 2014

- 939,600 contacts with GP out of hours services
- 14,689 referrals to Community Intervention Teams
- 764,967 physiotherapy contacts with 156,628 seen as a first assessment
- 238,000 occupational therapy contacts with 83,633 seen for a first assessment
- 20,050 patients received orthodontic services
- 96.5% of those waiting for orthodontic assessment were on the waiting list for assessment ≤12 months
- 9,369 clients received opioid substitute treatment outside prisons
- 1,858 service users were admitted to homeless emergency accommodation on average each quarter

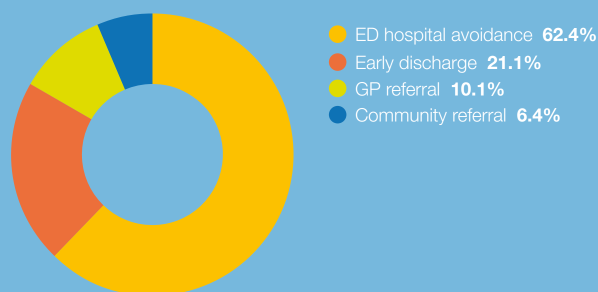
Progressing our Strategic Priorities

- Implementation of a universal GP service free at the point of use to children aged under six is dependent on legislation, which was published in 2014. Contract negotiation is being led by the HSE under a framework agreement entered into between the Department of Health, the HSE and the Irish Medical Organisation.
- The discharge of special care babies from children's hospitals, using packages of care in the community for babies with tracheotomies, was supported by the provision of €1.2m.
- Quality assessment and improvement tools for self assessment against the *National Standards for Safer Better Healthcare* have been developed. Five regional Standard Assessment workshops were hosted for ISA managers and their senior management teams with over 200 in attendance.
- An Incident Support and Learning Team was established to ensure all serious incidents are managed in an effective and timely manner.

Pictured at the opening of Summerhill Primary Care Centre, Co. Meath are (L-R): Fiona Monaghan, Physiotherapy Manager; Dermot Monaghan, Area Manager; Mary O' Hare, Network Administrator; Alex White TD, former Minister of State for Primary Care; Dr. Joe Clarke, GP; and Dervila Eyres, A/General Manager

New Primary Care Centre in Loughrea, Co. Galway

Figure 16: Community Intervention Team activity by source



Data source: HSE Performance Reports

- Incident management training was delivered to 67 senior primary care staff in accordance with the *Incident Management Policy 2014*.
- The Dental Inspector's role on assessment of all new contract holders entering the Dental Service Scheme continues to strengthen the standards of practitioners and premises.

Enhancing Primary Care Services

- Work is continuing to strengthen primary care teams and health and social care networks. Currently, there are 4,366 whole time equivalents within 485 primary care teams in 126 networks.
- The Tobacco Free Campus policy continues to be rolled out for all new primary care centres; 69% of all existing primary care centres are now tobacco free.
- Seven new primary care centres became operational with work progressing on the procurement of an additional 14.
- A review of Community Intervention Team services was undertaken during the year. The future development of services will be informed by the outcome of this review. During 2014:
  - 14,689 patients received support from eight Community Intervention Teams (CITs). Of these:
    - 9,169 were ED hospital avoidance cases
    - 3,099 enabled early discharge
    - 1,484 were GP referrals
    - 937 were community referrals.
- Referrals for physiotherapy services increased by 4.6% in 2014. Referrals for occupational therapy services increased by 14.2% on the previous year.
- The Healthlink electronic referral system for GPs, part of the national pilot project, is now in place in all acute hospitals in Cork and Kerry for GPs referring patients for public outpatient hospital appointments. Tallaght Hospital, which is also part of the pilot, is accepting electronic referrals to its paediatric services. To date almost 20,000 referrals have been received by these hospitals with almost 364 GPs using the system. This represents 67% of all Cork and Kerry based GPs. It is planned to roll this out nationally in 2015.
- A new national service was launched in November enabling secure clinical communication between healthcare providers in primary and secondary care. Healthmail/secure email allows GPs with @healthmail.ie accounts to send patient identifiable clinical information to clinicians with an @hse.ie or @voluntaryhospital.ie account. The emails are secure and confidential. GPs have signed up for this new service and all HSE and major voluntary hospitals are now securely connected to Healthmail. More information is available on *https://www.healthmail.ie*. The Healthmail service was implemented in co-operation with the Irish College of General Practitioners and the Department of Health. The managed service provider, chosen after a public procurement process, is Three Ireland (Hutchinson) Limited.
- Chronic disease prevention and management in primary care settings continues to be developed with the recruitment of 16.5 Diabetes Nurse Specialists.

Audiology Services

- The Newborn Hearing Screening Programme is in place in all maternity hospitals offering parents the opportunity to have their baby's hearing tested shortly after birth. The test is provided free of charge. During 2014 the programme screened its 100,000th baby. About 75,000 babies each year in Ireland are undergoing hearing screening. On average 6,000 babies are screened each month, approximately 3% of whom are referred to audiology services for further hearing diagnostic assessments.
- Implementation of recommendations from the *National Audiology Review* is continuing. Four assistant national clinical leads are in post. In addition nine audiology graduates have been appointed. A number of initiatives are underway to target both adult and paediatric waiting lists.

Community Oncology – NCCP

- A referral tool-kit for head and neck cancers has been developed.
- Electronic referral for suspected malignant melanoma is available to GPs.
- The Community Oncology Nursing Programme has been accredited by the National University of Ireland, Galway. The programme is now being implemented on a phased basis across the country.
- A three day cancer training programme has been developed for nurses who work in any acute setting but not directly in oncology.

Children First

- An action plan for implementation of Children First was completed. An Oversight Group comprising representatives from across all divisions was established and a national lead was appointed.

National Clinical Programmes

Some key achievements in 2014 included:

- Asthma: a Model of Care for Asthma was completed.
- Chronic Obstructive Pulmonary Disease (COPD): the COPD Outreach programme was rolled out in 12 sites.
- Medicines Management: work continued with the Medicines Management Programme on the identification and prescribing of preferred drugs.
- Ophthalmology: the diabetic retinopathy screening and treatment programmes continued to be rolled out in conjunction with the National Cancer Screening Service.

Social Inclusion

During 2014:

- 9,369 patients were in receipt of opioid substitute treatment at the end of December (excluding prisons). This included 3,960 treated by 343 GPs in the community. Opioid substitute treatment was dispensed by 627 pharmacies catering for 6,403 patients. This is a 2.2% increase on 2013.
- 73 HSE clinics provided opioid substitute treatment and an additional ten clinics were provided in the prison service.
- 1,109 or 97% of substance misusers, over 18 years commenced treatment within one calendar month following assessment.
- 67 or 97% of substance misusers, under 18 years commenced treatment within one week following assessment.
- A progress report was published on implementation of the *National Drugs Strategy 2009-2016* for the period to end of 2014. Good progress is being made by government departments and agencies around the five pillars of supply reduction, prevention, treatment, rehabilitation and research.
- Screening/assessment of people presenting with early indicators of drug and alcohol issues, and screening and brief intervention training programmes were delivered to 508 participants.
- A National Alcohol Strategy Implementation Group was established to progress implementation of the *National Substance Misuse Strategy*. Areas prioritised include the recruitment of a clinical lead for addiction services, an alcohol social marketing campaign, input into the proposed *Public Health (Alcohol) Bill* and the development of a strategic statement between the HSE and TUSLA on the impact of parental problem alcohol and other drug use on children ('Hidden Harm').
- A report examining the damage from alcohol to people other than the drinker was launched as part of Alcohol Awareness Week. The information is based on self-reported responses in the national drinking surveys of 2006 and 2010. The report *Alcohol's harm to others in Ireland* was prepared by the Department of Public Health and Primary Care in Trinity College and was funded by the HSE.

Asthma Education Pilot Project

The Asthma Education Pilot project – an innovative approach to develop and deliver a culturally appropriate programme for members of the Traveller community was developed as a collaborative initiative of HSE Social Inclusion, the Asthma Society of Ireland and Pavee Point.

Using a Train the Trainer model, the programme was delivered to 32 community health workers from the Traveller Community. The selected healthcare workers undertook training and then returned to their regions, where they in turn trained their community health worker colleagues. Following this the Traveller community healthcare workers worked in pairs to educate the families affected by asthma in their area.

The programme was launched in October. Evaluation has shown this to be an effective, low cost and appropriate means of supporting Travellers to learn about asthma and improve control of managing it. This programme may also be suitable for rollout across other marginalised groups. Response to the programme has been very positive, with a commitment to further rollout across three Traveller Health Units in 2015.

- The Drug and Alcohol, HIV/Sexual Health and Hepatitis helpline/email support dealt with 2,579 contacts.

Pictured at the launch of the Asthma Education Pilot Project were (L-R): Brian Murphy, Primary Care, HSE; Diane Nurse, Social Inclusion, HSE; Ronnie Fay, Pavee Point; Sharon Cosgrove, Asthma Society of Ireland; Malachy Corcoran, Department of Health

Deputy Lord Mayor, Cllr. Tony Fitzgerald; Kathleen Lynch, TD, Minister of State for Primary and Social Care; Dave Roche, Cork Gay Project; Rebecca Loughry, HSE Social Inclusion; and Fiona Finn, Nasc (Irish Immigrant Support Centre)

Partnership for Health Equity

A pilot primary healthcare service for marginalised groups was established in Limerick City. The aim of the project is to improve access to primary health care for groups such as the homeless, drug users, travellers, migrants and others who have difficulties in accessing and availing of primary care services. The service operates at two locations in the city – Ana Liffey Drug project and St. Vincent de Paul Drop in Centre. Response to this service has been very positive. In the 10 months since opening, 78 clinics have been held, involving 184 clients and 408 contacts.

Pictured (L-R): Dr. Patrick O'Connell, Graduate Entry Medical School, UL; Diane Nurse, Social Inclusion, HSE; Prof. Anne MacFarlane, Graduate Entry Medical School, UL; Cllr. Kathleen Leddin, Mayor of Limerick; and Tony Quilty, Social Inclusion, HSE

New Voluntary Group Alliance Launched in Cork City

A new alliance *Cork Equal and Sustainable Communities Alliance* (CESCA) has been formed which brings together 14 diverse community and voluntary groups in Cork City, to better address issues of disadvantage in the city. By formalising how they work together, CESCA facilitates the pooling of resources and expertise and helps achieve cost savings by maximising existing resources and addressing gaps in services.

This new and innovative way of working will harness and protect the vast experience and excellent work of these front line organisations that are at the heart of social inclusion services in Cork city.

Supporting people with Hepatitis C

- Implementation of recommendations of the *National Hepatitis C Strategy* is continuing. A Hepatitis C education and awareness campaign was co-ordinated to support World Hepatitis Day on the 28th of July. The aim of the campaign was to urge anyone who may be at risk of Hepatitis C to get tested. It is estimated that between 20,000 and 50,000 people in Ireland are chronically infected with Hepatitis C.

Addressing Homelessness

- A number of areas were progressed during the year on the Implementation Plan on the State's Response to Homelessness. In addition, a senior manager was appointed to co-ordinate all health related activities under the recently developed Government 20 point Action Plan to tackle emergency and short term homelessness in the Dublin region, following a major summit on homelessness in December.

Primary Care Reimbursement Service

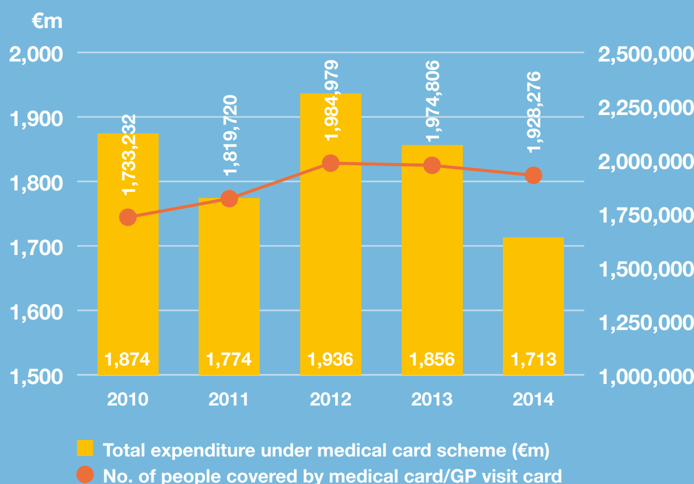
Services are provided to 3.4m people in their community through over 7,000 primary care contractors. Primary care schemes include:

- General Medical Services (GMS)
  - Medical Card Scheme including GP Visit Cards
  - Drug Payment Scheme
  - Long Term Illness Scheme
  - Dental Treatment Services Scheme (DTSS)
  - High Tech Drug Arrangements
  - Primary Childhood Immunisation Scheme
  - Community Ophthalmic Scheme
  - *Health (Amendment) Act 1996*
  - Methadone Treatment Service

During 2014

- 127,742 new or upgraded medical cards were issued in 2014. This was enabled by the provision of additional funding of €35m.
- Eligibility for medical cards increased by 54% since 2005:
  - The number of eligible persons for medical cards at 1st January 2005 was 1,145,803
  - The number of eligible persons for medical cards at 31st December 2014 was 1,768,700.
- A new dedicated GP support line was introduced to enhance the collaboration between GPs and the HSE for those applying or renewing their medical cards.
- The Medicines Management Programme and PCRS continued to enhance the analysis and reporting of GP prescribing and the implementation of reference pricing/ generic drug substitution. The Programme also provides leadership on issues such as the quality of the medicines management process, access to medicines and overall expenditure.

Figure 17: Total expenditure under medical card scheme (€m) and no. of people covered by medical card/GP visit card



Data source: PCRS Management Accounts and PCRS Statistical Analysis

FACTS AND FIGURES IN 2014

- Almost 1.77m people or 39% of the population were covered by a medical card
- 159,576 people were in receipt of a GP visit card
- 96% of completed medical card applications were processed and issued within 15 days
- Over 2.1m drug payment scheme claims were processed
- 1.29m long term illness claims were processed
- 1.31m dental treatments and 839,649 community ophthalmic treatments were provided
- Almost 19.14m GMS prescriptions were processed covering over 58m items

Medical Card Reform

- Two reports were commissioned in 2014 to examine and review the GMS Scheme which governs access to medical cards in Ireland.
  - An expert panel was established to examine and recommend the range of medical conditions that should be considered as a basis of eligibility. The panel included 23 clinical experts from primary care, specialist services and therapies, in addition to a patient representative. A patient representative forum was held which was attended by 24 patient representative groups. The issues and themes from the forum informed the work of the expert panel.
  - An external review was commissioned to examine how the medical card application process is administered and to recommend ways in which the process could be made more efficient, simple and user-friendly in the future.
- Arising from these reports a number of actions are being taken which will enhance the operation of the medical card scheme. These include:
  - A more integrated and sensitive processing of applications, involving greater exchange of information between the central assessment office and local offices in relation to people's medical circumstances and needs.
  - Appointment of a senior manager to lead reform of the systems for handling medical card applications and reviews, with a focus on a high-quality customer service and easy-to-understand information and processes.
  - Establishment of a clinical advisory group to develop guidance on assessing applications involving significant medical conditions.
  - Engagement with the Irish Medical Organisation to encourage and support the use by GPs of the facility to temporarily extend the validity of discretionary medical cards where sensitive renewal is appropriate.
  - Development of a single integrated process for people to apply for medical cards, GP visit cards, the long-term illness scheme and the drugs payment scheme.
  - Establishment of access points around the country in local offices to support and assist people in making applications.

Palliative Care

Introduction

Palliative care is an approach which improves the quality of life of patients and their families, facing the challenges associated with life-limiting illness. This is achieved by the prevention and relief of suffering through early identification, assessment and management of pain and other physical, psychosocial or spiritual problems. In recent years, the scope of palliative care has broadened and includes not only cancer related diseases but supporting people through non-malignant and chronic illness.

A key priority in 2014 was the strengthening of quality, safety, effectiveness and governance of services.

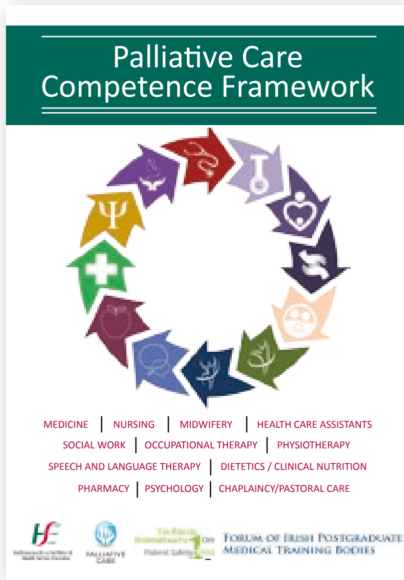
Progressing our Strategic Priorities

- 18 inpatient beds were opened in St. Francis Hospice, Blanchardstown, Dublin with the remaining six opening in early 2015. €1m was provided for these developments.
- 16 additional specialist inpatient beds were opened in Marymount in Cork with a further four beds due to open in 2015.

FACTS AND FIGURES IN 2014

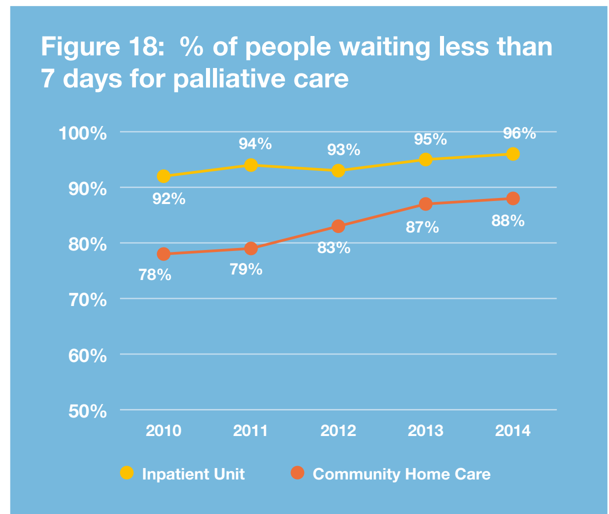
- 11,459 people received specialist palliative care in the community with a total of 117,660 visits
  - 72% with a primary diagnosis of cancer and 28% non-cancer
  - 88% of patients received specialist palliative care in the community within seven days of referral
- 346 people received specialist palliative day care services on average each month
  - 83% with a primary diagnosis of cancer, 17% non-cancer
- 381 patients received specialist palliative inpatient care on average each month – a total of 3,094 admissions were recorded in the year
  - 88% with a primary diagnosis of cancer and 12% non-cancer
  - 96% of patients were admitted to an inpatient bed within seven days of referral
- 206 new patients were in receipt of specialist palliative care from the children's outreach service

St. Francis Hospice



- A series of resources were published which assist staff to have the skills they need to provide high quality, person-centred care to people with life limiting conditions and their families. These include:
  - *Towards Excellence in Palliative Care* Quality Assessment and Improvement workbooks designed to support Specialist Palliative care services to complete a self-assessment against the Safer Better Healthcare standards and develop their own quality improvement plans. Work has commenced to support implementation including the development of a resource file.
  - The *Palliative Care Competence Framework* describes core palliative care competences that are shared by all staff and individual discipline-specific level competences. Competences are described at three levels of practice (palliative care approach, general palliative care and specialist palliative care competences).
- The Report of the First National Survey of Palliative Care Support Beds was launched with a study day in October. The establishment of a working group is planned for early 2015 to support implementation of the ten recommendations in the report.
- The first ever palliative care week took place in October and was co-ordinated by the All Ireland Institute of Hospice and Palliative Care supported by the Department of Health, HSE and providers of hospice and palliative care across the country, as well as health agencies in Northern Ireland. The focus of the week was *Making the Most of Life* and highlighted how palliative care improves the quality of life of a person with a life limiting condition. A series of events and information evenings were held throughout the country which raised awareness about the work of palliative care services.
- Engagement continued with the Irish Hospice Foundation on initiatives such as the Hospice Friendly Hospital, Design and Dignity, End of Life Audit Tool and implementation of recommendations from *Palliative Care For Children With Life-Limiting Conditions In Ireland – A National Policy*.

Figure 18: % of people waiting less than 7 days for palliative care



Data source: HSE Performance Reports

Social Care

Introduction

Social care services support and facilitate older people and people with disabilities, through the design and implementation of models of care and services, to live independently, promoting their independence and lifestyle choice in as far as possible.

We provide a range of support services so that older people can live at home or in their own communities wherever possible or, if needed, can access quality residential care.

We also provide support to people with disabilities, to help them achieve their full potential including living as independently as possible, while ensuring that people are heard and involved in all stages of their care needs.

Social care services are delivered by the HSE, non-statutory providers and private providers. Approximately 80% of all disability services are delivered by the non-statutory sector, funded through section 38 and 39 of the *Health Act 2004* and covered by either Service Arrangements or Grant Aid Agreements. 76% of Nursing Home Support Scheme NHSS places are delivered by private nursing homes.

We launched a new policy, *Safeguarding Vulnerable Persons at Risk of Abuse*, in December for all HSE and HSE funded services. It builds on and includes existing policies in both disability and elder abuse services and supports the development of long term, sustainable and evidence based safeguarding practices and programmes.

FACTS AND FIGURES IN 2014

- 10.3m home help hours were delivered to 47,061 people (5.8% increase in hours from 2013)
- 13,199 people were in receipt of a home care package at the end of December (21.4% above the expected level of service)
- 22,360 people were supported under the Nursing Homes Support Scheme for long term residential care
- 2,555 new referrals were made to elder abuse teams
- 90 non-statutory providers of disability services delivered services in 908 designated residential centres for people with disabilities
- 2,895 people with a disability availed of rehabilitative training
- 90 people completed the transition from congregated to community settings
- 1,606 work or work like places were provided for people with either a physical and/or sensory disability/intellectual disability and/or autism (day services)
- 4,908 assessments of need were carried out under the Disability Act, 2005 (15% increase on 2013)

Disability Services

Our aim is that people with disabilities are supported to participate fully in economic and social life, and have access to a range of quality supports and services to enhance their quality of life and wellbeing.

Our priorities in 2014 included:

- Implementing the *Value for Money and Policy Review of Disability Services in Ireland* and continuing to develop person centred models of services and supports.
- Improving the quality of services used by people with disabilities and enhancing service user engagement.
- Improving information systems, data collection and developing outcome focused performance indicators.

Progressing our Strategic Priorities

The quality and safety of our services is paramount. In late 2014 serious allegations of totally unacceptable behaviour and attitudes towards residents in Unit 3, Áras Attracta were brought to our attention. As soon as we became aware of the serious issues immediate action was taken including:

- Ensuring a safe and caring home for the residents in Áras Attracta with ongoing communication and meetings with families of the residents involved.
- A full assurance review of all of the units in the facility under an independent chairman (Dr. Kevin McCoy).

Residential Services – 6 Step Programme

A system-wide programme of measures was put in place to assure that the quality and safety of services delivered by all service providers in all designated residential centres for people with disabilities was in line with the requirements of the regulations and standards as inspected by HIQA.

A National Implementation Task Force held its first meeting in December which will drive the implementation of a six step programme and develop long term sustainable and evidence based safeguarding practices and training programmes specific to residential settings. The six steps involved are as follows:

1. Launch of a new policy, *Safeguarding Vulnerable Persons at Risk of Abuse*, in December for all HSE and HSE funded services. This builds on and includes existing policies in both disability and elder abuse services.
2. Commencing an Evaluation, Quality and Practice Improvement Programme in Disability Residential Centres.
3. Working with families and service users, a national Volunteer Advocacy Programme in adult disability residential settings was initiated. This will be further developed in 2015.
4. An assurance review (McCoy Review) of all the Units in the Áras Attracta facility commenced.

5. The first ‘national summit’ was held to help transfer learning and oversight. Numerous stakeholders and interested parties participated including the non-statutory services, HIQA, National Disability Association and the Department of Health. It is planned to hold these quarterly in 2015.
6. HIQA published 493 inspection reports during the year. A number of situations arose where poor performance was identified. Processes were established to address service improvement requirements and to ensure the safety of residents at all times.

- In progressing our services for children and young people (0-18s programme), additional funding of €4 million was allocated to meet increases in demographic pressures:
  - Five out of 24 local implementation groups fully reconfigured their children’s services into children’s disability network teams in Meath, Cork West, Kerry, Mid West and Galway with a further eight reconfiguring their Early Intervention Services and completing their plans. The remaining groups are at development phase. All groups will be fully reconfigured by the end of 2015.
  - 55 children’s disability network teams are now in place and 80 new therapy posts have been approved.
  - Funding was also used for waiting list initiatives, to train over 400 staff on the implementation of the 0-18s programme and to purchase essential therapy equipment.
- An extensive consultation and engagement process was undertaken on standards relating to *New Directions – Personal Support Services for Adults with Disability*. An additional €10 million was allocated and a revised process put in place to provide day places for young people with disabilities leaving school and exiting rehabilitation training places. 1,365 additional young people received one of these day places in 2014.
- As part of implementation of the policy report *Time to Move on from Congregated Settings* (aimed at supporting people to move from institutional settings to community settings), 90 people completed the transition from congregated to community settings, with a further 60 people delayed due to housing issues. These were resolved at the end of the year with once off funding from the Department of Health and the Department of the Environment, Community and Local Government for property purchases and adaptations. These people are expected to transfer to community settings in early 2015.
- Under the *Disability Act, 2005* process, 4,908 applications for a disability assessment were received, with 44% of these being for children aged 5 years and over. This was a 15% increase on 2013 (4,261).
- The implementation of our Value for Money and Policy Review programme continued, with working groups established to progress the recommendations. This includes a new model of person centred community based service to give people greater choice and access to the supports they require.
- A National Service Improvement Team was established to support the services through our reform programme, changing models of care and developing sustainable models of best practice into the future.

HSE Tobar Training Centre, Gweedore

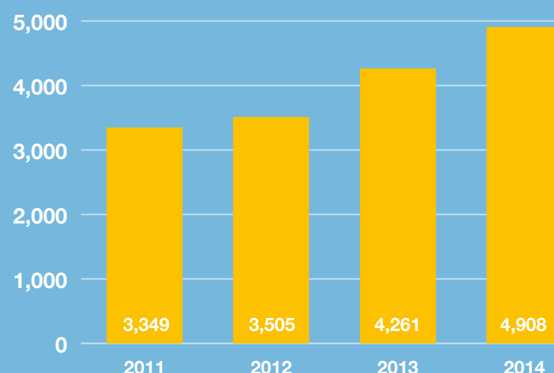
Tobar participants at the garden party

HSE Tobar Training Centre, Gweedore

In June, the HSE Tobar Training Centre, Gweedore held a garden party for family, friends and members of the local community to visit and see the results of everyone’s efforts in the garden this year. It was also an opportunity to view all the different arts and crafts Tobar have been working on.

Tobar is a HSE training centre for adults with intellectual disabilities under Donegal Training and Personal Support Services. Tobar provides day services and also offers a rehabilitative training programme and a sheltered occupational programme, through centre and community based modules.

Figure 19: No. of requests for assessment received under *Disability Act, 2005*



Data source: HSE Performance Reports

The Maria Goretti Foundation Respite Centre for Children with Disabilities in Lordship, Co. Louth

Staff from West Limerick Children's Services setting up the Occupational Therapy Room in the new centre in Newcastle West (L-R): Louise Bourke, Speech and Language Therapist; Yvonne Ryan, Physiotherapist; Clodagh Corduff, Occupational Therapist; Chris O Connor, Clerical Officer and John Fitzgerald, Social Worker

Children and Young People's Services

In February after many years of planning and public support the Maria Goretti Foundation Respite Centre for Children with Disabilities in Lordship, Co. Louth was finally completed.

The facility will cater for children with disabilities aged 0-18 years living in Louth and will enable parents and carers have a break from the often challenging demands of providing full time care.

Working with a multidisciplinary team, the centre will open on a phased basis, initially with four beds Thursday to Sunday. Children on respite breaks will be provided with social, sport and leisure activities and will also be supported in attending their full time education centres.

Rehabcare will be the service providers on behalf of the HSE by means of a service agreement.

In May, West Limerick Children's Services, a partnership between Brother of Charity Services and the HSE, opened a new centre for families of West Limerick in Newcastle West.

The Greenfield site facility supports various services in one location with spacious specially designated therapy rooms for different disciplines and treatments.

The West Limerick Early Intervention and School Age Teams provide specialist therapeutic assessment and intervention to children with complex disabilities and/or development delay. It works in partnership with families of children and young people with disabilities to minimise the impact of disability and maximise opportunities for growth and development.

Services for Older People

The majority of people in Ireland over 65 years remain independent into very old age, some with the informal support of family and friends, and some occasionally needing to access services such as home help services, home care packages, respite care, day care, meals on wheels, community physiotherapy, occupational therapy and health promotion programmes, as and when required.

For those who can no longer be cared for at home, we continued to provide high quality public residential care. In 2014, 4.1% of people over 65 years were in long stay care (4.5% in 2013). This is now lower than the average OECD rate of 4.5%.

Priorities in 2014 included:

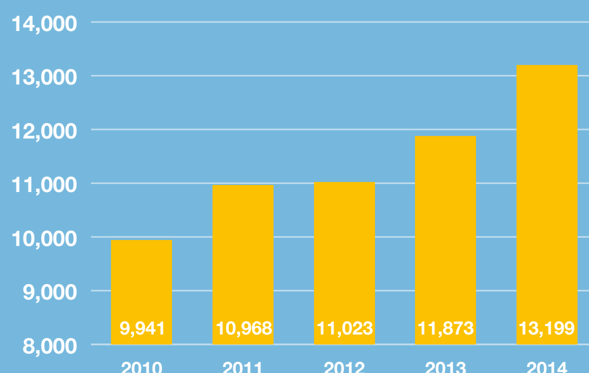
- Engaging, encouraging and supporting older people to keep healthy, remain living at home and stay out of hospital.
- Providing comprehensive home and community supports.
- Developing more integrated models of care and, corresponding service improvement programmes realigned towards home care and community supports.
- Providing quality long stay residential care for older persons, who can no longer be maintained at home, in HSE public community nursing units.

Progressing our Strategic Priorities

A number of initiatives commenced to support older people to keep healthy, this included:

- Implementing the Falls Prevention and Bone Health Strategy aimed at preventing harmful falls amongst persons aged 65 years and older, enhancing the management of falls, and improving health and wellbeing through a focus on bone health (fracture prevention). The strategy is being jointly implemented by the HSE and the State Claims Agency.
- The Carers Strategy was supported by providing a range of services and supports to older persons and their carers. A major initiative that progressed in 2014 was the joint HSE/Genio Projects (supported through Atlantic Philanthropies) which were set up to support the needs of carers of people with dementia.
- The *Irish National Dementia Strategy* was published. A National Strategy Implementation Office is planned to support the roll-out of the Strategy. A joint HSE/ Atlantic Philanthropies funded programme of €27.5m was also announced to support the implementation of the strategy. It will focus on the delivery of intensive home supports for people with dementia, a dementia awareness campaign, and a GP/Primary Care Team education programme.
- There were 2,555 elder abuse referrals, 16% above expected activity, with psychological abuse remaining the most common category (35%). 92% of active cases were reviewed within six months, against a target of 80%.
- In providing community supports:
  - Nearly 10.3m home help hours were delivered, with 47,061 persons in receipt of home help services at December 2014 – an increase of 5.8% on 2013.
  - A total of 13,199 persons received home care packages (HCPs), an increase of 11% on 2013.
- During the year our focus was on ensuring that people were kept no longer than necessary in hospital when they no longer needed acute care (known as delayed discharges):
  - €3m was utilised to support 75 Transitional Care Beds (TCBs) in Cork, Limerick, Waterford and Galway to facilitate discharge of delayed discharge patients from Acute Hospitals in the Dublin Area.
  - In July, an additional €5m funding was allocated to assist with delayed discharges in the Dublin, Kildare and Louth areas. This funding supported over 400 TCBs, 224 HCPs and nine complex discharge placements from the acute hospitals in these areas.
- Actions to support people who could no longer remain at home and required quality residential care included:
  - Progressing the Action Plan to bring all public long stay residential care services in compliance with the *National Quality Standards for Residential Care Settings for Older People in Ireland*, in line with available resources.
  - Supporting 22,360 long term public and private residential places funded under the Nursing Homes Support Scheme (NHSS) – A Fair Deal. This included 300 additional places in December as part of the Delayed Discharge initiative. The NHSS waiting time at the end of December was 11 weeks.
- The introduction of a Single Assessment Tool (SAT) for older people was progressed:
  - Following a procurement exercise, a software development company was appointed to develop a national SAT Information System and an eLearning System to support the training of staff.
  - A multi-disciplinary and multi-agency group was established to develop Irish editions of the assessment forms and manuals.
  - The development of a Carer's Needs Assessment was also progressed, with Ireland being a leader in the development of a carer's assessment.

Figure 20: No. of people in receipt of a home care package (HCP)



Data source: HSE Performance Reports

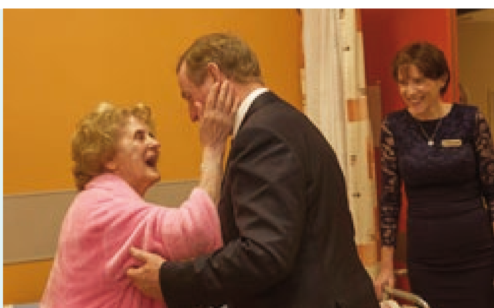
- A SAT Implementation Team was established in each of the four first phase implementation locations (Dublin South West, Dublin North, Cork and Galway) and the teams conducted information sessions with all relevant staff on the SAT system.
- Ensuring that our residential services can meet modern, high quality standards, a number of capital projects were progressed including:
  - Kenmare Community Nursing Unit officially opened in May. Built at a cost of €8m, the 40 bed facility replaced the 100 year old hospital and provides continuing care, convalescent and respite care to high quality standards.
  - The extended and refurbished Ballina District Hospital was opened in December by An Taoiseach, Mr. Enda Kenny TD, at a cost of €1m, of which €0.25m was provided by the Mayo Roscommon Hospice Foundation.
  - In addition a number of Community Nursing Units were upgraded and refurbished to meet HIQA environmental standards to ensure re-registration in 2015.

National Clinical Programmes

We are committed to developing a single integrated model of care for older people across hospital and community services and have established a cross divisional programme between social care and the national clinical programmes. The model is defining appropriate care pathways both from a clinical and social perspective to support older people to live in their own homes and communities. As part of developing an integrated model of care for older people between hospital and community services, 2014 saw progress made in developing the acute hospital model of care. The following took place in 2014:

- Establishment of specialist geriatric service/wards/MDT/ rehabilitation on and off site.
- Evaluation of day hospital services for older people on and off site.
- GAP analysis and follow up recommendations and support implementation for each site completed.

Pictured at the turning of the sod of Mercer's Institute for Successful Ageing at St. James's Hospital were (L-R): Ms. Rose-Anne Kenny, Director of Mercer Institute; Kathleen Lynch TD, Minister of State for Primary and Social Care; Theo Cullinane, Chief Executive, BAM Group Ireland (Photograph: Conor McCabe Photography)



An Taoiseach, Enda Kenny TD, receives a warm welcome from patient Celia Joyce during the Official Opening of the newly extended and refurbished Ballina District Hospital. Also in the photograph is Marie Alexander, Director of Nursing, Ballina District Hospital.

Kenmare Community Nursing Unit

Mental Health

Introduction

It is estimated that one in five of us will experience some mental health problems in our lifetime. Mental health problems can range from a low or sad period to a more serious depression, with a small number of people going on to experience severe mental health problems. Most people with mental health problems can be treated by their GP and are only referred to mental health services when necessary.

A Vision for Change (2006) is the national policy for improving mental health services in Ireland. That policy recommended creating a national structure to effectively manage the strategic, operational and financial activities for mental health services. Those who work in the mental health services want to deliver the best outcomes for the people in our care and provide a service that we can all be proud of. In order to do this we have a number of core objectives:

- Design integrated, evidence based and recovery focused services
- Deliver timely, clinically effective and standardised safe services
- Ensure that the views of users, carers and family members are central to the design and delivery of services
- Support improvement in the mental health of the population and in our approach to suicide prevention
- Fully implement the Health Reform programme within mental health services in a way which ensures appropriate integration with other health and social services.

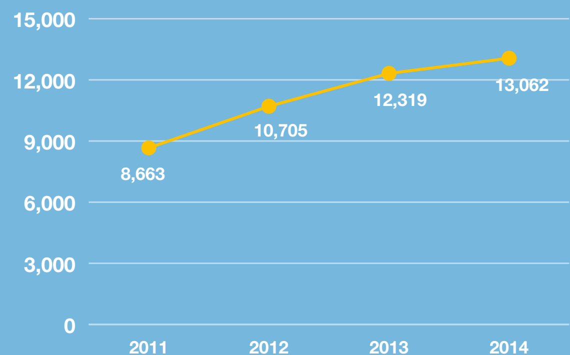
Progressing our Strategic Priorities

- A big part of how we will achieve change and improvement in our services will be by listening, with purpose, to our service users and advocates. A Service User Reference Group was established to ensure that service users are involved in the design and delivery of services. We also completed over 30 national 'Listening' events throughout the country, and met 1,200 service users, families and carers.
- The multi-annual Child and Adolescent Service Improvement Project was established in 2014, which, despite the increasing demand on the service, is focused on maintaining access to age appropriate child and adolescent inpatient capacity and minimising the length of stay for those under 18 admitted to adult mental health facilities.
- Additional government funding of €20m enabled over 250 posts to be allocated to community based child and adolescent, adult and older age mental health services. This funding will support the development of new teams, expansion of existing teams and services and further enhancement of specialist mental health services for people with an intellectual disability, and for people who are homeless, together with forensics and liaison services.

FACTS AND FIGURES IN 2014

- 74% of adults referred to the General Adult Mental Health Teams were seen within three months
- 22% of adults did not attend for their appointments
- 97% of people referred to the Psychiatry of Old Age Teams were seen within three months (3% did not attend)
- 3,329 people were admitted to adult acute inpatient units (4% decrease on 2013)
- 14,407 referrals were received by the Counselling in Primary Care Service, 41,942 appointments were offered, 6,760 clients were assessed for counselling, and 285.5 days of counselling are provided each week across 140 locations
- One in every 100 adults in Ireland are now estimated to have received suicide prevention training through ASIST and safeTALK, free of charge
- 6% increase in referrals accepted by the Child and Adolescent community mental health teams

Figure 21: Increase in referrals accepted by Child and Adolescent Mental Health services (CAMHs) Community Mental Health teams since 2011



Data source: HSE Performance Reports

- In addition, the majority of approximately 900 development posts from 2012 and 2013 were also in place by the end of the year.
- The National Incident Support and Learning Team was established. Significant progress was made implementing the HSE Safety Incident Management policy and guidelines. The Mental Health Risk Register was maintained and an updated reporting process established.

- A number of projects are underway to ensure standardised working practices; they include the recovery-based approach to service delivery through the Advancing Recovery in Ireland (ARI) Project. Team co-ordinators are being put in place and on-going training and support is being provided to community mental health teams to work collaboratively to support the service user.
- Work on key ICT infrastructural deficits was completed, including the Proof of Concept for an Interim Data Gathering Solution, and the establishment of a national eRostering Project. Each of these projects is aimed at providing decision support for the planning and delivery of the mental health services to meet the needs of the population.
- A dedicated Project Management Office to support the continued and more effective implementation of Vision and reform of mental health services was established which will be further developed during 2015.

National Clinical Programmes

Some key achievements in 2014 included:

- Appointment of National Clinical Advisor and Group Lead to work between clinical strategy and programmes and mental health services.
- Implementation of Self Harm Presentations Programme to Emergency Department:
    - 25 Clinical Nurse Specialist posts were recruited to this clinical programme.
    - Standard Operating procedure for assessment and Continuous Professional Development in place.
    - Programme was implemented in December 2014.
    - Data collection is underway.
- Two further programmes are also being progressed
    - Early Intervention in Psychosis
    - Eating Disorders.

National Office for Suicide Prevention

The National Office for Suicide Prevention (NOSP) leads the implementation of *Reach Out*, the Government's strategy for suicide prevention 2005-2014. Working with over 40 agencies from the voluntary, statutory and non-statutory sectors, work continued to promote positive mental health and reduce suicide and self harm. In 2014, NOSP:

- Worked with Government and progress was made on a new Strategic Framework to build on and enhance the suicide prevention approach based on the learning from *Reach Out*.
- In partnership with Console, a new Family Suicide Bereavement Service was rolled out, which supports bereaved individuals, families, organisations, communities in the aftermath of a death by suicide.
- A campaign was launched, *#littlethings*, an integrated national health education campaign to create awareness about the activities that people can do to positively impact on their health and mental wellbeing. It has been developed according to international evidence, partner collaboration and local research. The campaign, which includes advertising materials for TV, radio, outdoor and digital, also includes the widespread dissemination of posters and postcards. The campaign uses stories to create awareness about the #littlethings that people can do to positively impact on their mental health. The campaign has over 32 committed partners.

Stories from the Front

Stories from the Front tells an insightful story of individual engagements by service users and family members with mental health services. In a unique collaboration between a small group of service users, family members and mental health professionals, stories of engaging with mental health services and the themes emerging have been captured on film and dramatic re-enactment with a view to providing training materials for mental health professionals.

> *"Our aim was to create a project that would educate, train and entertain general members of the public in an informal manner and encourage participation and generate self confidence and fun among all those who performed in the play."*

The stage play has now been presented to a general audience to great acclaim and to full houses in Smock Alley Theatre and Liberty Hall Theatre in Dublin.

There are future plans to present this production and use the material from it in other locations across the country in 2015.

The cast of Stories from the Front with Kathleen Lynch TD, Minister of State for Primary and Social Care at a performance in Smock Alley Theatre

In March 2014, a new free to call number – **116 123** – for people who are struggling to cope was launched by the National Office for Suicide Prevention in partnership with Samaritans Ireland. The number makes it possible for people to access the service round the clock, every single day of the year, free of charge. The new free to call number has been made possible by a partnership between Samaritans and the telecommunications industry.

In 2007, the European Commission decided to reserve numbers beginning with 116 for services of social value that would be common across all EU member states. The number 116123 has been given for all 24 hour emotional support helplines. ComReg awarded Samaritans the 116123 number as it is the only organisation in Ireland already meeting and exceeding all of the minimum standards for these services.

#littlethings

Here are the #littlethings that can make a big difference to our mental health and wellbeing:

Keeping Active – being active every day, something as simple as a walk, is proven to have a positive impact on your mood.

Talking about your problems – problems feel smaller when they are shared with others, without having to be solved or fixed. Just talking about it will do you good.

Looking out for others – Lending an ear to someone else in trouble, or catching up with someone who seems distant, can change their day, or their lives. You don't have to fix it for them – just listening is a huge help.

Doing things with others – Taking part in a group activity that you enjoy is proven to have a positive impact on how you feel, be it a game of football, joining a choir, volunteering.

Eating healthily – A regular healthy, balanced and nutritious diet will help both your physical, but also your mental health, and have a positive impact on how you feel.

Staying in touch – Catching up with friends and family is good for our mental health, reminding us that we're part of a community, and having a positive impact on how we feel.

Drinking less alcohol – For the average Irish drinker, reducing alcohol will have a positive impact on their health and mental wellbeing, making it easier to cope with day to day difficulties and stresses.

Sleeping well – Getting a good night's sleep of seven or eight hours, as often as you can, will have a positive impact on how you feel. Protect your sleep if you can, it will do you good.

PROBLEMS FEEL SMALLER WHEN YOU SHARE THEM

Talking about your problems is proven to have a positive impact on how you feel.

#littlethings can make a big difference

Pictured at the launch of the *#littlethings* campaign are Alan O'Meara (far left) and Robert Carley (far right) who featured in the advertisements. Also pictured are Kathleen Lynch TD, Minister of State for Primary and Social Care and Gerry Raleigh, Director, National Office for Suicide Prevention

New Child and Adolescent Mental Health Day Hospital in Galway

In the summer of 2013 a potential premises was identified for a new Day Hospital that would serve the Galway/ Roscommon CAMHs. The premises were located in an old unit on the grounds of Merlin Park Hospital and required substantial refurbishment to create a youth friendly space. A group of ten highly motivated and creative teenagers attending the South Galway CAMHs worked collaboratively with the team's Occupational Therapist and other staff members to design, plan and decorate the premises.

The group met every Wednesday evening and during school holidays over a ten month period (October 2013-July 2014) and had a therapeutic focus. An innovative 'upcycling' approach was adopted in order to deliver a unique space on a small budget. 'Upcycling' is the process of converting old or disused materials into something useful and attractive. HSE stores of disused furniture provided a rich supply of desks, filing cabinets, dressers, sideboards, benches and chairs which were then transformed using paint, wallpaper and lots of imagination. The group also received donations of used couches which created the relaxation space in the large group room. The space created by the teenagers was featured in the Irish Interior Design magazine 'Upstairs Downstairs' in June 2014.

The Day Hospital was officially opened by Kathleen Lynch TD, Minister of State for Primary and Social Care on the 15th October 2014. The service began to accept referrals from the 20th October with the first admission on the 6th November. The Day Hospital's current capacity is four young people (aged 14-18 years). It is currently staffed by two fulltime staff both of whom are seconded from the CAMHs Inpatient unit (one Clinical Nurse Manager II and one Staff Nurse).

Clinical responsibility currently remains with the Community Child and Adolescent Psychiatrist, and multidisciplinary input is provided by the referring community team. The Day Hospital's capacity will expand this year with the welcome addition of a senior occupational therapist and three nurses allocated under new development funding. Two of the teenagers involved in the upcycling project now act as Youth Representatives on the Day Hospital Steering Committee, alongside multidisciplinary representatives from each of the Galway Hospitals.

Corporate Support Services

Introduction

Providing a safe, modern, efficient health care system is not solely the role of our front line services. Behind the scenes, essential support services such as Human Resources, Finance, Health Business Services, Information and Communication Technology etc. produce and deliver the 'tools' to make sure that the services the public interact with on a daily basis can actually function effectively.

In 2014, we continued to develop all our corporate support services to drive quality, efficiency, and value for money.

FACTS AND FIGURES IN 2014

- HSELanD, *www.hseland.ie*, has 75,927 active users
- There are over 100 e-learning resources and programmes on *www.hseland.ie*
- Over 51,000 e-learning programmes were completed, 12,000 of which were for Hand Hygiene for Clinical Staff

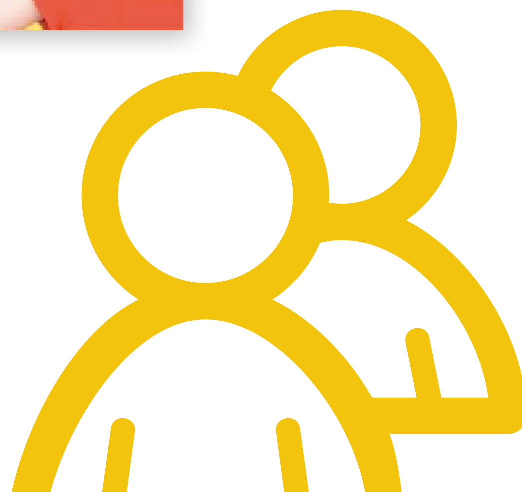
Progressing our Strategic Priorities

Corporate Human Resources

Developing and delivering better, safer, quality care to our patients is dependent on the collective contribution of our workforce. We are committed to identifying, attracting and employing the very best people at every level in the organisation and providing a work environment that motivates and engages to ensure we keep our most talented people. We seek to care for all our stakeholders equally – employees and service users – and our leaders and managers are committed to building a strong adaptive culture based on shared values, trust, leadership and accountability.

In 2014:

- The first ever health service wide employee engagement survey was conducted at the end of the year to measure opinions and attitudes across a variety of topics on all aspects of working life. The results of the survey will be used to develop Staff Engagement Improvement Plans to be actioned in 2015 aimed at improving the working lives of staff, leading to better care for patients.
- A unified health and safety management structure was implemented. A national health and safety manager was appointed and four national teams set up to cover Policy, Inspection and Audit, Training, and Information and Advice. This national structure will deliver many benefits including better use of limited resources, better integration, more structured service delivery, and greater opportunities for learning and consolidation of health and safety best practice.
- The HSE's Corporate Safety Statement was updated and a Health and a Safety Management Advisory Committee established.
- The development of a national integrated strategic framework for health workforce planning was progressed through joint working between the DoH and the HSE. Workshops and briefings were held across all services with staff and unions.
- 96 managers took part in a Succession Management Development Programme. This will be followed by a bespoke 12 month intensive development pathway in 2015.
- A multidisciplinary leadership development programme was piloted and successfully evaluated in conjunction with the Institute of Leadership, RCSI. It will be rolled out through five national multidisciplinary leadership development programmes.
- An Executive Coaching and Mentoring Framework was launched and evaluated during the year and will be offered across the health sector in 2015.
- A number of key policies and procedures were finalised including the Policy on *Management of Work-Related Aggression and Violence*.



Corporate Finance

The Finance Reform Programme (FRP) is an important element in the overall health system reform programme. The following elements have been implemented or progressed:

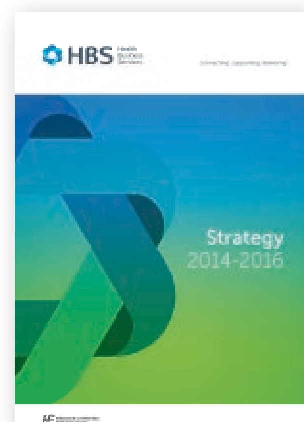
- An agreed Finance Operating Model was completed.
- A business case was submitted to the Department of Health in May for endorsement and onward submission to the Department of Public Expenditure and Reform.
- One to one market engagement sessions commenced in September in addition to a due diligence of finance systems and Organisation Design and Change Management.
- A Finance National Management Team was established with full accountability and responsibility for implementation of the new finance operating model including the redesign of organisational structures.
- One to one pre-procurement market engagements were undertaken with a draft document completed. A number of procurement approaches are under review as well as the development and approval of a procurement strategy.
- A due diligence of legacy finance systems was completed in December. A series of recommendations from this will form part of the FRP 2015 workplan.

Money Follows the Patient (Activity Based Funding)

We are committed to introducing 'money follows the patient' funding models for healthcare, in line with our health reform programme. A Healthcare Pricing Office was established in 2014 and Activity Based Funding was launched in the 38 hospitals in the Casemix Programme. Key elements included:

- Specifying activity targets for each hospital with monthly monitoring and reports to each hospital/group against plan
- Rolling out of a new Business Intelligence system to each hospital allowing them to interrogate their HIPE data flexibly and quickly down to the level of individual consultant/ patient/length-of-stay etc.
- Significant mobilisation of the system was undertaken – engagement with the RCSI, RCPI, and a wide range of clinicians, hospital groups and other stakeholders
- Considerable work was undertaken on the timeliness and quality of HIPE coding with most hospitals now meeting the 30-day coding timeline
- A major programme of work was carried out to upgrade the HIPE coding classification to the 8th Edition of ICD10-AM. This involved re-training all coders nationally and re-designing all manuals, reference materials etc.
- An *Implementation Plan 2015-2017 for Activity Based Funding* was drafted and submitted to the Department of Health for approval

Health Business Services (HBS)



Implementation of the *Health Business Services Strategy 2014-2016* commenced. In line with modern business practices we are aiming that all health and personal social services have access to a range of common support business services on a shared basis. This will enable operational services to focus management attention on its core business. Key items progressed in 2014 included developing the HBS Service Catalogue and business partnership arrangements with the operational business.

FACTS AND FIGURES IN 2014

- 318 new capital ICT funded projects progressed
- 313 major capital projects supported
- 121 capital ICT projects completed
- €39.824 million spend on ICT Capital Projects
- Over 99,000 staff, 45,000 devices and over 1,750 systems supported
- Over 170,000 support calls from Health Service staff processed
- €30.5m procurement savings were achieved
- 1,008 projects initiated by Procurement
- NRS received on average 432 requests to recruit each month
- 13,610 pensioners on national pension payroll by year end. National pension payroll cost was €198m
- 80,749 staff paid and 30,792 pensioners paid. Additionally 4,178 Tusla staff paid through a dedicated payroll service from HBS Finance.
- 33,036 staff and 2,924 retirees registered on line for payslips. Additionally 662 Tusla staff are registered.

HBS staff engagements/ cultural workshops

Almost 33% HBS staff participated in a series of engagements and cultural workshops, led by HBS senior management, across the country. This commitment to engage with all HBS staff will continue into 2015. The workshops are designed to provide opportunity for staff to gain a full understanding of the requirements to implement the HBS model and to allow their views to be heard and considered in moving this agenda forward.

- The **Customer Relationship Management** *function of HBS has been established to work in partnership with HBS functions and their customers to support and develop business services to ensure they are fit for purpose and can meet customer requirements*. Progress in 2014 included:
    - Developing the HBS *Customer Relationship Management Strategy 2014-2017*.
    - Recruiting HBS Business Relationship Managers to facilitate effective relationship management between HBS and the customer base.
- **HBS Procurement** *is responsible for sourcing, purchasing, storage and distribution of goods and services, ensuring compliance with governing procurement legislation and EU directives and government guidelines.* In 2014 we focused on:
    - Defining and implementing a standard procurement operating model designed to comply with requirements of Government decision 'One Voice for Health'.
    - Delivering on procurement savings of €30.5m.
    - Setting out relationships with the voluntary sector and Hospital Procurement Services Group and commencing implementation of a service management framework covering governance, service catalogue, Service Level Agreement (SLA) development and performance reporting.
    - Working with the Office for Government Procurement in developing SLAs/Memorandum of Agreement between HBS and its customers.
    - Continuing the implementation of a National Distribution Centre to support a number of geographically located hubs located across the country.
- **HBS Estates** *is responsible for maximising the value of HSE properties and facilities and managing the multi-annual Capital Plan, to ensure that appropriate infrastructure is in place to enhance patient, client and staff wellbeing. The Health Service estate comprises of 2,459 properties.* A wide variety of capital projects progressed in 2014 including:
    - Ten new Primary Care Centres were completed or became operational.
    - Planning permission received for 14 Primary Care Centres, delivered through Public Private Partnership.
    - Nine mental health projects were completed.
    - Construction commenced on a further 24 projects.
    - Purchasing of Mount Carmel Hospital, Dublin which will open as a step-down facility in 2015.
    - Appointing a design team to the project for the new integrated National Children's Hospital on the St. James Hospital Campus.
    - Completing the National Ambulance Service Control and Command Centre in Tallaght which won the best public sector fit out at the National Fit Out Awards 2014.
    - Continuing HIQA compliance works in older people long term care facilities.
    - Appointing a design team for the re-development of the national Maternity Hospital at St. Vincent's University Hospital Campus and completing design.
    - Commencing detailed design for the national Forensic Mental Health Services Project (replacement of Central Mental Hospital, Dundrum) and lodging the Strategic Infrastructure Development planning application with An Bord Pleanála.
    - The turning of the sod of Mercer's Institute for Successful Ageing (MISA), Ireland's first dedicated centre for successful ageing at St. James's Hospital.

Additional information in relation to all capital projects can be found throughout the report and summarised in Appendix 4.

- **HBS Finance** *delivers core business services to frontline operational services including payroll, accounts payable, general accounting and financial reporting.* In 2014 highlights included:
    - Leading the management account aspect of the technical SAP upgrade project (former Eastern Region).
    - Implementing full Finance Shared Services to Tusla.
    - Continuing the roll out of online payslips.
    - Developing the electronic Health Private Insurance Management System (Claimsure) across all hospitals.
- **HBS Human Resources** *oversees the management of critical HR support services including pensions management, recruitment and administration of personnel records. 2014 was a particularly busy year across all these areas, for example there was a 40% increase in activity levels for National Recruitment Services.* Key projects pursued in 2014 included:
    - Implementing full personnel/payroll service for Tusla.
    - Continuing to implement the national project, electronic document management for personnel records.
    - Obtaining approval for a dedicated ICT project team to progress the pensions shared service register system to superannuation departments and to procure and implement a pension enterprise system for the health service.
- **Enterprise Resource Planning Services** *supports, maintains and develops the SAP HR/Payroll system and related business intelligence capability for HR/Payroll data on behalf of our business partners.* In 2014 the focus was on:
    - Implementing Tusla HR/payroll system.
    - Implementing Tallaght Hospital SAP HR/Payroll System.
    - Completing structural authorisations pilot project.

Office of the Chief Information Officer (Information and Communication Technology)

In late 2014, the Office of the Chief Information Officer (OoCIO) was created as an enabler for the health service throughout Ireland. In December, all elements of the ICT function moved from HBS to under the leadership of the newly appointed Chief Information Officer.

The focus is to facilitate the adoption of new technology and innovations identified within the *eHealth Ireland* strategy at a pace that will provide a return on additional investment made in information and technology within health.

Delivery will be managed through a governed, programmatic structure to facilitate successful, standardised deployment into the health and social care environments. The newly formed office has responsibility for Information Technology throughout the HSE. It consists of specific technical expertise, service management capability, programme and project resources, information governance and IT security resources.

A number of systems were introduced or rolled out during 2014 including:

- The National Electronic Blood Tracking System (EBTS). Phase 3 also commenced.
- National Patient Administration System framework was extended and solutions deployed successfully in the South East, Portlaoise, Mullingar and Mid-West. A process is now in place to deploy these solutions safely and efficiently throughout Ireland.
- National New Born and Maternal Clinical Information System.
- Health Insurance Claims System phase 4 (Claimsure).
- National Endoscope Tracing System.
- National Radiology Quality Assurance Programme.
- Finance System was upgraded in some areas.
- National Ambulance Control Centres were made digital.
- Computer Aided Dispatch for ambulances.
- National Radiology PACS solution is expanding to St. James's and Tallaght Hospitals, Dublin and a framework is in place to deploy throughout Ireland.
- Successful completion of eReferral project and the definition and design of a full implementation for supporting the referral process with a digital solution.
- Replacement of Windows XP technology with Windows 7 and 8 devices.

National Electronic GP Referral Pilot Project

The National Electronic GP Referral Pilot Project was tasked with the introduction of electronic general referral to the six acute hospitals in Cork and Kerry and Tallaght Hospital, Dublin. Utilising the general referral form for GP Referrals, recommended by HIQA, electronic general referral is now integrated into the four accredited GP Systems with a Healthlink online version also available. The coded message is transmitted securely via Healthlink and is accepted at:

- Bantry General Hospital
- Cork University Hospital
- Kerry General Hospital
- Mallow General Hospital
- Mercy University Hospital
- South Infirmary Victoria University Hospital
- Tallaght Hospital.

Over 20,000 electronic GP referrals have now been received by participating hospitals, with 67% of Cork and Kerry GPs now using the system. Based on the success of this pilot, it is planned to roll out electronic GP referral nationally in 2015.

Appendix 1 Membership of Directorate and Leadership Team

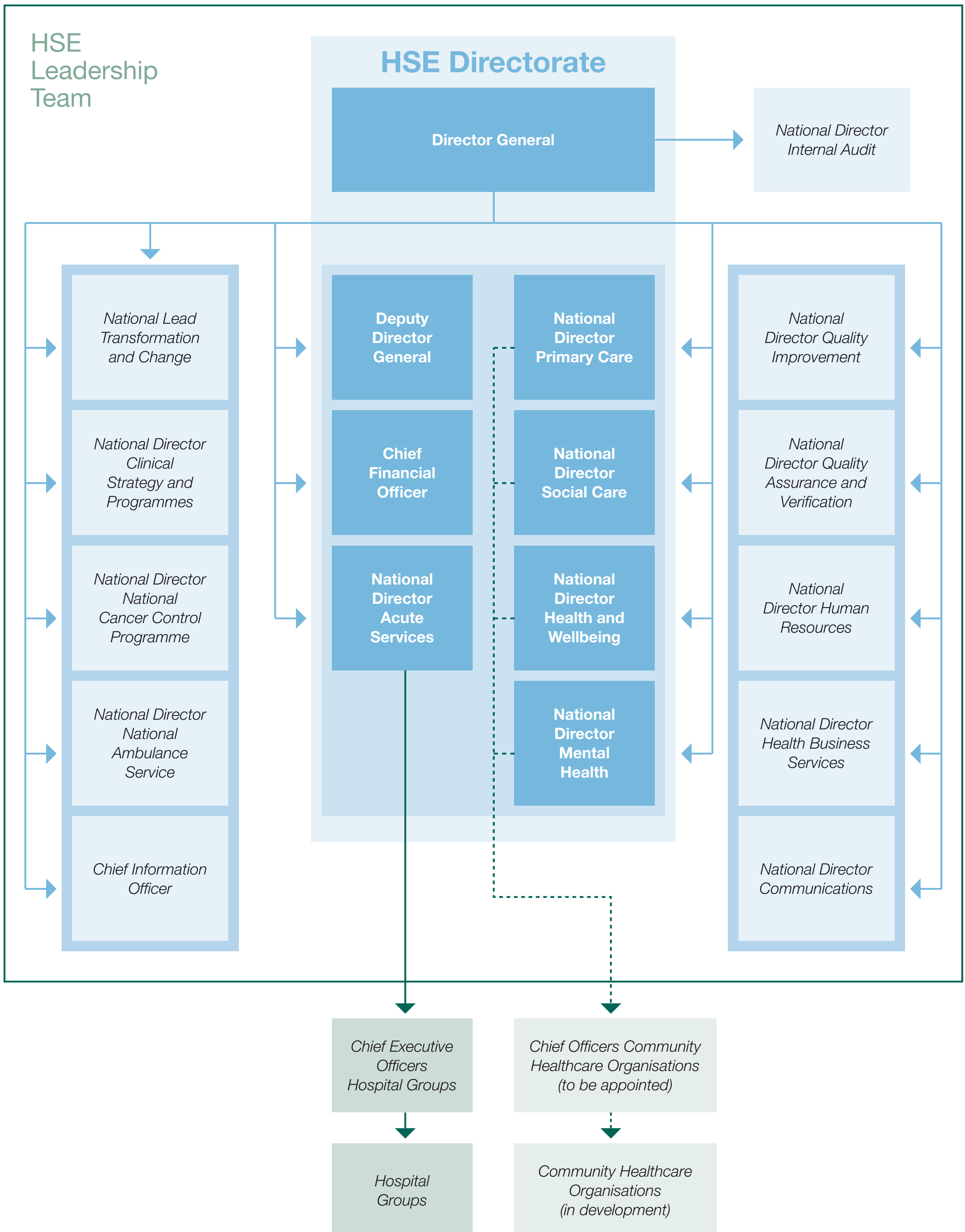
As at 31st December 2014

- ***Mr. Tony O'Brien** (Director General)
- **Dr. Áine Carroll** (National Director, Clinical Strategy and Programmes)
- **Mr. Ian Carter** (National Director, Quality Assurance and Verification)
- **Dr. Jerome Coffey** (National Director, National Cancer Control Programme)
- **Dr. Paul Connors** (National Director, Communications)
- **Mr. Richard Corbridge** (Chief Information Officer)
- **Mr. John Cregan** (National Director, National Ambulance Service)
- **Dr. Philip Crowley** (National Director, Quality Improvement)
- **Mr. Michael Flynn** (National Director, Internal Audit)
- ***Mr. Pat Healy** (National Director, Social Care)
- ***Mr. John Hennessy** (National Director, Primary Care)
- **Mr. Leo Kearns** (National Lead, Transformation and Change)
- ***Ms. Laverne McGuinness** (Deputy Director General)
- ***Mr. Stephen Mulvany** (Chief Financial Officer)
- ***Dr. Tony O'Connell** (National Director, Acute Services)
- ***Ms. Anne O'Connor** (National Director, Mental Health)
- ***Dr. Stephanie O'Keeffe** (National Director, Health and Wellbeing)
- **Mr. Dara Purcell** (Secretary to the Leadership Team)
- **Mr. Ian Tegerdine** (National Director, Human Resources)
- **Mr. Liam Woods** (National Director, Health Business Services)

* Directorate member

Appendix 2 Organisational Structure

As at 31st December 2014



Appendix 3 Performance against Key National Service Plan 2014 Indicators

Note: Where the reported actual figure is a percentage, this figure is cumulative for the relevant year; where the reported actual figure is a number, this figure is as at end December of that year, except where otherwise indicated

	Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
HEALTH AND WELLBEING	**Health Protection** (Quarterly)				
	% children 24 months of age who have received the **Measles, Mumps, Rubella (MMR)** vaccine	92.4%	95%	93.0%	-2.1%
	% children 12 months of age who have received the **6-in-1** vaccine	91.1%	95%	92.0%	-3.2%
	% children 24 months of age who have received 3rd dose of **MenC**	86.3%	95%	87.8%	-10.7%
	% first year girls who have received third dose of **HPV** vaccine by August 2014	84.1%	80%	83.6%	4.5%
	Child Health (Quarterly)				
	% **newborn babies** visited by a PHN within 48 hours of hospital discharge	84.2%	95%	85.7%	-9.8%
	% of children reaching 10 months who have had their **child development health screening** before 10 months (monthly)	88.1%	95%	92.1%	-3.1%
	Chronic Disease Prevention (Quarterly)				
	% of PCTs in Monitoring sites trained in Health Service – ICGP Weight Management Treatment Algorithm for Children	New PI 2014	70%	Data not available	–
NATIONAL AMBULANCE SERVICE	**Response Times** (Monthly)				
	% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	69.3%	> 80%	76.4%	-4.5%
	% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less (HIQA target 95%)	63.8%	> 80%	65.0%	-18.8%
	Clinical Outcome (Quarterly)				
	Return of Spontaneous Circulation (ROSC) at ED in bystander witnessed Out of Hospital Cardiac Arrest (OHCA) with initial shockable rhythm using the Utstein comparator group calculation	New PI 2014	40%	Data not available	–
ACUTE HOSPITAL SERVICES	**Inpatient and Day Case Waiting Times** (Monthly)				
	No. of adults waiting > 8 months for an elective procedure (inpatient)	4	0	4,454	–
	No. of adults waiting > 8 months for an elective procedure (day case)	0	0	8,961	–
	No. of children waiting > 20 weeks for an elective procedure (inpatient)	179	0	1,378	–
	No. of children waiting > 20 weeks for an elective procedure (day case)	14	0	904	–

ACUTE HOSPITAL SERVICES

Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
Colonoscopy/Gastrointestinal Service (Monthly)				
No. of people waiting > 4 weeks for an urgent colonoscopy	0	0	21	–
No. of people waiting > 13 weeks following a referral for routine colonoscopy or OGD	96	0	4,850	–
Emergency Care (Monthly)				
% of all attendees at ED who are discharged or admitted within 6 hours of registration	66.3%	95%	67.6%	-28.8%
% of all attendees at ED who are discharged or admitted within 9 hours of registration	80.8%	100%	81.3%	-18.7%
Reduction of trolley waits	New PI 2014	10%	Increase of 6.1%	-161.0%
HIQA Tallaght Report (Quarterly)				
No. of patients who re-attend the ED with the same clinical condition within 7 days	New PI 2014	< 5%	Data not available	–
No. of patients being cared for in inappropriate care	New PI 2014	< 5%	Data not available	–
% of patients who leave the ED without completing their treatment	4.0%	< 5%	4.4%	0.0%
Outpatients (OPD) (Monthly)				
No. of people waiting longer than 52 weeks for OPD appointment	4,937	0	61,400	–
Acute Medical Patient Processing (Monthly)				
% of medical patients who are discharged or admitted from AMAU within 6 hours AMAU registration	Data not available	95%	63.7%	-32.9%
ALOS (Monthly)				
Medical patient average length of stay	6.7	5.8	6.9	-19.0%
Surgical patient average length of stay	4.5	5.3	5.3	0.0%
ALOS for all inpatients	5.4	5.6	5.3	5.4%
ALOS for all inpatient discharges excluding LOS over 30 days	4.5	4.5	4.5	0.0%
Stroke Care (Bi-annually)				
% of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated who receive thrombolysis	12.6%	9%	11.8%	31.1%
% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute or combined stroke unit	59.0%	50%	61.5%	23.0%
Acute Coronary Syndrome (Quarterly)				
% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	88.3%	70%	84.1%	20.1%
Surgery (Monthly)				
% of elective surgical inpatients who had principal procedure conducted on day of admission	67.0%	85%	65.0%	-23.5%
Time to Surgery (Monthly)				
% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	83.2%	95%	82.0%	-13.7%

	Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
ACUTE HOSPITAL SERVICES	**Hospital Mortality** (Annually)				
	Standardised Mortality Rate (SMR) for inpatient deaths by hospital and clinical condition	New PI 2014	National average or lower	Data not available	–
	Re-Admission (Monthly)				
	% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	10.7%	9.6%	11.0%	-14.6%
	% of surgical re-admissions to the same hospital within 30 days of discharge	2.0%	< 3%	2.0%	0.0%
	Medication Management (Quarterly)				
	% of medication errors causing harm/no harm/death reported to CIS – as a % of bed days or population	New PI 2014	Hospital variance with national baseline	0.139%	–
	Delayed Discharges (Monthly)				
	Reduction in bed days lost through delayed discharges (cumulative data)	243,394	10% reduction	236,774	-8.1%
	Reduction in no. of people subject to delayed discharges	669	10% reduction	719	-19.4%
	Healthcare Associated Infections				
	Rate of MRSA bloodstream infections in acute hospital per 1,000 bed days used (Quarterly)	0.064	< 0.057	Data not available	–
	Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used (Quarterly)	2.3	< 2.5	2.2	0.0%
	Median hospital total antibiotic consumption rate (defined daily dose per 100 bed days) per hospital (Bi-annually)	New PI 2014	83	79.5	4.2%
	Alcohol Hand Rub consumption (litres per 1,000 bed days used) (Bi-annually)	New PI 2014	25	27.1	8.4%
	% compliance of hospital staff with the World Health Organisation's (WHO) 5 moments of hand hygiene using the national hand hygiene audit tool (Bi-annually)	New PI 2014	90%	85.6%	-4.9%
	Patient Experience (Annually)				
	% of hospitals conducting annual patient experience surveys amongst representative samples of their patient population	New PI 2014	100%	Data not available	–
	Compliance with EWTD (Monthly)				
	< 24 hour shift	New PI 2014	100%	94%	-6%
	< 48 hour working week		100%	67%	-33%
	National Early Warning Score (NEWS) (Quarterly)				
	% of hospitals with full implementation of NEWS in all clinical areas of acute hospitals and single specialty hospitals	New PI 2014	95%	98.0%	3.2%
	% of all clinical staff who have been trained in the COMPASS programme	New PI 2014	> 95%	Data not available	–

	Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
ACUTE HOSPITAL SERVICES	**National Standards** (Quarterly)				
	% of hospitals who have commenced first assessment against the NSSBH	New PI 2014	95%	Data not available	–
	% of hospitals who have completed first assessment against the NSSBH	New PI 2014	95%	Data not available	–
	MFTP				
	% of HIPE coding episodes completed within 30 days of discharge	New PI 2014	> 95%	95.0%	0.0%
NATIONAL CANCER CONTROL PROGRAMME	**Symptomatic Breast Cancer Services** (Quarterly)				
	% of attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of 2 weeks for urgent referrals	97.9%	95%	94.0%	-1.1%
	Lung Cancers (Quarterly)				
	% of patients attending the rapid access clinic who attended or were offered an appointment within 10 working days of receipt of referral in the cancer centre	91.2%	95%	88.0%	-7.4%
	Prostate Cancers (Quarterly)				
	% of patients attending the rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral in the cancer centre	55.4%	90%	51.1%	-43.2%
	Radiotherapy (Quarterly)				
	% of patients undergoing radical radiotherapy treatment who commenced treatment within 15 working days of being deemed ready to treat by the radiation oncologist (palliative care patients not included)	80.5%	90%	87.6%	-2.7%
PRIMARY CARE	**Orthodontics** (Quarterly)				
	Reduce waiting times of those waiting for assessment	New PI 2014	90% assessed within one year	96.5%	7.2%
	Reduce the proportion of patients on the treatment waiting list longer than 4 years **(grade 4 and 5)**	New PI 2014	< 5%	5%	0.0%
	Quality and Patient Safety				
	Healthcare Associated Infection: Medication Management (Bi-annually)				
	Consumption of antibiotics in community settings (defined daily doses per 1,000 inhabitants per day)	New PI 2014	< 21.7	22.9	-5.5%
	Physiotherapy and Occupational Therapy Wait List Management (Quarterly)				
	Occupational Therapy – No. of patients waiting over 16 weeks for an assessment	8,511	< 10%	8,141	-6.3%
	Physiotherapy – No. of patients waiting over 12 weeks for an assessment	7,181	< 10%	7,433	-15.0%

	Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
SOCIAL INCLUSION	**Substance Misuse** (Quarterly)				
	% of substance misusers **(over 18 years)** for whom treatment has commenced **within one calendar month** following assessment	97.0%	100% (1,260)	97.0% (1,109)	-3.0%
	% of substance misusers **(under 18 years)** for whom treatment has commenced **within one week** following assessment	99.0%	100% (105)	97.0% (67)	-3.0%
	Homeless Services (Quarterly)				
	% of individual service users admitted to homeless emergency accommodation hostels/facilities whose health needs have been assessed as part of a Holistic Needs Assessment (HNA) within two weeks of admission	66.0%	85%	68.0%	-20.0%
PCRS	**Medical/GP Visit Cards** (Monthly)				
	% of properly completed medical/GP visit card applications processed within the 15 day turnaround	97.8%	95%	96.4%	1.5%
PALLIATIVE CARE	**Inpatient Units – Waiting Times** (Monthly)				
	Specialist palliative care inpatient bed provided within 7 days	95.0%	94%	96.0%	2.1%
	Community Home Care – Waiting Times (Monthly)				
	Specialist palliative care services in the community provided to patients in their place of residence within 7 days (Home, Nursing Home, Non-Acute Hospital)	87.0%	82%	88.0%	7.3%
SOCIAL CARE	**DISABILITY SERVICES**				
	0-18s Programme (Bi-annually)				
	Proportion of Local Implementation Groups which have Local Implementation Plans for progressing disability services for children and young people	3	25 of 25	13	-48.0%
	Disability Act (Quarterly)				
	% of assessments completed within the timelines as provided for in the regulations	23.2%	100%	33.0%	-67.0%
	Day Services (Report Sept onwards – Bi-annually)				
	% of school leavers and RT graduates who have received a placement which fully meets their needs	New PI 2014	100%	100%	0.0%
	Quality (Bi-annually)				
	In respect of agencies in receipt of €5m or more of public funding, the % which employ an internationally recognised quality improvement methodology such as EFQM, CQL or CARF	New PI 2014	100%	100%	0.0%
	OLDER PEOPLE'S SERVICES				
	Elder Abuse (Quarterly)				
	% of active cases reviewed within six month timeframe	New PI 2014	80%	92.2%	15.3%

	Key Performance Indicators	Reported Actual 2013	Target 2014	Reported Actual 2014	% Variance from Target 2014
MENTAL HEALTH	**Adult Mental Health Services**				
	% of General Adult Community Mental Health Teams serving a population of circa 50,000 (range of 45,000 to 60,000) as recommended in Vision (Quarterly)	New PI 2014	≥ 60%	39.0%	-35.0%
	% of accepted referrals/re-referrals offered first appointment and seen within 12 weeks/3 months by General Adult Community Mental Health Teams (Monthly)	New PI 2014	≥ 75%	74.0%	-1.3%
	% of accepted referrals/re-referrals offered first appointment and seen within 12 weeks/3 months by Psychiatry of Old Age Community Mental Health Teams (Monthly)	New PI 2014	≥ 95%	96.0%	0.0%
	Child and Adolescent Community Mental Health Services				
	Admissions of children to Child and Adolescent Acute Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units (Quarterly)	New PI 2014	≥ 75%	69.0%	-8.0%
	% of accepted referrals/re-referrals offered first appointment and seen within 12 weeks/3 months by Child and Adolescent Community Mental Health Teams (Monthly)	70%	≥ 75%	67.0%	-10.7%

Note: 2014 data shown may, in some instances, reflect data in arrears

Appendix 4 Capital Projects

National Ambulance Service

Project Stage – Planning

- Replacement Ambulance Station – Midleton, Co. Cork.
- Cork Compute Centre – Cork University Hospital.
- Ambulance Base and Head Quarters – Cork City.
- New Ambulance Station – Caherciveen Community Hospital, Killarney, Co. Kerry.
- Ambulance Restroom – St Joseph's Hospital, Stranolar, Co. Donegal.

Project Stage – Continuation of construction in 2014

- New Ambulance Base (interim) – Swords, Co. Dublin.
- New Ambulance Station – Sligo.
- Replacement Ambulance Programme – Including ambulances, rapid response vehicles LEAD/ECT02 defibrillators and maintenance of existing fleet.

Project Stage – Construction completed in 2014

- Reconfiguration of National Ambulance Control and Call Centre – Provision of a National Ambulance Control and Call Centre and National Ambulance Headquarters at the Rivers Building, Tallaght, Dublin.
- Upgrade Ballyshannon Ambulance Headquarters to provide backup and support to the Tallaght Centre, Dublin.
- New Ambulance Stations – Loughglynn, Co. Roscommon and Galway.

Acute Hospitals

Project Stage – Planning

Ireland East Hospital Group

- Midland Regional Hospital, Mullingar – Phase 2(b), including replacement ward accommodation and theatre department.
- St. Vincent's University Hospital (SVUH), Dublin – Relocation of the National Maternity Hospital, Holles Street to the SVUH campus.

Dublin Midlands Hospital Group

- Naas General Hospital, Co. Kildare – Provision of a day procedures unit, oncology and physical therapy unit and provision of a replacement endoscopy suite.
- Midland Regional Hospital, Portlaoise – Redevelopment, including maternity unit, theatre department, hospital sterile services department, medical assessment unit (MAU), main concourse and refurbishment of vacated units to expand day services.
- Midland Regional Hospital, Tullamore – Provision of a replacement MRI and additional ultrasound.

RCSI Hospital Group

- Our Lady of Lourdes Hospital, Drogheda – Phase 2, construction of a ward block and provision of a new theatre department.
- Connolly Hospital, Blanchardstown, Dublin – Phased upgrade of the existing radiology department.
- Cavan General Hospital – New endoscopy unit, central sterile services department, inpatient cystic fibrosis unit, upgrade of wards, inpatient palliative care unit, communications room and general electrical upgrade.
- Beaumont Hospital, Dublin – Provision of accommodation for the cochlear implant programme.

Acute Hospitals

Project Stage – Planning

South/South West Hospital Group

- Cork University Hospital (CUH) – Radiation oncology (phase 2), blood sciences (laboratory) project, haematology/oncology ward upgrade, provision of isolation facilities and new helipad.
- Cork University Maternity Hospital – Emergency Department (ED) upgrade.
- Waterford University Hospital – New replacement mortuary and post mortem facilities, new inpatient block to include replacement inpatient beds and a palliative care unit.
- St. Mary's Orthopaedic Hospital (SMOH), Cork – Upgrade of existing ward to facilitate the relocation of Mercy University Hospital (MUH) outpatients department (OPD) to SMOH.
- Mercy University Hospital, Cork – Regional gastroenterology centre, replacement/upgrade of boiler and heating controls.
- Kerry General Hospital, Tralee – Blood sciences (laboratory) project.
- South Infirmary University Hospital (SIUH), Cork – Relocation of ophthalmology OPD to SIUH and provision of a modular facility.

University of Limerick Hospital Group

- Nenagh Hospital, Co. Tipperary – Ward block upgrade programme.
- Limerick University Hospital – Maternity relocation, fit out of ED, construction and fit out of a renal dialysis unit over ED.

Saolta University Health Care Group

- Galway University Hospital (GUH) – Radiation oncology (phase 2)
- Letterkenny General Hospital, Co. Donegal – Following flooding in 2013, restoration and upgrade of coronary care unit, haematology and oncology units, replacement of radiology department including additional ultrasound and computed tomography (CT) room plus a multipurpose interventional suite, restoration and upgrade of OPD, laboratory department, mortuary, central staff changing, underground service duct (and services) and flood prevention works including overflow culvert, redesigned screening and culvert entrance alarms and controls.
- Sligo General Hospital – Acute mental health unit (MHU), upgrade of building fabric and fire compartmentation works, provision of a neuroscience facility in Molloway House, Sligo.
- Portiuncula General Hospital, Ballinasloe, Co. Galway – New replacement ward block.

The Children's Hospital Group

- Children's University Hospital, Temple Street, Dublin – Development of the National Paediatric Hospital and site development at Davitt Road including ambulance base and motor cycle response base.
- Our Lady's Hospital for Sick Children, Crumlin, Dublin – Cardiac catherisation laboratory unit.

National Cancer Control Programme

- Radiation Oncology Project in CUH, GUH and St. Luke's Hospital, Rathgar, Dublin.

Project Stage – Continuation of construction in 2014

Ireland East Hospital Group

- Wexford General Hospital – Fire alarm upgrade.
- National Maternity Hospital, Holles Street, Dublin – Construction of a new neo-natal intensive care unit.
- St. Luke's Hospital, Kilkenny – Phase 1, construction of new ED, MAU and day service including endoscopy and medical education unit. Phase 2, hepatology department, oncology department and provision of an MRI.
- Midland Regional Hospital, Mullingar – ED (phase 2b).
- Cappagh National Orthopaedic Hospital, Dublin – Provision of a recovery unit to serve the theatre department.

Dublin Midlands Hospital Group

- Tallaght Hospital, Dublin – Upgrade/replacement of the existing renal dialysis unit and reverse osmosis water system, ED expansion and upgrade (phase 2).

Acute Hospitals

Project Stage – Continuation of construction in 2014

RCSI Hospital Group

- Beaumont Hospital, Dublin – Renal dialysis – provision of 44 additional dialysis stations and upgrade and refurbishment of St. Damian's ward, expansion of histocompatability and immunogenetics laboratories and equipping of theatre 12 to facilitate expansion of the national renal transplant programme.

South/South West Hospital Group

- Mercy University Hospital, Cork – Phased upgrade of inpatient accommodation.
- South Infirmary University Hospital, Cork – Phased upgrade of inpatient accommodation, refurbishment and upgrade of accommodation to facilitate relocation of ophthalmic surgery from CUH.
- Waterford University Hospital – Cystic fibrosis unit and new decontamination facility for the day unit.
- South Tipperary General Hospital, Clonmel – Extension of the radiology department to accommodate a CT and future MRI.
- Cork University Hospital – Ward refurbishment and upgrade (phase 1), provision of a 50 bed decant ward to enable the refurbishment works to commence, reconfiguration of existing paediatric care OPD and provision of CT and MRI.

University of Limerick Hospital Group

- Limerick University Hospital – Completion (shell space) and fit out of ED, symptomatic breast, dermatology, acute stroke and CF inpatient and outpatient block, clinical research and education centre and acute MHU (final phase).
- Ennis Hospital, Co. Clare – Phase 1(a), redevelopment including fit out of vacated areas in existing building to accommodate physiotherapy and pharmacy. Development of a local minor injuries unit.

Saolta University Health Care Group

- Galway University Hospital – Modular ward block (75 beds); Acute MHU (replacement).
- Letterkenny General Hospital, Co. Donegal – Restoration and upgrade of the catering department following flood damage in 2013, new medical education centre, shell and core construction to facilitate future expansion of renal dialysis unit.
- Mayo General Hospital, Castlebar – Provision of a new cystic fibrosis unit.
- Roscommon County Hospital – Provision of an endoscopy unit.
- Sligo General Hospital – CSSD upgrade, construction of medical education and training facility and upgrade of boiler and plant room.
- Merlin Park University Hospital, Galway – Upgrade of orthopaedic theatre air handling units (AHUs) and theatre plant, including new plant room.

The Children's Hospital Group

- Children's University Hospital, Temple Street, Dublin – Interim works including an ECG room, an admissions unit and OPD waiting room reconfiguration.

Project Stage – Construction completed in 2014

Ireland East Hospital Group

- Our Lady's Hospital, Navan – Upgrade of existing facility to provide ED and urgent care accommodation.
- Wexford General Hospital – New ED, delivery suite and obstetrics theatre and main concourse.

Dublin Midlands Hospital Group

- Tallaght Hospital, Dublin – ED expansion and upgrade (phase 1).
- St. James Hospital, Dublin – Campus wide electrical infrastructure upgrade.

Acute Hospitals

Project Stage – Construction completed in 2014

RCSI Hospital Group

- Beaumont Hospital, Dublin – Provision of a second catheterisation laboratory.
- Connolly Hospital, Blanchardstown, Dublin – Acute MAU and expansion of urology unit.
- Rotunda Hospital, Dublin – Electrical distribution system upgrade and completion of boundary wall, stabilisation works and mortuary upgrade.
- Our Lady of Lourdes Hospital, Drogheda – Acute MHU and refurbishment of the former nurses home to provide a medical education centre.

South/South West Hospital Group

- Waterford University Hospital – Campus wide hospital infrastructure upgrade and upgrade of theatre AHUs.
- Cork University Hospital – Acute respiratory care and cystic fibrosis inpatient unit, development of an acute MAU (phased development) and an Acute MHU.
- Bantry General Hospital, Co. Cork – Provision of a MAU.
- Kerry General Hospital – Upgrade and extension to the acute MHU including high observation unit.

University of Limerick Hospital Group

- Limerick University Hospital – Refurbishment of and extension to the Acute MHU on grounds of the hospital, a critical care block, infrastructural upgrade (including electrical distribution system) to facilitate present and future developments and underground car park.
- Nenagh Hospital, Co. Tipperary – Provision of two theatres.

Saolta University Health Care Group

- Letterkenny General Hospital, Co. Donegal – Following flood damage 2013, reinstatement of ED, emergency works, programme of flood protection work and interim interventional radiology.
- Mayo General Hospital – Renal unit refurbishment and upgrade.
- Merlin Park University Hospital, Galway – School of podiatry (phase 2), provision of a minor procedures unit and rehabilitation unit.
- Galway University Hospital – Upgrade of maternity unit (phase 1), clinical research facility and infrastructural service upgrades to facilitate future developments.

The Children's Hospital Group

- Our Lady's Hospital for Sick Children, Crumlin – Acute child sexual assault assessment and treatment unit, (Earl Street).

National Cancer Control Programme

- Mater Misericordiae University Hospital, Dublin – Relocation of the oncology day unit and drug compounding facility.

Primary Care

Project Stage – Planning

Primary Care Centres

- Primary Care Centres by lease agreement – Clondalkin Village, Shankill, Rathmines/Rathgar, Balbriggan, Kilnamanagh/Tymon, Cashel Road/Walkinstown Dublin; Celbridge, Co. Kildare, Kildare Town; Killeshandra, Co. Cavan; Tipperary Town; South Wicklow/Carnew; Limerick City (Market 1 and 2, Garryowen); Listowel, North Kerry; Mullingar, Co. West Meath; Newmarket, Co. Cork.
- Primary Care Centres – Finglas, Rowlagh/North Clondalkin (including Community MHU and dental), Knocklyon/Rathfarnham, Grangegorman, Dublin; Innisbofin, Co. Galway (replacement); Hacketstown/Tullow/Rathvilley, Co. Carlow; Newtowncunningham, Co. Donegal; Edgeworthstown, Co. Longford; Grange/Drumcliffe, North Sligo; Monaghan Town; Cork City North West (site of SMOH); Borrisokane, Co. Tipperary (extension of hospital/day centre to accommodate a PCC).

Community Health

- North Great George's Street, (Dublin City) – Audiology screening service.
- St Finbarr's Hospital, Cork – New audiology unit.

Primary Care

Project Stage – Planning

Social Inclusion

- Portlaoise, Co. Laois – Community addiction services unit.
- Ennis. Co. Clare – Residential addiction treatment service.

Project Stage – Continuation of construction in 2014

Primary Care

- Primary Care Centres by lease agreement – Wicklow Town; Rathangan/Monasterevin, Co. Kildare; Kells, Co. Meath; Deansgrange, Navan Road, Dublin; Charleville, Co. Cork; Gorey, Co. Wexford.
- Primary Care Centres – Ballyshannon, Co. Donegal (refurbishment and upgrade of former convent and school); Corduff, Dublin; Nazareth House, Sligo (refurbishment, relocating child development services, mental health day centre, primary care team and other community services).

Community Health

- St Fintan's Hospital, Portaloise, Co. Laois – Refurbishment of Alvernia House.
- Tullamore, Co. Offaly – Refurbishment of vacated original hospital (Scott's) buildings to replace rented accommodation in the Tullamore area.
- Meath Hospital, Dublin – Refurbishment of a number of buildings (city lodge and doctor's residence) to accommodate services currently in rented accommodation in the south city area.
- St. John's Hospital, Sligo – Campus upgrade (phase 1) to accommodate staff in Coolock health centre.
- St. Ita's Hospital, Portrane, Co. Dublin – Upgrade and refurbishment of 123 Block.
- National Fluoridisation Programme – Upgrade of fluoridisation plant in local authority water treatment plants.

Project Stage – Construction completed in 2014

Primary Care

- Primary Care Centres by lease agreement – Bride Street/Liberties, Dublin; Clane, Co. Kildare; Athlone, Co. West Meath; Summerhill, Co. Meath; Kinsale, Co. Cork.
- Primary Care Centres – Loughrea, Co. Galway; Manorhamilton, Co. Leitrim.

Community Health

- Ballinamore, Co. Leitrim – CNU co-located with primary care centre.
- Ballybofey, Co. Donegal – Phase 1, refurbishment of St Joseph's Hospital, Stranolar (ground floor) as local area headquarters.
- St Ita's, Portrane, Co. Dublin – Stabilisation work to listed buildings.

Palliative Care

Project Stage – Planning

- **Hospices** in Newbridge, Co.Kildare, Castlebar, Co. Mayo and Co. Wicklow
- **Inpatient Units** in Cavan General Hospital and Waterford University Hospital

Project Stage – Continuation of construction in 2014

- Design and Dignity Scheme – Capital grant scheme for family rooms in EDs, ICUs and wards and upgrade of mortuary viewing rooms/public areas in acute hospitals.
- Kerry General Hospital – Provision of a palliative care unit.

Project Stage – Construction completed in 2014

Palliative Care

- Ballina District Hospital, Co. Mayo – Provision of a level II (2 bedded) facility.

Social Care

Project Stage – Planning

Disability Services

- Ballinasloe, Co. Galway – High support hostel accommodation for residents with intellectual disabilities in St. Brigid's Hospital.
- Fethard, Co. Tipperary – High support hostel accommodation to replace accommodation in St. Luke's.
- Letterkenny, Co. Donegal – Refurbishment and upgrade of existing early learning day and outreach facility.
- Swords, Co. Dublin – Disability day activity centre.
- Mercy University Hospital, Cork – Provision of high support hostel accommodation for residents with intellectual disabilities.
- National Rehabilitation Hospital, Dun Laoghaire, Co. Dublin – Redevelopment (phase 1).

Service for Older People

- Upgrade of non-acute residential facilities (CNUs) to meet HIQA standards including Belvilla, South Circular Road, Ashgrove House and St. Marys, Phoenix Park, Dublin; Dalkey, Co. Dublin; Maynooth, Co. Kildare; Raheen, Co. Clare.
- Bandon, Co. Cork – Bandon Community Hospital extension and refurbishment (phase 1).
- Mount Carmel Hospital, Dublin – Upgrade of hospital to provide a step down facility.
- Sacred Heart Hospital, Castlebar – Refurbishment and extension to 3 long stay wards and a rehabilitation ward.
- Community Nursing Units – St. Coleman's (Rathdrum), Tymon (North Tallaght), St. Ita's (Portrane), Connolly Hospital and Grangegorman, Dublin; Letterkenny and Ballyshannon Co. Donegal; St. Vincent's Athy, Co. Wicklow; Waterford City; Limerick City; Cork City (South and North Lee) and Tralee, Co. Kerry.

Project Stage – Continuation of construction in 2014

Services for Older People

- Upgrade of non-acute residential facilities (CNUs) to meet HIQA standards including Seanchara and Clarehaven, Dublin; St. Josephs,Trim, Co. Meath; St. Oliver Plunkett's, Dundalk, Co. Louth; Virgina Healthcare, Cavan; St. Mary's, Castleblaney, Co. Monaghan; Our Lady's, Cashel, Co. Tipperary; Ennistymon and Regina House, Kilrush, Co. Clare (phase 1).
- St. James's Hospital, Dublin – Mercer Institute for Successful Ageing.
- Keel, Co. Mayo – St. Coleman's day care centre.

Project Stage – Construction completed in 2014

Disability Services

- Deansgate, Kilkenny – Purchase and refurbishment of day facility.

Services for Older People

- Upgrade of non-acute residential facilities to meet HIQA standards – St. Augustine's, Ballina, Co. Mayo; McBride Home and Dalton Home, Claremorris, Co. Mayo; Cuan Ross, Dublin; Áras Mhuire, Tuam, Co. Galway.
- Baltinglass Community Hospital, Co. Wicklow – Upgrade and refurbishment.
- St. Ita's, Newcastle West, Co. Limerick – Extension and upgrade of the rehabilitation Unit.

Mental Health

Project Stage – Planning

- Clonmel, Co. Tipperary – 10 bed crisis housing unit.
- Tuam, Co. Galway – Community mental health team (CMHT) base and day hospital.
- Loughrea, Co. Galway – CMHT base.
- Sligo General Hospital – Acute MHU.
- Clonskeagh, Dublin – Community MHU.

Mental Health

Project Stage – Planning

- Inchicore, Dublin – Refurbishment and extension of Woodlands, Goldenbridge.
- National Forensic Mental Health Services Project – National Forensic Central Hospital (80 replacement and 40 additional beds), four intensive care rehabilitation units (ICRUs – 30 beds each), intellectual disability ICRU and child and adolescent ICRU (10 beds each) as proposed in Vision for Change.
- Limerick – St. Joseph's community child and adolescent mental health facility.

Project Stage – Continuation of construction in 2014

- Nazareth House, Sligo – Delivery of a centre for child and adolescent mental health services (CAMHS) in Nazareth House primary care centre.
- Ballinasloe, Co. Galway – Reconfiguration of admissions building to accommodate POL Beds from St. Brendan's CNU, disability day centre, St. Joseph's and to provide accommodation for a rehabilitation team.
- Brú Chaoimhín, Dublin – Refurbishment of Unit 4 to accommodate adult day mental health services.
- Cherry Orchard, Dublin – Child and adolescent residential unit.
- Crumlin, Dublin – Interim primary care centre and community mental health day hospital.
- Galway University Hospital – Acute MHU (replacement).
- Killarney, Co. Kerry – Combined challenging behaviour and mental health residential unit.
- Loughrea, Co. Galway – Accommodation for the CMHT.
- Portlaoise, Co. Laois – Mental health residential unit.
- St. John's, Enniscorthy, Co. Wexford – Crisis housing unit.
- St. Joseph's, Ennis, Co. Clare – Refurbishment of Gort Glas to provide a mental health day centre.
- Limerick University Hospital – Acute MHU (final phase).

Project Stage – Construction completed in 2014

- Mullingar, Co. Westmeath – 12 bed high support hostel.
- Cherry Orchard, Ballyfermot, Dublin – Refurbishment of existing office accommodation to provide accommodation for community mental health facility and other accommodation.
- Crumlin, Dublin – 17 bed high support hostel.
- St. Ita's, Portrane, Dublin – Provision of mental health residential accommodation in Carriage House, Maryfield, Dun Na Ri and Glebe House for existing residents of St. Ita's.
- Kerry General Hospital – Upgrade and extension to the acute MHU including high observation unit.
- Donegal – Refurbishment of Rowanfield House to provide a community MHU and a CMHT base in Donegal town.
- Cork University Hospital – Acute MHU.
- Our Lady of Lourdes Hospital, Drogheda – Acute MHU.

Appendix 5 Annual Energy Efficiency Report

Introduction

The European Union (Energy Efficiency) Regulations 2014 together with the *National Energy Efficiency Action Plan (NEEAP) 2009-2020* place several obligations on public bodies regarding their role in relation to energy efficiency. The NEEAP sets out a public sector target indicating that by 2020 the HSE must improve energy efficiency by 33%. As one of the largest consumers of energy in the State the HSE recognises its commitment to achieving sustainable development, public sector targets and cost savings.

The HSE's National Health Sustainability Office (NHSO) which was established in 2013 acts as the central focal point for all health sustainability issues. The primary scope of the NHSO is to develop and implement effective management of the energy, waste and water nationally for the HSE, along with developing staff, patient and public awareness of sustainability issues, leading to lower costs and a healthier environment.

In response to SI 426 of 2014 (previously SI 542 of 2009), which requires public sector organisations to report annually, this appendix outlines the Health Service's position on its energy use, the actions taken to reduce consumption and the actions planned for 2015.

Overview of Energy Usage in 2014

The NHSO is fully compliant with the requirement of legislation SI 426 and has verified all HSE meter points for 2014. It is anticipated that verified energy consumption data will be made available from the Sustainable Energy Authority of Ireland (SEAI) in mid 2015. The overview below is an estimate of energy usage in 2014. The actual, when issued by SEAI, will be made available at *www.hse.ie/sustainability*.

- 221,862 MWh of electricity
- 733,081 MWh of fossil fuels
- 800 MWh of renewable fuels

Actions undertaken in 2014

A number of key items were progressed through the NHSO during the year including:

- The first HSE national seminar 'Sustainable Health Systems – Making it Happen' was held in May in partnership with Connolly Hospital, Blanchardstown. This was attended by more than 130 health sector stakeholders. The seminar showcased best practice sustainable healthcare from Ireland and from health systems across the UK and Europe. In August, a second seminar 'Enabling the Delivery of Sustainable Healthcare: Sharing the Learning' took place in Cork University Hospital (CUH).
- A number of sustainability related programmes commenced, including the 'Engaging People Energy Awareness' trial programmes in Connolly Hospital and CUH in conjunction with SEAI.
- The development of a Sustainability Management Concession Contract commenced to provide a model for energy performance contracting in the health sector, utilising the €70m National Energy Efficiency Fund (NEEF).
- The development of a Corporate Sustainability Management Service commenced to provide the capacity to monitor and report on energy efficiency projects.
- A National Register of Opportunities for sustainabilty projects was developed which is an ongoing process of energy efficiency improvement by facility upgrade, funded through the NEEF.
- The pilot process for energy efficient design reviews was completed.
- National tenders for provision and supply of refined petroleum products were completed, resulting in substantial savings to the HSE.
- A sustainability microsite was developed on www.hse.ie which includes information on energy efficiency, waste prevention, water conservation, healthcare buildings, HSE publications, factsheets, best practice guidance and case studies.

Green Flag Hospital Award

Cork University Hospital was awarded the world's first Green Flag Hospital award for its efforts in reducing its carbon footprint, preventing waste and increasing recycling. This prestigious award, given by the Foundation for Environmental Education and An Taisce, the National Trust for Ireland, acknowledges the hospital as a leading healthcare organisation in green initiatives. An Taisce granted the international accreditation following a stringent review of the hospital's waste, energy, water use, transport, recycling efforts and emissions, representing extensive efforts over four years by CUH, HSE Estates and the NHSO. In 2013 the hospital achieved a saving of 1.2 MWhr or 493 tonnes of greenhouse gases reduction.

Actions planned for 2015

The National Health Sustainability Office will:

- Continue the development of the Sustainability Management Concession Contract and Corporate Sustainability Management Services nationally.
- Develop a programme for the management and implementation of Energy Efficiency Design Reviews and include in the scope of services for design teams.
- Develop a National Programme for negotiation with Obligated Energy Suppliers.
- Develop a formal Energy Projects reporting system and a national database on sustainability projects.
- Host the annual sustainability seminar.
- Formulate a National HSE Action Plan on Display Energy Certificates.
- Develop a HSE National Transport Strategy.
- Complete the Tender for the Provision and Supply of Liquid Petroleum Gas.
- Continue the development of the sustainability microsite on hse.ie to include Sustainable Transport and Staff Sustainability Awareness information.
- Run an Engaging People Energy Awareness Programme in Cherry Orchard Campus (inc. Meath Hospital Primary Care) and Sligo Regional Hospital in conjunction with SEAI.

Appendix 6 Acute Hospitals

HEALTH INTELLIGENCE IRELAND

Acute Hospitals Ireland

N

Cappagh
Beaumont
Connolly
Mater
Temple St
Rotunda
Royal Victoria E&E
Holles St
St James'
St Vincent's
Crumlin
Coombe
St Michael's
Tallaght
St Columcille's

Letterkenny General
Sligo General
Monaghan General
Cavan General
Louth County Dundalk
Mayo General Castlebar
Lourdes Drogheda
Our Lady's Navan
Roscommon County Hospital
Midland Regional Mullingar
Galway University
Portiuncula Ballinasloe
Tullamore General
Naas General
Midland Regional Portlaoise
Mid Western Regional Ennis
Nenagh General
Mid Western Regional Maternity
St John's
Mid Western Regional Limerick
St Luke's Kilkenny
Kilcreene
St Nessan's Ortho Croom
South Tipperary Clonmel
Wexford General
Kerry General Tralee
Waterford Regional
Mallow General
Mercy Hospital
South Infirmary/Victoria
Cork University
Bantry General

South/South West Hospital Group
Univ. of Limerick Hospital Group
Dublin Midlands Hospital Group
Ireland East Hospital Group
RCSI Hospital Group
Saolta Univ. Health Care Group
The Children's Hospital Group

County boundary

70 km
40 mls

Z-48560 OSI 030601

Appendix 7 Community Healthcare Organisations

Financial Governance

Operating and Financial Review

The operating and financial review highlights the key financial results for 2014 and outlines the principal factors influencing the performance of the Health Service Executive (HSE) during the year.

Financial Summary

The HSE delivered a balanced year-end position for 2014. The 2014 Gross Estimate was €13.588bn including supplementary funding of €680m (2013: €13.894bn including supplementary funding of €219m). It is a statutory requirement of the Accounting Officer to ensure that spending does not exceed the Gross Estimate. In practice, this usually results in a small surplus being returned to the Exchequer at the end of the year. The surplus to be returned in respect of 2014 is €26.764m or 0.2% of net expenditure (2013: €31.074m). These results are shown at Table 7 below.

The National Service Plan (NSP) 2014 was developed against an on-going backdrop of difficult economic conditions and presented a considerable challenge to the Health Service in terms of delivery. In order to maintain existing levels of service, continue to improve patient safety and deliver priority service initiatives within the funding available, significant budget and expenditure reductions were required. NSP 2014 identified the financial risks associated with these reductions and highlighted in particular the scale of the pay and pay-related savings targets being imposed on the system. While many of the efficiency and cost containment measures delivered substantial savings over the course of the year, it was not possible to realise the required amounts in full. The shortfall was funded as part of the supplementary estimate and following the receipt of the additional funding the HSE was able to return a balanced position for the year.

Key Financial and Operational Messages

Financial

- Gross revenue expenditure for health and personal social services was €13.220bn in 2014. The comparative figure for 2013 (excluding CFA) was €13.076bn. This represents an increase of €144.307m year on year (cf. Table 8);
- A supplementary estimate of €680m was approved in December 2014 relating to expenditure pressures including the following; Maintenance and misc. receipts (€50m); PCRS and local schemes (€165m); Statutory and Voluntary services (€390m); Pension and Pension Levy (€20m); State Claims Agency (€55m).

Workforce

- The health sector employed 97,791 whole-time equivalent (WTE) staff at the end of 2014;
- Compared to the downwards trend in previous years' employment, in 2014 the health service saw growth in the numbers of staff employed;
- Adjusted employment figures for the health services show that the workforce has reduced by 14,980 WTEs, approximately 13%, from the peak employment levels of 2007;
- The figure in December 2014 was 3,582 WTEs (4%) above the approved employment ceiling at the year-end; Agency costs increased over the prior year to €341m (2013: €249m) increasing mainly within the acute sector.

Table 7: Key Financial Information 2014 – Vote Accounting

	2014 Profile post 2014 Supplementary Estimate	2014 Vote Outturn	Over/(Under)	Over/(Under)
	€'000	€'000	€'000	%
Gross Revenue Expenditure	13,213,650	13,174,212	(39,438)	(0.30%)
Gross Capital Expenditure	374,159	368,705	(5,454)	(1.46%)
Total Gross Vote Expenditure	**13,587,809**	**13,542,917**	**(44,892)**	**(0.33%)**
Revenue Receipts – HSE	992,708	982,605	(10,103)	(1.02%)
Revenue Receipts – other	354,605	348,393	(6,212)	(1.75%)
Capital Receipts	8,000	6,187	(1,813)	(22.66%)
Total – Appropriations-in-Aid	**1,355,313**	**1,337,185**	**(18,128)**	**(1.34%)**
Total Net Expenditure	**12,232,496**	**12,205,732**	**(26,764)**	**(0.22%)**

Source: Draft 2014 Appropriation Account

Table 7 shows expenditure against the Vote. For this purpose expenditure is reported on a cash basis in line with Government Accounting rules. That is to say that it represents payments made during the period. It includes amounts paid in 2014 in respect of liabilities brought forward from 2013 but does not include liabilities incurred in 2014 which have not been paid at the year-end.

Services

A summary of key performance indicators by service area is provided below. Additional commentary and information on activity levels, quality initiatives and service improvements is provided in the relevant section of the Annual Report.

Hospital Activity

- 1.4m people received either inpatient or day case treatment during 2014;
- Over 3.2m people attended at hospital outpatient departments over the period;
- 396,936 people were admitted as emergencies in our acute hospitals that provide an Emergency Care service during 2014. This is 6,614 or 1.69% greater than in 2013;
- New Emergency Department attendances increased by 47,000 or 4.4% during 2014;
- Total number of Bed Days used increased by 104,500 or 3.2% – the equivalent of 286 beds;
- Inpatient activity rates are broadly in line with 2013 with 591,725 people receiving inpatient treatment in 2014;
- 79.9% of inpatients were treated in publicly funded hospitals during 2014 (80.2% in 2013);
- 860,763 people received day case treatment, a 2.9% increase on 2013;
- There was a 4.6% decrease in elective admissions compared to 2013. Part of this decrease can be accounted for by increased emergency admissions and an increase in delayed discharges which constrained capacity;
- Additional funding was secured in 2014 to address pressures in hospitals due to delayed discharges. Measures are being put in place for additional long term care beds and a range of community supports which will improve patient flow within hospitals by reducing delayed discharges and also the volume of patients waiting on trolleys in EDs for admission to inpatient beds. Further details can be found in both acute and social care sections of the Annual Report.

Waiting Times and Access at end 2014

- 68% of patients attending emergency departments were discharged home or admitted within 6 hours (Target: 95%);
- 81% of patients attending emergency departments were discharged home or admitted within 9 hours (Target: 100%);
- As of mid-December 2014, the INMO trolley count indicated that there were 3,617 more patients on trolleys than in 2013. This represents an increase of 6.5% and is a cause of concern and ongoing focus for the service;
- 82% of emergency hip fracture surgery was carried out within 48 hours (Target: 95%);
- 65% of surgical inpatients had principal procedure conducted on day of admission, an improvement against 62% in 2013, but further improvement is still required;
- The number of people waiting over 8 months for an elective procedure increased to 4,454 at the end of 2014;
- 63% of people on the GI endoscopy waiting list were waiting less than the target 13 weeks. Specific initiatives to address patients waiting over 13 weeks are underway;
- 94% of urgent breast cancer referrals were offered an appointment within two weeks (Target: 95%);
- 88% of attendees at rapid access clinics were offered an appointment within 10 working days (Target: 95%);
- 51% of reported attendances for prostate cancer services were offered an appointment within the twenty day timeframe (Target: 90%).

Primary Care Services and Schemes

- 1,768,700 people or 39% of the population had Medical Cards or GP Visit Cards at the end of 2014. This represents a net reduction of 80,680 from the end of 2013;
- 14,689 patients had been seen by Community Intervention Teams in 2014;
- 939,600 patients availed of GP out of hours services in 2014;
- 183,945 patients received a primary care physiotherapy referral in 2014 (2013: 175,926);
- 156,628 patients were seen for a first physiotherapy assessment in 2014 (2013: 145,213);
- 5,805 patients (96.5%) waiting for orthodontic assessment were seen within twelve months of referral as of December 2014.

Disability

- 2,583 rehabilitative training places were provided for persons with disabilities in 2014;
- As weekly places are utilised by more than one person, 2,895 people availed of these places nationally;
- An extensive consultation and engagement process was undertaken on standards relation to New Directions – Personal Support Services for Adults with Disability;
- Additional funding was allocated and a revised process put in place to provide day places for young people with disabilities leaving school and exiting rehabilitation training places;
- 1,365 additional young people received one of these day places in 2014, with a total of 1,606 work or work-like activity places provided for service users in 2014, benefiting 3,097 (as places are used by more than one person);
- 90 people completed the transition from congregated to community settings;
- Five Local Implementation Groups (LIGs) have fully reconfigured their children's services into children's disability network teams (Meath, Cork West, Kerry, Mid West and Galway) with a further 8 partially completing their service reconfigurations. 80 new therapy posts were approved to support this;
- Under the *Disability Act 2005*, 4,908 applications for a disability assessment were received, representing a 15% increase in demand on 2013 (4,261);
- The implementation of the Value for Money and Policy Review programme continued, with working groups established to progress the recommendations;
- A National Service Improvement Team was established to support the services through our reform programme, changing models of care and developing sustainable models of best practice into the future;
- A six step programme for disability residential services was established in 2014 to enhance the quality and safety of our disability services (further detail of this system-wide programme of measures to assure that the quality and safety of services delivered by all service providers is available in the 2014 annual report and 2015 operational plan).

Older Persons

- 13,199 people received home care packages in 2014 (21.4% above the expected level of service);
- 47,061 people received home help which amounted to 10.3 million hours over the year (a 5.8% increase on 2013);

- 22,360 long term residential places were funded under the Nursing Homes Support Scheme (23,007 in 2013); the total number of applications on the national placement list was reduced from 1,937 in November 2014 to 1,188 by year end, reducing the waiting time from 16 weeks to 11 weeks;
- Ensuring people were kept no longer than necessary in hospital when they no longer needed acute care (delayed discharges) was a key priority;
- Additional delayed discharge initiatives put in place included provision of 300 additional long stay care places, 400 home care packages to benefit 600 additional clients, and over 400 short stay beds to enable complex discharge placements from acute hospitals;
- There were 2,555 elder abuse referrals, 16% above expected activity. 92% of active cases were reviewed within six months, against a target of 80%;
- A Service Improvement Team for Older Peoples Services was established. 65 public long stay units were visited and associated action plans focused on roster realignments, skill mix and other service improvement initiatives were provided to the units;
- A number of Community Nursing Units were upgraded and refurbished to meet HIQA environmental standards to ensure registration in 2015. In addition, new units opened including the Kenmare Community Nursing Unit and the extended and refurbished Ballina District Hospital.

Mental Health

- 3,329 people were admitted to adult acute inpatient units in 2014 (4% decrease on 2013);
- 14,407 referrals were received by the Counselling in Primary Care Service, 41,942 appointments were offered, 6,760 clients were assessed for counselling, and 285.5 days of counselling are provided each week across 140 locations;
- One in every 100 adults in Ireland are now estimated to have received suicide prevention training through ASIST and safeTALK, free of charge;
- 6% increase in referrals accepted by the Child and Adolescent community mental health teams.

Financial Performance in 2014

During the period 2008-2013 health service budgets were reduced by more than €1.5 billion. Given the continued reduction in its funding base in 2014 and the requirement to deliver a significant level of additional savings, the National Service Plan (NSP) acknowledged that the health service was facing a severe financial challenge in 2014.

National Service Plan 2014[1]

The National Service Plan noted an overall reduction to the Vote of €272m in 2014. It also identified a total additional savings target of €619m, which required to be achieved in-year, in order to deliver the service commitments within the funding available. This represented a very significant challenge for the system and the HSE flagged the risks associated with such demanding savings targets from the outset.

The efficiency measures required as part of NSP 2014 predominantly related to reductions in pay, provisions for pension lump sum liabilities and primary care reimbursement schemes. Pay-related efficiency savings totalling €268m were required (€140m through measures agreed as part of the Haddington Road Agreement, €108m in other, non-specific pay-related savings and €20m in respect of adherence to the Employment Control Framework). Pension lump sum provisions were reduced to partly offset the 2013 incoming deficit. The Primary Care Reimbursement Service was allocated a cost reduction target of €294m, in addition to the cost reduction target of €353m applied in 2013. Further budget adjustments and cost containment measures of €129m were also identified.

Within the overall settlement, arrived at as part of NSP 2014, a sum of €304m was earmarked for approved service developments and to address some of the unavoidable service pressures known in the system. Of this amount, €178m was allocated for prioritised developments and demographic pressures and the remaining €126m was provided on a once-off basis to address the full year costs in 2014 of initiatives commenced in 2013.

The extent to which existing levels of service and approved new initiatives were dependent on achieving such a high level of additional savings presented a considerable financial risk to the system. To that end and in an effort to appropriately manage service quality and risk budgets were not reduced by the amount of the €108m unspecified pay savings target. It was the view of the directorate and the leadership team that it was not deliverable and would harm services if we sought to reduce costs to meet it. This savings target was therefore centrally held.

From early in the year the HSE engaged with the Department of Health around a projected likely deficit of approximately €510m in core service areas. The most significant element of this deficit related to funding shortfalls and demand driven pressures in the acute hospital sector. The final core service deficit came in at €548m with the increase again attributable primarily to the acute sector (€17m) and demand-driven services such as statutory pensions (€16m) and local schemes (€4m).

Overall, net expenditure for 2014 was €653m over Vote profile. This was made up of the €548m core deficit as well as overruns on the State Claims Agency (SCA) and other technical items in relation to the Vote. The most significant overspends were:

Savings targets not within control/direct control of HSE (Final deficit €142m) – Included:

- €108m – Unspecified pay savings;
- €12m – Targeted savings related to the proposed introduction of a nurse bank;
- €10m – Graduate Nurses savings target;
- €7m – Excess target re: adjusting the asset based contribution in the Fair Deal scheme;
- €5m – Target related to proposed licensing of tobacco retailers.

The above had either no identifiable savings measure, were dependant on the enactment of legislation or were otherwise outside of the control of the HSE to deliver.

Cost of Historic Claims (managed by the SCA – Final deficit €13m) – Precise cost prediction in this area has proven to be extremely challenging and deficits in recent years have been met by way of supplementary funding at year end.

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1 All deficit figures included in this section refer to financial overruns based on the Performance and Activity Report (PAR) for December 2014 in which expenditure is reported against service plan targets.

Table 8: Expenditure 2014 vs. 2013 – Accruals Basis of Accounting[2] (Excluding Child and Family Services)

	2014	2013 (Excl. CFA)	Change	% Change
	€'000	€'000	€'000	%
Revenue Expenditure				
Pay and Pensions (HSE only)	4,795,427	4,653,807	141,620	3.0%
Non Pay (HSE only)	4,999,440	5,035,630	(36,190)	(0.7%)
Grants to outside agencies	3,425,454	3,386,577	38,877	1.1%
Total Revenue Expenditure	**13,220,321**	**13,076,014**	**144,307**	**1.1%**
Capital Expenditure	**356,888**	**342,227**	**14,661**	**4.1%**
Total Expenditure	**13,577,209**	**13,418,241**	**158,968**	**1.1%**

Primary Care Reimbursement Service (PCRS) (Final deficit €99m – PCRS €50m and €49m Local Demand Led Schemes) – The PCRS managed to reduce its costs by €110m during 2014 so that despite having to deal with a net budget reduction/savings target of €86m it was able to reduce its deficit from €74m at the end of 2013 to €50m at the end of 2014, an improvement of €24m beyond the delivery target. Additionally, €11m of the PCRS target relates to measures for the retention of medical cards that were dependent on legislation which did not progress

Statutory Pension including Pension Levy (Final deficit €46m) – The deficit reflects the difficulty in predicting the scale and number of retirements in any financial period.

Acute Hospitals (Final deficit €284m) – the Acute Hospital system was projected to be approximately €267m in deficit by the end of 2014 within the €510m. Hospitals had a deficit of €180m in 2013 of which it was possible to deal with €100m in the 2014 budget setting process leaving an incoming problem of €80m in 2014. Hospital costs have grown by €89m in 2014 in addition to hospital workload which has also grown. In 2014 clinical non pay costs have risen the most within non pay (drugs, medical supplies etc.) with medical agency the most significant cost driver year on year. Additionally Hospital pay and non-pay budgets were reduced by €115m in 2014 (€80m+€89m+€115m = €284m).

Agency Services – HSE year to date agency costs were €341m versus €249m for the corresponding period in 2013, an increase of €92m (37%) year on year. Agency costs incurred in acute hospital services were €231m and this compares to €165m for last year. The 2014 agency costs for hospitals include €100m in respect of the medical/dental pay category. Hospital agency costs overall have increased by €66m (up 40%) compared to the same period last year. This primarily reflects the diminishing capacity to recruit doctors and price increases for agency provision rather than volume growth in medical staff inputs. However, 81% of the increase in hospital agency expenditure is in the medical and support services pay categories. These staff were already at the HRA maximum hours and therefore the hospitals did not benefit from additional hours.

Social Care Services (Final Deficit €40m) – Largely offset on a once-off basis by using temporary positive variances across a range of expenditure headings (primarily time related savings, emergency planning contingency, phasing of screening, mental health, primary care etc. It is also the case that there have been significant cost pressures and deficits within our community services including those driven by the need for expensive external and emergency residential placements and similar arrangements across primary care, mental health, disability and elderly services. It has been possible to manage most of these pressures on a once off basis in 2014 due to specific cost containment initiatives and savings arising from the phasing of other funded initiatives.

All projected overspends were monitored and reported regularly during the year and every effort was made to ensure they were minimised to the greatest extent possible. These overspends were funded in-year through a Supplementary Estimate passed by the Dáil on 11th December 2014.

Financial Outturn 2014

A comparison of expenditure between 2013 and 2014 is provided for information at Table 8 above. On January 1st 2014, the HSE's Child and Family Services were transferred to the Child and Family Agency (CFA). For the purposes of reviewing year on year performance, expenditure relating to CFA has been excluded from the 2013 figures above.

Statutory Sector

Pay and Pension costs (HSE) have increased (€141.620m or 3%) year on year. There was a 2.7% increase in the clinical pay category and a 3.7% increase in the non-clinical pay category with an increase of 3.5% in other client/patient services. A significant driver of this year on year increase relates to the growth in agency pay costs.

Non-Pay Costs (HSE) have decreased by €36.190m (0.9%) from 2013. Within this category, clinical costs increased by €68.872m (8.5%) reflecting growth in expenditure on drugs and medicines, blood and blood products, and medical and surgical supplies and equipment. Primary care and medical care schemes reduced by €83.803m (3%), reflecting a reduction in doctors' fees and allowances and a reduction in cash allowances. Payments to the State Claims Agency reduced by €18.518m (14%).

2 Table 8 shows expenditure as reported in the Annual Financial Statements. For this purpose expenditure is reported on an accruals basis in line with Generally Accepted Accounting Principles (GAAP). That is to say it represents expenditure incurred during 2014 including amounts owing at the year-end.

Grants to Outside Agencies

Grants to Outside Agencies include allocations made to voluntary service providers. Overall once account is taken for the transfer of childcare services to Child and Family Agency (CFA), grant payments increased by €38.877m (1.1%) year on year. In total, 1987 agencies were funded, with over 3,087 separate funding arrangements in place. Nine agencies accounted for over 51% of the funding and ninety agencies accounted for over 90% of the funding.

Capital

Funding for capital projects in 2014 amounted to €356.9m (2013: €342.2m), of which €303.6m was expended on HSE capital projects and €53.3m on capital grants to service providers. Accordingly, a surplus of €11.8m for 2014 (2013: deficit €6.5m) was reported in the Capital Income and Expenditure Account. A list of service providers and the respective capital grant amounts is detailed in Appendix 2 to the Annual Financial Statements.

Service Divisions

National Service Divisions and Care Groups were established in 2013 as part of the Health Service Reform Programme. This meant that, for the first time, as part of the service planning process for 2014, there was the opportunity to redistribute resources across each of the Care Groups and new Service Divisions.

Overall, €5.2bn (39%) was spent on Acute Hospitals and the National Ambulance Service, €3.4bn (26%) on Primary Care Services and Schemes, €0.7bn (5%) on Mental Health Services, €2.6bn (20%) on Social Care, €0.2bn (1%) on Health and Wellbeing and the remaining €1bn (8%) on other National and Corporate Support Services.

The Reform Programme

As part of the Health Reform Programme, the HSE Vote is being disestablished with effect from 1st January 2015 and the funds added to the Vote of the Department of Health. This brings with it a number of changes, including the introduction of a 'first charge', whereby any overrun from 2015 onwards will fall to be dealt with by the HSE in the subsequent financial year. This places further emphasis on the need for all services to operate within the available limit in 2015, or face the prospect of having to deal with any overrun as a first charge on their resources the following year.

2015 will be an important year in the on-going reform of the HSE, with a particular focus on a) key infrastructural changes such as Hospital Groups and Community Healthcare Organisations; b) service improvements in areas such as integrated care and services for people with a disability; and c) strategic enablers such as the individual health identifier.

The following are the key reform programmes being progressed:

- Establish and develop Hospital Groups, including the National Children's Hospital;
- Establish and develop Community Healthcare Organisations;
- Develop clinically led, multidisciplinary, patient centred Integrated Models of Care Programmes. This will also involve the alignment of key enablers including ICT, HR and Finance;
- Continue to develop and implement ICT reform in line with the eHealth Strategy under the leadership of the Chief Information Officer;
- Continue to develop and implement the reform of Human Resource Management;
- Continue to develop and implement activity-based funding;
- Develop and implement the new finance operating model;
- Develop and incrementally implement the individual health identifier;
- Continue to develop service-specific reform programmes within the Divisions;
- Continue to embed health and wellbeing goals and key performance indicators throughout all reform programmes.

Establishment of the Child and Family Agency

The Child and Family Agency (CFA) was established on 1 January 2014 under the *Child and Family Agency Act 2013* and it is now the dedicated state agency responsible for improving wellbeing and outcomes for children. The child and family programmes were disaggregated from the HSE and transferred without the payment of consideration to the CFA. This resulted in the transfer of tangible assets to the CFA valued at €76.15m and current assets of €5.09m also transferred to the agency. In addition, current liabilities of €41.94m and creditors falling due after more than one year of €0.19m also transferred to the CFA. The transfer of assets and liabilities from the HSE to the CFA is reported as an exceptional item in the Revenue Income and Expenditure Account which is consistent with comparable practice in the Irish public sector. Approximately 3,204 WTEs transferred from the HSE to the Child and Family Agency.

The HSE continues to provide general administrative services to the CFA which are subject to legal agreement and transacted on an arms-length basis. This includes the recharge of rental and related utility costs for the proportion of HSE properties jointly occupied by CFA services.

Finance Reform

The Financial Reform Programme (FRP) (Phase 2) under the leadership and direction of the Chief Financial Officer was completed with the submission of a business case to the Department of Health (DOH) in May 2014 for endorsement and onward submission to the Department of Public Expenditure and Reform (DPER). Phase 3 of the programme commenced September 2014 which was focused primarily around one to one market engagement sessions, due diligence of finance systems and Organisation Design and Change Management.

Whilst it is recognised that the implementing of an Integrated Financial Management System (IFMS) is a key, requirement there is also a requirement for significant organisational change within the Finance function and accordingly, another critical work stream within the FRP relates to the redesign of organisational structures which will underpin and support the new operating model and enable the organisational changes required to successfully transform financial management in health. This process commenced with an agreed new operating model and, in particular, the establishment of a Finance Division National Management Team (FDNMT). Five assistant CFOs have now been assigned. The National Finance Division will carry full accountability and responsibility for implementation of the new finance operating model as part of the Finance Reform Programme.

With regard to the procurement of a new financial management system, one to one pre-procurement market engagements with the Full Scope Service Providers (FSSPs) were completed in late 2014 with a draft document completed on the FSSP market engagement process. There are a series of recommendations arising from this report which will form part of the current Finance Reform Programme (FRP) work plan in 2015.

A number of procurement approaches are under review as well as the development and approval of a procurement strategy. It is envisaged that the procurement process will begin in 2015, subject to appropriate engagement and approvals.

In addition a high level due diligence of legacy finance systems was completed in December 2014. The purpose of the due diligence process was to understand the financial systems and business arrangements in place in each of the main former health areas. The due diligence evaluated these financial systems and business arrangements using standard criteria concerning ownership, standardisation of accounting procedures, HBS involvement including SLA and governance arrangements, business risk of existing systems etc. The process also evaluated the future of these finance systems and reviewed existing problems. An interim report was completed in December 2014 with a series of recommendations which will form part of current FRP 2015 work plan.

Community Healthcare Organisations

The publication in October 2014 of the *Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group* provided a framework for new governance and organisational structures for community health care services. An intensive communication and engagement process is underway including feedback to all those involved in the original consultation, together with other staff and partners in the wider health service. A National Steering Group will oversee the implementation of the report's recommendations and a high level implementation plan is in development. The first step in this has been the appointment of Chief Officers.

Accountability Framework

The HSE is the statutory body tasked with the responsibility for the delivery of health and personal social care services in Ireland. In discharging its public accountabilities, the HSE has in place a Governance Framework covering corporate, clinical and financial governance. While the HSE's primary accountability is to the Minister for Health, it has a range of other accountability obligations to the Oireachtas and to its Regulators.

The HSE recognises the critical importance of good governance and of continually enhancing its accountability arrangements. In this regard, and in the context of the establishment of the Hospital Groups and Community Healthcare Organisations, the HSE is strengthening its accountability arrangements and is putting in place a new Accountability Framework in 2015.

Improving Performance Management

A key priority as the health system continues to reform is to ensure that financial and service performance is actively reported on and managed in a timely manner. Building on the work of recent years, the 2015 accountability framework will ensure that performance will be measured against agreed plans which include financial and service delivery commitments in terms of access targets, service quality and volumes. Performance will be monitored through the introduction of a Balanced Score Card which will include both quantitative and qualitative metrics to assess delivery against these priority areas. Service managers will be held to account and under-performance will be addressed.

Key features of the new Accountability Framework include the introduction of formal Performance Agreements for the statutory service providers and new Service Arrangements and Grant Aid Agreements governing s38 and s39 providers. In addition, as part of the new Framework, there will be a particular focus on differentiating levels of performance, with explicit arrangements for escalating areas of underperformance and specifying a range of interventions to be taken in the event of serious or persistent underperformance.

Risks to Financial Performance

Given the significant financial challenges facing the Health Service, set out below are some of the key risks in 2015. While every effort will be made to mitigate these risks, it will not be possible to eliminate them in full.

- Continued demographic pressures and the increasing demand for services over and above the planned levels for 2015.
- Insufficient capacity of the Nursing Homes Support Scheme to meet current and estimated additional requirements for residential nursing home care.
- Meeting of Health Information and Quality Authority (HIQA) standards for both public long stay residential care facilities and the disability sector.
- The capacity to recruit and retain a highly skilled and qualified medical and clinical workforce.
- The significant requirement to reduce agency and overtime expenditure given the scale and complexity of the task including the scale of recruitment required and the information system constraints.
- The potential of pay cost growth which has not been funded.
- Management capacity risk including financial management, given the scale of change underway.
- Risks associated with the delivery of procurement savings.
- Financial risks associated with statutory and regulatory compliance in a number of sectors.
- Cash risk related to the requirement to reach agreement with the private health insurers in relation to a set of revised payment terms.
- Lack of contingency funding to deal with unexpected service or cost issues.
- Continued implementation of the Reform Programme requires building the organisational capacity to deliver change and effective planning to ensure the governance and stability of services in the midst of change.

Conclusion

It is clear that 2014 was a difficult year in terms of delivering services with restricted financial and human resources. Through the dedication and commitment of our staff we continually strive to meet that challenge and place patient safety and quality of care at the centre of all we do. The HSE welcomes the increase in resources in 2015, received as part of a two year funding programme. This will assist with the allocation of more realistic budgets to hospitals and community healthcare organisations. While there will be on-going challenges in an ever-increasing demand-led service, the HSE will continue to work towards maximising the delivery of services while at the same time ensuring that quality and patient safety remains at the core of the delivery system. This will be supported by the introduction of the 2015 Accountability Framework, which will improve the accountability of managers for delivering services against target and within the financial and human resources available.

Directorate Members' Report

Directorate

The HSE Directorate has collective responsibility as the governing authority for the HSE and the authority to perform the HSE's functions. The Directorate is accountable to the Minister for the performance of the HSE's functions and its own functions as the governing authority of the HSE.

The Director General as Chairman of the Directorate accounts on behalf of the Directorate to the Minister (through the Secretary General, Department of Health). The other members of the Directorate are appointed by the Minister from persons employed as HSE National Directors or no less senior grade.

Under Section 16(G) of the *Health Service Executive (Governance) Act 2013*, the Director General is responsible for carrying on and managing and controlling generally the administration and business of the HSE.

The Director General is also the accounting officer in relation to the 2014 Appropriation Accounts of the HSE for the purposes of the *Comptroller and Auditor General Acts* 1866 to 1998 and Section 40 (G) of the Health Act 2004 (as inserted by Section 17 of the *Health Service Executive (Governance) Act, 2013)*.

The legislation recognised that neither the Directorate nor the Director General could exercise these functions personally and provided for a formal system of delegations under Sections 16(C) and 16(H) of the *Health Service Executive (Governance) Act, 2013*.

In practice, the Directorate delegates to the Director General all the functions of the HSE, except for the specific functions it reserves to itself.

Meetings

In accordance with Part 3(A) of the *Health Act 2004* (as inserted by Section 16(K) of the Health Service Executive (Governance) Act, 2013), the Directorate is required to hold no fewer than one meeting in each of 11 months of the year. In 2014 the Directorate met on 13 occasions, holding 11 monthly Directorate meetings and two additional meetings. The attendance at Directorate meetings is recorded in Table 9.

Committees

The *Health Service Executive (Governance) Act 2013* provides that 'the Director General shall establish an audit committee to perform the functions specified in section 40I' and sets out the duties of the Committee.

The legislation also provides for the establishment by the Directorate of such other Committees it considers necessary for the purposes of providing assistance and advice to it in relation to the performance of its functions. The Directorate determines the membership and terms of reference for each of these committees.

Table 9: Attendance at Directorate meetings

	HSE Directorate monthly meetings		HSE Directorate additional meetings	
Member	Total number of meetings	Attendance	Total number of meetings	Attendance
T. O'Brien	11	11	2	2
L. McGuinness	11	11	2	2
T. Byrne[1]	4	4	0	0
I. Carter[2]	4	3	0	0
P. Healy	11	11	2	2
J. Hennessy	11	10	2	2
S. Mulvany	11	11	2	2
S. O'Keeffe	11	11	2	2
A. O'Connor[3]	7	7	2	2
T. O'Connell[4]	7	6	2	2

Number of meetings scheduled and number of meeting attended during members' tenure

Note 1: T. Byrne resigned from Directorate 19/05/14

Note 2: I. Carter resigned from Directorate 12/05/14

Note 3: A. O'Connor appointed to Directorate 11/07/14

Note 4: T. O'Connell appointed to Directorate 12/05/14

Audit Committee

The new Audit Committee was established and convened for the first time in January 2014.

The Audit Committee is appointed by the Directorate. It acts in an advisory capacity and has no executive function.

The Audit Committee's duties, as set out in legislation, are, to advise both the Directorate and the Director General of the HSE on financial matters relating to their functions, including advising them on the following matters:

a) The proper implementation by the Executive of Government guidelines on financial issues;

b) Compliance by the Director General with Section 22 of the *Exchequer and Audit Departments Act 1866*, section 19 of the *Comptroller and Auditor General (Amendment) Act 1993* and any other obligations imposed by law relating to financial matters;

c) The appropriateness, efficiency and effectiveness of the Executive's procedures relating to:

   i. public procurement,

   ii. seeking sanction for expenditure and complying with that sanction,

   iii. the acquisition, holding and disposal of assets,

   iv. risk management*,

   v. financial reporting, and

   vi. internal audits.

* The Directorate mandated that non-financial risk management comes within the role of the Risk Committee

A new Charter of the HSE Audit Committee was put in place and adopted by the Committee in early 2014. The Charter sets out in detail the role, advisory duties and authority of the Committee, along with certain administrative matters[3].

The Audit Committee Charter recognises the establishment by the HSE of a separate HSE Risk Committee, reporting to the Directorate, which is responsible for advising the Directorate on matters relating to all risks of a non-financial nature.

The focus of the Audit Committee, in providing its advice to the Directorate and the Director General, is on the 'regularity' and 'propriety' of transactions recorded in the published accounts of the HSE and on the effectiveness of the system of internal financial controls operated by the HSE.

Membership

The Audit Committee is appointed by the Directorate and consists of one member of the Directorate and not fewer than four other people with relevant skills and experience to perform the functions of the committee. In accordance with best practice neither the HSE Directorate Chairman nor the Chief Financial Officer is a member of this Committee. In accordance with the legislation, the Chairman of the Audit Committee cannot be a member of the HSE Directorate.

The following individuals have been members of the Audit Committee since January 2014:

- Mr. Peter Cross (Chairman) – Managing Director of Trasna Consulting (and a Fellow of the Institute of Chartered Accountants in Ireland);
- Dr. Gerardine Doyle – Senior lecturer in accounting and taxation at University College Dublin (and a Fellow of the Institute of Chartered Accountants in Ireland);
- Mr. Joe Mooney – former Principal Officer of the Department of Finance;
- Mr. John Hynes – former Secretary General at the Department of Social and Family Affairs;
- Mr. David Smith – Principal Officer at the Department of Health; and
- Ms. Laverne McGuinness – Deputy Director General of the HSE (and a Fellow of the Institute of Certified Public Accountants; Professional Diploma in Corporate Governance – Michael Smurfit Business School).

Meetings

The legislation requires the Committee to meet at least four times in each year.

The Audit Committee met on nine occasions in 2014, and a joint meeting of the Audit Committee and the Risk Committee took place on one further occasion. Attendance by each member of the Committee at these meetings is set out in Table 10.

Table 10: Attendance at Directorate Committee meetings – Audit Committee

Member	Total number of meetings	Attendance
P. Cross (Chair)	9	9
G. Doyle	9	8
J. Mooney	9	8
J. Hynes	9	6
L. McGuinness	9	8
D. Smith	9	8

The Chief Financial Officer and the National Director of Internal Audit attend meetings of the Committee regularly, while the Director General and other members of the Leadership Team attend when necessary.

The external auditors (Office of the Comptroller and Auditor General) attend Audit Committee meetings as required and have direct access to the Committee Chairman at all times. The Committee meets with the HSE's external auditors to plan and review results of the annual audit of the HSE's annual financial statements and appropriation accounts.

3 The Audit Committee Charter has been revised to include new legislative functions prescribed in the HSE (Financial Matters) Act 2014 which came into effect from January 2015.

The Audit Committee is responsible, along with the Director General, for guiding, supporting and overseeing the work of the HSE's Internal Audit division. The National Director of Internal Audit attends all Audit Committee meetings, and has regular individual meetings with the Chairman of the Audit Committee.

The Committee receives reports from management on aspects of financial control, financial risk management and value for money from time to time.

In accordance with legislation the Committee provided a report in writing to the Director General and to the Directorate, on the matters upon which it has advised and on the activities of the Committee during 2014. A copy of this report was provided to the Minister.

Risk Committee

The Directorate appointed a Risk Committee in accordance with the *Health Service Executive (Governance) Act, 2013* for the purposes of providing assistance and advice in relation to HSE Risk management systems to ensure that there is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurances that responses are effective.

The Risk Committee acts in an advisory capacity and has no Executive function.

The Committee's duties are to advise both the Directorate and the Director General of the HSE on non-financial matters relating to their functions, including advising them on the following matters:

- Processes related to the identification, measurement, assessment and management of risk in the HSE
- Promotion of a risk management culture throughout the health system.

In accordance with good governance practice, the Charter of the HSE Risk Committee was put in place and adopted by the Committee in early 2014. The Charter sets out in detail the role, advisory duties and authority of the Committee, along with certain administrative matters. The Risk Committee Charter recognises the establishment by the HSE of a separate HSE Audit Committee, reporting to the Directorate, which is responsible for advising the Directorate on matters relating to all risks of a financial nature.

Membership

The Risk Committee is appointed by the Directorate and consists of one member of the Directorate and not fewer than four other people with relevant skills and experience to perform the functions of the committee.

The following individuals were members of the Risk Committee in 2014:

- Mr. Tom Beegan (Chairman) – CEO and Managing Director, and former CEO Health and safety Authority;
- Mr. Ger Crowley – Social Worker;
- Mr. Simon Kelly – Energy Consultant and former CEO of the National Standards Authority of Ireland;
- Mr. Pat Kirwan – Deputy Director, State Claims Agency;
- Ms. Margaret Murphy – WHO Patients for Patient Safety;
- Dr. Stephanie O'Keeffe – National Director Health and Wellbeing.

Meetings

The National Director of Quality and Patient Safety attends all meetings of the Committee. The Director General, other National Directors, or any other employees attend meetings at the request of the Committee.

The members of the Committee met separately with the National Director of Quality and Patient Safety at least once a year.

Table 11: Attendance at Directorate Committee meetings – Risk Committee

Member	Total number of meetings	Attendance
T. Beegan (Chair)	6	6
G. Crowley	6	5
S. Kelly	6	6
P. Kirwan	6	5
M. Murphy	6	5
S. O'Keeffe	6	6

The Committee provided a report in writing to the Director General and to the Directorate, on the matters upon which it has advised and on the activities of the Committee during 2014. A copy of this report was provided to the Minister.

Liaison between the Audit and Risk Committees

The Audit Committee and the Risk Committee both have responsibilities for the provision of advice on certain areas of risk management and internal controls. The Chairmen of the two committees met on a number of occasions during the year in order to co-ordinate the work programmes of the two committees and to ensure continuing clarity in the committees' respective areas of responsibility.

Minutes of the meetings of each committee were tabled regularly at meetings of the other during the year, and a joint meeting of the two committees was held on one occasion.

Advice was provided by both Committees in relation to the development of the HSE's Corporate Risk Register, encompassing both non-financial and financial risks, and in relation to improving the processes for managing and maintaining the Register.

Support to the Committees

Support to the Directorate, and its committees, is provided by the Corporate Secretary, Mr. Dara Purcell.

Statement of Directors' Responsibilities

in Respect of the Annual Financial Statements

The Directorate is responsible for preparing the annual financial statements in accordance with applicable law.

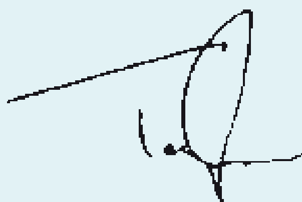
Section 36 of the *Health Act 2004* (as amended by the *Health Service Executive (Governance) Act, 2013*), requires the Health Service Executive to prepare the annual financial statements in such form as the Minister for Health may direct and in accordance with accounting standards specified by the Minister.

In preparing the annual financial statements, Directors are required to:

- Select suitable accounting policies and then apply them consistently;
- Make judgements and estimates that are reasonable and prudent;
- Disclose and explain any material departures from applicable accounting standards; and
- Prepare the financial statements on a going concern basis unless it is inappropriate to presume that the Health Service Executive will continue in business.

The Directors are responsible for ensuring that accounting records are maintained which disclose, with reasonable accuracy at any time, the financial position of the Health Service Executive. The Directors are also responsible for safeguarding the assets of the Health Service Executive and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Signed on behalf of the HSE



Tony O'Brien
Chairman

18 May 2015

Statement on Internal Financial Control

This Statement on Internal Financial Control represents the position for the year ended 31 December 2014.

1. Responsibility for the System of Internal Financial Control

The Health Service Executive (HSE) was established by Ministerial order on 1 January 2005 in accordance with the provisions of the *Health Act 2004*, as amended by the *Health Service Executive (Governance) Act, 2013*. The HSE must comply with directives issued by the Minister for Health under the Acts.

The HSE Directorate is accountable to the Minister for Health, for the performance of the HSE. The *Health Service Executive (Governance) Act 2013* allows the Minister for Health to issue directions to the HSE on the implementation of Ministerial and government policies and objectives and to determine priorities to which the HSE must have regard in preparing its service plan.

The Directorate is the governing body of the Executive with authority, in the name of the Executive, to perform the functions of the Executive. The Directorate may delegate some of the functions of the Executive to the Director General. The Directorate may establish committees to provide assistance and advice in relation to the performance of its functions. The Directorate has established a number of Committees including an Audit Committee and a Risk Committee, each of which comprises one appointed Director and external nominees.

The Directorate has responsibility for major strategic development and expenditure decisions. Responsibility for operational issues is devolved, subject to limits of authority, to executive management.

In addition to his functions as a member of the Directorate and as the chairperson of the Directorate, the Director General's functions include carrying on, managing and controlling generally the administration and business of the Executive. The Director General is the Accounting Officer for the HSE for the period ending 31 December 2014. The Vote of the HSE was disestablished on 1 January 2015, in accordance with the provisions of the *Health Service Executive (Financial Matters) Act, 2014*. The Director General is accountable to the Minister on behalf of the Directorate for the performance by the Directorate of its functions and those of the Executive.

The Directorate has overall responsibility for the HSE's system of internal financial control and for reviewing its effectiveness. The system of internal financial control is intended to provide reasonable assurance that organisational objectives, including propriety, regularity and the safeguarding of assets will be achieved. Management at all levels of the HSE is responsible to the Director General for the implementation and maintenance of internal financial controls over their respective functions. This embedding of the system of internal financial control is designed to ensure that the HSE is capable of responding to business risks and that significant control issues, should they arise, are escalated promptly to appropriate levels of management. A system of internal financial control is designed to reduce rather than eliminate risk. Such a system can provide only reasonable and not absolute assurance that assets are safeguarded, transactions are authorised and properly recorded and that material errors or irregularities are either prevented or detected in a timely manner.

2. Basis for Statement

I, as Chairman of the Directorate, make this statement in accordance with the requirement set out in the Department of Public Expenditure and Reform's *Code of Practice for the Governance of State Bodies*.

3. Financial Control Environment

The HSE spends public funds on the provision of health and personal social services to the population of Ireland. The duties relating to total expenditure of €13.6 billion incurred by the HSE in 2014 are stringent in terms of accountability and transparency in order to fulfil our responsibility for funding received from the Exchequer and other sources in this respect. These duties are set out in the *Health Act 2004* as amended by the *Health Service Executive (Governance) Act, 2013* and in the Public Financial Procedures of the Department of Public Expenditure and Reform.

The system of internal financial control is by its nature dynamic. It is continually developed, maintained and monitored in response to the emerging requirements of the organisation. The current systems environment in the HSE presents additional challenges to the effective operation of the system of internal financial control. Devolved financial systems are multiple and fragmented and numerous external reviews have reiterated the consensus amongst the finance community in the HSE that the current financial systems are not fit for purpose. The financial systems are not capable of providing the level of detailed analysis of Vote expenditure which is required by Government Accounting rules. The HSE relies on an interim reporting solution to support all national level financial reporting, including monthly management reports, the Annual Financial Statements and the Appropriation Account. This system imports data from 12,000 cost centres per month from HSE legacy systems and is manually reanalysed to support national reporting. The absence of a single national system requires that significant work is undertaken manually to ensure that the local ledgers and the national system are synchronised and reconciled. This reporting approach is becoming increasingly challenging in the light of changes to organisation structure and the ageing of the systems.

The HSE's Finance Reform Programme initiated in 2013 is addressing these challenges. Implementing a new finance operating model provides an opportunity to completely transform the financial management of the health system and will support the delivery of key elements of the reform agenda of *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*, including introducing Hospital Groups, Community Healthcare Organisations, and activity-based funding (Money Follows the Patient). The fundamental changes in healthcare heralded by Future Health have amplified the need to address these challenges. Phase 1 of the programme is complete and this included the development of a new Finance Operating Model. The new operating model will require far reaching and fundamental change in financial management practice and will be an important enabler of wider Systems Reform. Underpinned by a single integrated financial management system and a mandated financial management framework, these changes will support financial stability within a reformed health system and will drive a culture of collective responsibility and cost consciousness.

Phase 2 began in December 2013 and a key element of this phase is to secure the necessary approval to procure a new integrated financial management system for the health service to underpin the new Finance Operating Model. A formal process commenced in September 2014 to present the high level requirements of the integrated financial management system and to begin market testing. While the proposals for a new system progress through the approval process, existing systems improvement initiatives continued in 2014, including the development of a standardised common chart of accounts and enterprise structure. This systems development will build on existing efforts to overcome systems and reporting challenges faced by the new National Divisions and emerging Hospital Groups and Community Healthcare Organisations.

4. Key Internal Financial Control Procedures

Key processes and procedures, designed to provide effective internal financial control are set out below under the following headings:

4.1. Governance and financial procedures

4.2. Directorate oversight

4.3. Planning, performance monitoring and reporting

4.4. Risk management

4.5. Controls over medical card eligibility

4.6. Governance of grants to outside agencies

4.1. Governance and financial procedures

4.1.1. The HSE's **Framework for Corporate and Financial Governance** is set out on www.hse.ie, and includes all supporting policies, procedures and guidelines which underpin the Framework. The Framework was approved by the Minister for Health in accordance with Section 35 of the *Health Act 2004* and reflects the requirements of the Code of Practice for the Governance of State Bodies. Staff are required to have full knowledge of their responsibilities which are clearly outlined in part II of the Framework and that it is against this that all compliance is benchmarked.

4.1.2. There is a **framework of administrative procedures** and regular management reporting in place including segregation of duties, a system of delegation and accountability and a system for the authorisation of expenditure.

4.1.3. The HSE's **National Financial Regulations** form an integral part of the system of internal financial control and have been prepared to reflect current best practice. Particular attention has been given to ensure that the Financial Regulations are consistent with statutory requirements, Department of Public Expenditure and Reform circulars and public sector guidelines. The National Financial Regulations set out the financial limits, by staff grade, for procurement contract approval, revenue and capital expenditure and property transactions. Compliance with National Financial Regulations is mandatory throughout the organisation. The development and maintenance of the HSE's suite of National Financial Regulations is an ongoing process, with new regulations and updates to existing regulations issued periodically in response to new or emerging requirements. While policies and regulations are nationally standardised, internal processes are largely systems-driven, and variations in process remain unavoidable until such time as the HSE has implemented a single organisation-wide financial system.

4.1.4. A detailed **standardised appraisal process** is conducted for all capital projects (excluding property acquisitions and disposals) budgeted in excess of €0.5 million. The Health Service's National Capital Steering Committee appraises all projects to be included in the Capital Plan in accordance with the Department of Public Expenditure and Reform's *Public Spending Code* (2012). Project applications must be accompanied by detailed project briefs including a needs assessment, a detailed capital appraisal or a cost benefit analysis, life cycle costs, projected capital budget and revenue and staffing implications. The National Capital Steering Committee validates the submissions received, checks alignment with the Health Service's National Service Plan, examines revenue implications(if any), and may reject, request additional information or recommend for inclusion in the Capital Plan subject to availability of capital funding. All proposed major capital projects which are budgeted in excess of €20 million are subject to a detailed **cost benefit analysis** carried out in accordance with the *Public Spending Code*. Leadership Team/ Directorate reviews of the capital programme take place on a regular basis. All Service Divisions are represented on the National Capital Steering Committee.

4.1.5. **Procedures for property acquisitions and disposals** by the HSE comply with the legal obligations set out in Sections 78 and 79 of the *Health Act 1947*, as amended by the *Health Act 2004*. The Head of Estates has authority to approve proposed property transactions up to a limit of €2 million, once recommended for approval by the Property Review Group. Transactions in excess of this amount must be approved by the Director General, once recommended for approval by the Property Review Group and endorsed by the Leadership Team. Transactions in excess of €2 million once approved by the Director General must then be submitted to the Directorate for final approval. Any disposal of property below market value requires approval of the Directorate.

4.1.6. The HSE has put in place procedures designed to ensure **compliance with all pay and travel circulars issued by the Department of Public Expenditure and Reform**. Any exceptions identified are addressed and are reported on an annual basis to the Minister for Health, in accordance with the Code of Practice for the Governance of State Bodies.

4.1.7. A **devolved budgetary system** is in place with senior managers charged with responsibility to operate within defined accountability limits and to account for significant budgetary variances to the Director General within a formal performance monitoring framework (National Planning, Performance Assurance Group process), described in further detail below.

4.2. Directorate oversight

4.2.1. A new **Audit Committee** with an independent chair and comprising a member of the Directorate and four external members was appointed in January 2014, in accordance with the provisions of the *Health Service Executive (Governance) Act, 2013*. The Audit Committee is appointed by the Directorate. It acts in an advisory capacity and has no Executive function.

A new **Charter of the HSE Audit Committee**, setting out in detail the role, advisory duties and authority of the Committee, along with certain administrative matters, was adopted by the Committee in early 2014.

The focus of the Audit Committee, in providing advice to the Directorate and the Director General, is on the regularity and propriety of transactions recorded in the accounts, and on the effectiveness of the system of internal financial controls operated by the HSE. In order to discharge its responsibilities, the Committee agreed a work programme for the year reflecting the Committee's Charter. In accordance with this work programme, the Committee received regular reports and papers from the Chief Financial Officer and the National Director of Internal Audit, both of whom attended Committee meetings regularly along with senior members of their teams. The Committee provides its advice to the Directorate principally by means of the minutes of its meetings. These minutes are made available to, and tabled at, meetings of the Directorate following the relevant Audit Committee meetings. The Audit Committee maintains a log of its agreed actions and reviews the progress of management in addressing those actions. The Chairman attended one meeting of the Directorate to provide the Audit Committee's advice in relation to the HSE's 2013 financial statements prior to their approval by the Directorate.

The Audit Committee met on nine occasions in 2014 and a joint meeting of the Audit Committee and Risk Committee took place on one further occasion. The Chairman of the Audit Committee also had individual meetings periodically throughout the year with the Director General, the Chief Financial Officer, senior members of the Finance team, the National Director of Internal Audit and his senior managers, other senior managers and the Chairman of the Risk Committee. The Chairman met with representatives of the Office of the Comptroller and Auditor General, who attended meetings of the Audit Committee periodically and had direct access to the Committee Chairman at all times.

4.2.2. A new **Risk Committee** was established in 2014, in accordance with the provisions of the *Health Service Executive (Governance) Act, 2013*. The Risk Committee, which reports to the Directorate, has an independent chair and comprises a member of the Directorate and four external members. The Committee operates under agreed Terms of Reference and focuses principally on assisting the Directorate in fulfilling its duties by providing an independent and objective review of non-financial risks. The Committee kept its terms of reference and work programme under review during the year.

The Committee considered the Corporate Risk Register, Divisional risk management plans, the HSE's Health and Safety function, internal audit reports concerning the effectiveness of non-financial internal controls and HIQA reports, including the implementation of HIQA recommendations. The National Director for Quality and Patient Safety attended the Committee meetings to provide assurance on the effectiveness of the systems established by management to identify, assess, manage, monitor and report on risks.

Liaison between the Risk Committee and Audit Committee is facilitated by periodic joint meetings of the two committees, one such meeting was arranged in 2014, and regular engagement between the two Committee chairs. Minutes of the meetings of each committee are shared reciprocally. The Risk Committee of the Directorate met on six occasions in 2014.

4.2.3. The HSE has an **Internal Audit** Division with appropriately trained personnel which operates in accordance with a written charter/terms of reference which the Directorate has approved. The National Director of Internal Audit reports to the Director General of the HSE through the Chairman of the Audit Committee and has a close working relationship with the Director General and is a member of the HSE leadership team. The Audit Committee is responsible, along with the Director General, for guiding, supporting and overseeing the work of the HSE's Internal Audit Division. Work of the National Director of Internal Audit and his team is informed by analysis of the financial risks to which the HSE is exposed. Annual Internal Audit plans, approved by the Audit Committee, are based on this analysis. These plans aim to cover the key risks and related controls on a rolling basis. IT audit services are engaged by the Division to assist in the conduct of specialist audits and Deloitte were appointed to conduct this work. The National Director of Internal Audit attends all Audit Committee meetings, and has regular meetings with the Chairman of the Audit Committee and the Director General.

During the year the Audit Committee reviewed reports from Internal Audit including the following:

- Internal Audit work plan for 2014
- Summary activity reports
- Summary Internal Audit reports and findings for Q3 and Q4 2013 and for Q1, Q2 and Q3 2014
- Internal Audit recommendation implementation tracking reports
- KPIs and performance reports

4.2.4. During 2014, the Audit Committee worked closely with the National Director of Internal Audit to develop further and improve the **Internal Audit Charter**, the division's KPIs and the format of the summary reports and recommendation implementation tracking reports issued by Internal Audit. Emphasis has been placed on having reports, summaries and trackers highlight potentially systemic financial control issues identified in audits, in order to allow the Directorate better focus senior management attention on any such issues. Procedures are in place to ensure that the recommendations of Internal Audit are followed up. Any instances of fraud or other irregularities identified through management review or audit are addressed by management and An Garda Síochána are notified. The HSE's Fraud Policy was reviewed and revised during the year. During the year, Internal Audit agreed a protocol with the Audit Committee and the Risk Committee so that any non-financial risk issues identified in audits would be reported to the Risk Committee.

4.2.5. **Monitoring and review of the effectiveness of the system of internal financial control** is informed by the work of the Internal Audit division, the Comptroller and Auditor General, the Audit Committee and the Directorate. Comments and recommendations made by the Comptroller and Auditor General in his management letters or other reports, such as reports of the Committee of Public Accounts are reviewed by the Directorate and Leadership Team and actions are taken to implement recommendations. Monitoring and review of their implementation is overseen by the Audit Committee.

4.3. Planning, performance monitoring and reporting

4.3.1. Planning takes place at several levels within the HSE and takes into account internal and external guidance provided through, for example, the Government's reform agenda, *Future Health*, the Department of Health's Statement of Strategy, national policy documents, specific strategies, economic forecasts and clinical and quality priorities. In line with Section 31, *Health Act 2004* and Section 12, *Health Service Executive (Governance) Act, 2013* a HSE **National Service Plan** is published each year, and contains information on the type and volume of service activity that is needed in order to deliver health and personal social care services, within the annual funding allocation. It includes performance indicators and activity measures (PIs) which are tracked and reported through the National Planning, Performance Assurance Group (NPPAG) process. The PIs are reviewed each year as part of the service planning process to check that they are still relevant, collectable and useful. In developing the plan, service managers reflect the type and level of service that is estimated to be required and can be delivered within the resources that are available in the year. Progress and outcomes against this plan are reported fully in the HSE Annual Report and Financial Statements. The 2014 National Service Plan was submitted to the Minister for Health on 25 November 2013 and the plan was approved by the Minister on 16 December 2013. The 2015 National Service Plan was submitted to the Minister for Health on 18 November 2014 and approved by the Minister on 26 November 2014.

4.3.2. To underpin the National Service Plan, **Divisional Operational Plans** 2014 for Acute Hospital, Health and Wellbeing, Primary Care, Mental Health, and Social Care Divisions were published. These support overall implementation, setting out a national and regional/hospital group position for each Division.

4.3.3. During 2014, as part of the overall planning and performance framework, the **National Planning, Performance Assurance Group** (NPPAG) met monthly, chaired by the Deputy Director General. As the principal planning and performance assurance group, NPPAG is responsible for:

- Ensuring the systems, controls and processes are in place to provide appropriate levels of assurance to the DG, the Directorate and the Minister that the HSE is delivering on its National Service Plan commitments.
- Undertaking a monthly review of performance across the organisation, including a detailed financial performance review.
- Managing the performance escalation and intervention process.
- Participating in the service planning process.
- Considering the draft version of the HSE's monthly performance assurance report for submission to the DG and HSE Directorate after which it is submitted to the Department and published.

The core membership of the NPPAG includes the CFO and all those who are responsible and accountable for budgets and service delivery.

To support performance assurance, a robust management process takes place in preparation of the monthly NPPAG meeting, following which the Deputy DG meets with the DG to review the draft Performance Assurance Report (PAR), prior to the report being tabled for a meeting of the Leadership Team at which it is formally considered. The draft PAR is also shared with the Department of Health. The Directorate, as the governing body for the HSE, considers the report at its monthly meeting. Once approved, the appropriate reports are formally submitted to the Secretary General of the Department of Health, to comply with reporting requirements to the Minister for Health (*Health Act 2004*) and published on www.hse.ie.

4.3.4. In August 2014, the governance and performance at regional level was transitioned to align into the new organisational design as part of the overall health system reform programme. This has resulted in operational responsibility to Community Healthcare Organisation (CHO) Chief Officers and Hospital Group CEOs.

4.3.5. As part of the strengthened accountability arrangements for 2015, a new **National Performance Oversight Group** (NPOG) was established and replaced the NPPAG. The Group, chaired by the Deputy Director General, has formal delegated authority from the Director General to serve as a key accountability mechanism for the health service and to support him and the Directorate in fulfilling their accountability responsibilities. National Directors continue to be directly accountable to the Director General for their performance and that of their Divisions.

It is the responsibly of the NPOG as a part of the overall accountability process to hold each National Director as the head of their Division to account for performance against the National Service Plan, under the four Balanced Score Card quadrants of Quality and Safety, Finance, Access and Workforce.

4.3.6. The introduction of an **Accountability Framework** as part of the HSE's overall governance arrangements is an important development and one which will support the implementation of the new health service structures. Many of the accountability processes are already in place and have operated over a number of years. The main developments in 2015 are:

- Strengthening of the performance management arrangements between the Director General and the National Directors and between the National Directors and the newly appointed Hospital Group CEOs and the CHO Chief Officers.
- The introduction of formal Performance Agreements between the Director General and the National Directors and between the National Directors and the Hospital group CEOs and the CHO Chief Officers.
- The introduction of a formal escalation and intervention process for underperforming services which will include a range of sanctions for significant or persistent underperformance.
- New national level management arrangements for the new CHO Chief Officers.
- The establishment of the National Performance Oversight Group to replace the National Planning, Performance Assurance Group (NPPAG).

4.3.7. **Timely and comprehensive reports** about how services are performing against various targets, including financial targets, enable HSE staff and managers to increase service efficiency and effectiveness. These include:

- CompStat (monthly web-enabled reports at hospital, hospital group and community/local health office (LHO) level) – Performance information within CompStat underpins the monthly Regional CompStat/Performance Assurance Fora chaired by the RDPI. The Regional Forum is attended by senior clinical and management personnel from hospitals and LHO's. Operational performance across key operational metric areas is reviewed and performance improvement plans are agreed. A change in structure and governance mid 2014 resulted in the regional performance assurance role passing from the RDPIs to the Divisional Directors who exercised their oversight through the hospital managers and ISA managers. This dovetailed with the structures put in place under the accountability framework for 2015;
- Monthly regional Performance Exception Reports are aggregated to produce a report to inform the Deputy DG of regional issues in advance of the NPPAG;
- The monthly PAR, drawn from the corporate activity, HR and Finance data sets, and informed by the regional reports is the primary paper considered by the NPPAG for performance assurance. This is supplemented by detail in a Management Data Report (MDR).

4.3.8. In addition, as part of the performance assurance process, the following key reports are compiled and published:

- HSE **Annual Report and Financial Statements** – produced and published each year to give an overview of performance for the preceding year. It is a comprehensive report on the organisation's activity, achievements, challenges and financial performance as set out in its National Service Plan. Through the audited financial statements, the HSE accounts for use of resources allocated from Government. The HSE Annual Report is a legal requirement under section 37 (Health Act 2004). Unlike other documents and reports required under the Health Act, the Minister is not required to approve the Annual Report. The report is published online at the end of June each year.
- The HSE **Appropriation Account** – prepared by the HSE and audited by the Comptroller and Auditor General is published in his Annual Report. The Appropriation Account is a comprehensive account of the HSE's financial performance in the year, prepared under Government accounting rules.

4.3.9. A **monthly dashboard** is provided to the CFO reporting on key performance and risk areas as follows:

- I&E financial results: Performance against budget by hospital group, division and national services.
- Vote results: A two month rolling view of Vote performance against subhead.
- Key Income KPI's: This includes claims submitted, claimed, pended or awaiting consultant action in addition to total claims by insurer rolling over a three month period and metrics around the top ten poorest performing hospitals.

4.3.10. The **monthly management accounts** provide a detailed view of the organisations financial performance against budget. The accounts include but are not limited to the following:

- Acute performance by hospital group and region.
- Performance by national division and by region.
- Primary Care Reimbursement Service – performance by scheme.
- National Services – performance by function.
- Corporate – performance by function.
- Pay, non-pay and income performance against profile.

A **commentary and analysis** accompanies the management accounts which provide context and commentary around emerging or existing trends and divisional performance.

4.3.11. A detailed **financial performance and outlook document** is produced each month for consideration by the CFO. This document outlines the key risk areas for the organisation in addition to illustrating likely scenarios regarding the financial challenge for the year. The report covers acute and divisional financial outlook for the year and separately highlights key organisational risk areas as well as offering scenarios relating to budgetary overruns based on detailed engagement with services. This detailed financial performance and outlook document is also shared with Government and members of the Health Service Directorate and is a key part of the performance management process.

4.3.12. The HSE is required to submit a **monthly vote issues report** and return to the Department of Health for transmission to Department of Public Expenditure and Reform (DPER). The monthly issues report and return is due five days before each month end and is an estimate of monthly vote expenditure compared to the monthly vote profile (budget). The issues returns from all Votes are consolidated by DPER and the Department of Finance and published on the 2nd or 3rd working day of each month as part of the monthly Exchequer Returns.

4.3.13. The HSE is also required to submit **monthly vote expenditure report** and return by the 5th working day of each month. This return reports actual vote expenditure by Subhead compared to the monthly vote profile (budget). Both the monthly vote report and return are signed by the Accounting Officer.

4.3.14. A **monthly Cash Report** is generated by the Treasury Unit that includes metrics from a number of sources, including the Cash Forecast model, to give early indications of the year-end position. This report forms part of the agenda of monthly meetings with the Department of Health and DPER. The report outlines the cash trends from a number of angles, giving early indications of the success or otherwise of cost containments plans to date as well as full year possible out-turns based on best case scenario to the most likely scenario.

4.3.15. The **Business Information Unit** (BIU) is the central repository within the HSE of activity information for acute and community services. Extensive amounts of data are collected, collated, validated and analysed by this unit. This data is used in performance monitoring and measurement which influences the HSE in taking both operational and strategic decisions.

Data returns are primarily based on the activity and targets as set out in the current year's National Service Plan. This data is collated and quality assured by divisional analysts. In addition, the analysts prepare graphs which identify trends in the performance of each Division and track service delivery against target. Where there are inconsistencies in data returns, queries are referred to the Business Managers to validate accuracy of information received. Queries are followed up by the team and information is validated with the services to ensure that data received is accurate.

4.4. Risk management

4.4.1. The HSE recognises the importance of **risk management, including financial risk management**, as an essential process for the delivery of quality and safe services. Risk management at an operational level is a line management function. Each Division is required to describe accountability arrangements for managing risk at all levels within the Directorate. These arrangements are part of the normal reporting mechanism to ensure that risk management is embedded into the business process. Each service/function is obliged to identify, assess and manage risk relevant to their area; the risk register is the principal tool to enable communication of this risk information. Where risks are identified that have significant potential to impact on the overall objectives of the HSE they are recorded on the Corporate Risk Register. The register is a mechanism to provide assurance (evidence) to the Directorate that risk is being identified, assessed and managed and that a range of control measures and action plans are in place at any time to mitigate the risks identified. Regular reports on the status of the corporate risks are submitted to the Risk Committee. The full suite of HSE risk management policies, procedures and guidelines are published on www.hse.ie.

4.4.2. The financial impact of clinical and operational incidents is reflected in cases settled by the State Claims Agency (SCA) and by insurers, on behalf of the HSE. The responsibility for management of clinical negligence, personal injury and property damage claims against the HSE has been delegated to the SCA under statute. The SCA also provides advice and assistance to HSE risk management, clinical and administrative personnel with the aim of supporting patient safety and reducing future claims and litigation. Where claims do arise the objective is to manage these claims so as to ensure that the State's liability and associated expenses are contained at the lowest achievable level. The SCA hosts an **electronic national adverse events management reporting system** which facilitates the investigation of any subsequent claims and also the identification and analysis of developing trends and patterns. The intention is that the lessons learned from this analysis support the improvement of patient safety and contribute to the reduction of claims in the HSE. Annually, the SCA plans and implements risk management work programmes based on claims and incident data trend analysis, legal requirements and precedents and recent developments in litigation risk management, nationally or internationally. A comprehensive programme of training and seminars was delivered by the SCA's risk management units during 2014. The SCA provides insurance advices on HSE contracts, licences, schemes and tenders in circumstances where State indemnity applies or on insurances required where it does not apply. This ensures that the State's liabilities are minimised in the most cost effective manner.

4.5. Controls over medical card eligibility

The scale of costs within the Medical Card and Primary Care Schemes and the volume of transactions associated with them means that there are potential areas of risk that need to be managed.

Eligibility to receive a medical card, in general, depends on an assessment of an applicant's means. This assessment is completed upon initial application for a medical card and an assessment is also repeated periodically to confirm continuing eligibility. Most medical cards are awarded for three years following eligibility assessment. However, eligibility may cease upon a change in circumstance and therefore a review of eligibility may be initiated during the eligibility period to confirm continuing eligibility.

During 2013, new legislation was enacted to enable the sharing of information with the revenue commissioners and with the Department of Social Protection. As soon as the information became available from the Revenue Commissioners, it was incorporated into the risk analysis process and it assisted with the determination of the review approach to adopt. The extent and quality of information sharing for the purposes of control over medical card eligibility continues to develop.

4.5.1. Renewal Notice Reviews

At 1 January 2014 there were 1,849,380 full medical cards and 125,425 GP visit cards in issue. During 2014, 1,005,299 cards were due to expire in monthly tranches. The full cohort of each monthly tranche which was approaching expiry was subject to a risk analysis to determine the review approach to adopt in each case. Renewal notices issued in relation to 631,630 persons. Renewal notices were not issued to the remaining 373,669 persons as it was concluded on the basis of risk assessment (which included data from the Revenue Commissioners) that those persons were at low risk or at no risk of being ineligible, and eligibility in those cases was extended for a further one year. Renewal of a medical card can be done by way of a full review of eligibility by the HSE or by cardholder self-assessment depending on the relative risk identified during the risk assessment process. Of the 631,630 renewals issued in 2014, 152,297 involved a full review and 479,333 requested the cardholder to self-assess.

As at April 2015 the assessment of eligibility had been concluded in relation to 472,794 (74.85%) cardholders.

- Continuing eligibility was confirmed in relation to 465,268 cards (98.4%).
- 7,526 cards were not renewed (1.6%) because the eligibility criteria e.g. income thresholds were not met.
- In 3,526 cases (0.56%) the cardholder was deceased.
- Almost 125,963 (19.94%) of the cards selected for review were not renewed because the cardholder did not respond to the renewal process.
- The assessment of eligibility was on-going in relation to 29,347 cards (4.65%).

4.5.2. Targeted Reviews

A review is 'targeted' when it is initiated during the eligibility period rather than when the card is due for renewal. During 2014, the HSE issued 58,422 targeted reviews. As at April 2015 the assessment of eligibility had been concluded in relation to 49,633 cardholders.

- Continuing eligibility was confirmed in relation to 49,144 cards (99% of the completed assessments).
- Eligibility was removed in 489 cases (1% of the completed assessments) because the eligibility criteria e.g. income thresholds were not met.

In a further 5,631 (9.6%) of targeted reviews, medical cards were not renewed because the cardholder did not respond to the renewal process. The assessment of eligibility was on-going in relation to 600 cards and in 2,558 cases the cardholder was deceased.

The total number of persons reviewed during 2014 was 690,052.

4.5.3. Residence Confirmation

In addition to the review of eligibility outlined above, the HSE also uses risk assessment to determine when to seek confirmation of residence in the State in relation to inactive cards.

During 2014, 96,902 individuals whose medical cards had been inactive were contacted requesting residence confirmation. As at April 2015, 71,823 individuals (74.12%) had confirmed residence. Eligibility was removed in relation to 25,079 cards (25.88%).

Overall Ineligibility Rate

The non-renewal and ineligibility rates found as a result of the risk based targeted reviews are likely to be higher than those applying to the population of medical card holders as a whole. The HSE does not currently have a reliable estimate of the level of ineligibility across the population of card holders. Options for developing a methodology to produce reliable estimates are being examined.

4.6. Governance of grants to outside agencies

In 2014, over €3.4 billion of the HSE's total expenditure related to grants to voluntary agencies. The legal framework under which the HSE provides grant funding to agencies is set out in the Health Act 2004.

Audit findings in previous years indicated control weaknesses in the governance of grants, in particular relating to the monitoring and oversight of agencies in receipt of exchequer funding, including:

- Insufficient evidence of formal monitoring and oversight of the agencies by the HSE;
- Lack of review and reconciliation of grantee financial statements to HSE records;
- Weaknesses in the systems of internal financial control within those agencies receiving Exchequer funding from the HSE;
- HSE procedures for processing grants in use by the local health offices were in draft format.

Policies and procedures in place for the governance of grants to agencies include the following:

4.6.1. The HSE has a formal **national governance framework** with national standardised documentation which governs grant funding provided to non-statutory organisations. This governance framework seeks to ensure the standard, consistent application of good governance principles which are robust and effective to ensure that both the HSE and the grant-funded agency meet their respective obligations.

4.6.2. It is the policy of the HSE to have properly executed **Governance Documentation** in place with each grant-funded agency in a timely manner. This policy is outlined in the National Financial Regulation, *NFR-31 Grants to Outside Agencies* and detailed in a comprehensive operational manual. The National Standard Governance Documentation, operating procedures, guides and process control forms are maintained on the HSE's intranet site. However, the extent of the financial challenge in 2014 and the additional focus on compliance adversely impacted the timeliness of the final sign-off of arrangements.

4.6.3. Both the Governance Documentation and the operating procedures detail the requirements for performance review, including submission and review of financial statements and periodic performance review meetings with agencies on a proportionate basis.

Further development and improvement of pre-existing controls took place in 2014, including:

4.6.4. A **Compliance Unit** has been established to provide programmatic oversight of the arrangements in place with the voluntary providers funded by the HSE. The Compliance Unit will place particular emphasis on issues raised and recommendations made by both the C&AG and the HSE's Internal Audit unit. In terms of monitoring and oversight, the Compliance Unit has established two working groups – one at corporate level and one at operational level – that will intensify the overall focus on this area.

4.6.5. The **National Standard Service Arrangement** has been revised during 2014 to incorporate the changes necessary to include updates to the regulatory requirements of agencies in receipt of Exchequer funding, including the provision of more accessible and transparent financial information particularly in relation to senior staffing salaries. Agencies' requirement to comply with public procurement is and was a condition of the Service Arrangement. Each Service Arrangement reflects the complexity of the services provided and includes corporate and clinical governance requirements, quality standards and codes of practice for services, and financial controls.

4.6.6. The HSE has expanded the management, governance and engagement with the Section 38 funded agencies by the introduction in 2014 of an **Annual Compliance Assurance Process**. The governing bodies of each Agency have been requested to perform an internal audit of their organisation's internal control frameworks and processes to ascertain their ability to comply with the conditions of the HSE Service Arrangement, and have provided the HSE with a signed declaration of their position in this regard. This process which included the submission of financial statements has been completed by all Section 38 agencies and the HSE is engaging with each agency to address identified areas of non-

compliance. To support the agencies, the HSE has hosted a national forum for all Chairs of the agencies' governing bodies to provide information and guidance, partnering with appropriate regulatory bodies such as the Office of the Director of Corporate Enforcement to support them in their accountability responsibilities.

All Section 38 agencies have signed the **Annual Compliance Statement** in respect of 2013. These Compliance Assurance Statements have been reviewed by the Compliance Unit and a template for 2014 has been issued to all agencies, informed by the review process. It includes an additional section on subsidiary companies.

4.6.7. The HSE has also developed a **national standard service specification template** with the disability sector which allows a high level of visibility and management control of individual centres of service delivery and the resources expended to deliver those services. These developments will allow the HSE to advance the strategies outlined in *Future Health*, and enable the development of a 'money follows the patient' funding model.

4.6.8. A national IT system, **Service Provider Governance On-Line**, was rolled out to support the local managers in their accountability responsibilities relating to the governance of grants.

5. Significant Breaches of the Control System in 2014

5.1. Compliance with procurement rules

In procuring goods and services, all areas within the HSE must comply with the relevant procurement procedures which are set out in detail in the HSE's National Financial Regulations.

In 2014 and in previous years, audits have identified a significant level of non-compliance with procurement rules, in particular where requirements for market testing, tendering or competitive processes were not observed.

The HSE is required to submit an annual return (the 40/02 return) to the Comptroller and Auditor General and the Department of Public Expenditure and Reform by 31 March in relation to the prior financial year. This return must disclose details of any contracts in excess of €25,000 (exclusive of VAT) which have been awarded without a competitive process. The HSE does not have an automated centralised system capable of identifying contracts awarded without a competitive process. Rather, it relies on individual areas to manually self-assess and identify and report such non-compliance. The HSE's 40/02 return for 2014 indicates that 299 contracts in excess of €25,000, with an aggregate value of €56.5m, were awarded without competitive process (2013: 116 contracts, with an aggregate value of €17.8m). There is however evidence to suggest that, as in previous years, returns submitted for 2014 did not include all instances of non-competitive procurement that were appropriate for declaration in the return.

The following summarises the actions taken by the HSE in 2014 to improve compliance with procurement rules.

- A number of framework agreements have been combined on the basis of similar requirements. There are currently 80 national framework agreements in place covering the majority of common expenditure categories and over 550 central contracts are in place covering an annual expenditure value of €426m. To improve staff awareness of the existence of framework agreements and contracts, the HSE has developed a Procurement Assisted Sourcing System (PASS) to allow budget holders to access current contracts information.
- The HSE has commenced the implementation, on a phased basis, of a National Distribution Centre model which will consolidate stock holding across the HSE, improve contract compliance, increase stock management at the point of use and control and deliver cost efficiencies. Since the beginning of 2014, HSE Procurement has achieved cost reductions of over €50m. Since the development of a centralised Procurement function in 2010, total savings of €250m have been achieved.
- Work has commenced on a Data Warehouse and Business Intelligence system which will allow for information to be extracted for reporting, data analysis and comparisons across the multiple financial systems currently in use across the HSE.
- A procurement training programme has commenced and will be delivered to staff across the HSE by Q2 2015. Over 100 staff have received formal training to date under this programme.
- During 2014, the HSE sought to increase the level of communication and training to staff on the requirements of Circular 40/02 and on procurement rules generally. This has resulted in significantly increased levels of disclosure in the 40/02 return for 2014.

These systems and enhanced processes will assist budget holders and Procurement in identifying areas where greater efficiencies can be achieved and support compliance with procurement rules. A key objective of any new financial and procurement system will be the provision of user friendly front end technology to support HSE's large community of non-professional buyers to improve compliance and achieve value for money.

A detailed proposal to commence implementation of the approved staffing structure required to establish a Sourcing and Contracts unit within HBS in the context of the new Government Procurement model was approved by the Health Business Services Committee in April 2015. An initial ten posts (of a total of 17) have been prioritised for immediate filling.

5.2. Cash Controls

Examinations undertaken by Internal Audit on canteen and car parking facilities have identified control risks in cash management and custody procedures, in particular relating to physical security of cash, adequacy of insurance for cash in transit, reconciliation of cash receipts to bank lodgements and segregation of duties. These control risks have been identified by Internal Audit as being potentially systemic.

Specific Internal Audit recommendations have been made in respect of each audit and the implementation of these are being progressed by management at the locations concerned. In addition, the overall approach to cash handling risk management is being considered by the National Financial Controls Assurance Group, with the objective of commencing the development of an overarching cash management strategy for the HSE during 2015. In the meantime, the HSE's National Financial Regulations have been updated to incorporate the recommendations of Internal Audit in relation to cash management procedures generally.

5.3. Tax compliance

A comprehensive self-review of tax compliance which was initiated in 2013 was completed in the year, with external specialist tax assistance. The self-review was conducted across all tax heads for which the HSE needs to account and focussed in particular on those risk areas identified by the formal tax risk assessment completed in 2012. Details of the underpayment of tax identified in the course of the self-review were set out in an unprompted voluntary disclosure submitted to Revenue (including interest and penalties) in December 2014. The disclosure was not material in financial terms in the context of the HSE's overall annual tax liability and full provision has been made in the 2014 financial statements. Revenue are auditing the unprompted voluntary disclosure submitted in accordance with their procedures.

Steps have been taken by the HSE to address areas of non-compliance identified during the self-review exercise, to seek to maximise tax compliance, as follows:

- A centralised permanent in-house tax department dealing with all tax matters for the HSE was established at the end of 2013.
- Where compliance risks have been identified, the tax team has made formal submissions to Revenue and in response has obtained written rulings from Revenue. This has formalised the position in a number of risk areas and has eliminated any ambiguity in the interpretation of Revenue guidance which could have otherwise exposed the HSE to a tax liability in future periods.
- Scheduled monthly meetings with Revenue as part of the co-operative compliance programme: the HSE met at least monthly during 2014 with Revenue officials to apprise them of progress with the preparation of the unprompted voluntary disclosure. The monthly meetings have promoted a constructive working relationship with Revenue and have also enabled the sharing of information on developments in tax generally.
- A formal tax policy has been developed for the HSE, which encompasses all tax policies, procedures and guidance notes. Financial regulations (NFRs) have been reviewed and, where appropriate, amended and updated for current tax law and practice and for written Revenue rulings and other issues identified as part of the self-review exercise. Guidance notes and explanatory memos on a broad range of common issues arising in the HSE across the tax heads have been prepared by the tax team and are available to all staff on the HSE intranet site. Training has been delivered by the tax team to financial processing staff in 2014.
- A rolling programme of tax health checks was designed by the HSE Tax team and will be rolled out during 2015. All processing sites will be required to perform detailed reviews on a rolling basis to provide continuous assurance of tax compliance. The use of e-audit techniques will also be investigated to seek to streamline the process.

The HSE remains committed to exemplary compliance with taxation laws.

6. Review of the Effectiveness of the System of Internal Control

The annual review of the effectiveness of the system of internal control of the HSE is directed at enabling the Director General, as Accounting Officer, and the Directorate HSE to deliver upon their requirement to satisfy themselves and represent to the Minister for Health and to the Oireachtas that there is appropriate effective control within the HSE. During 2014 a formal Review of the System of Internal Control in the HSE was completed by the Finance Directorate, the results of which have informed this Statement on Internal Financial Control. The review was carried out by finance managers with specific expertise in the areas of finance, audit, control and risk. Annual reviews of the system of internal control use an established controls assurance process methodology which has been further developed in carrying out this review during 2014.

The review process was significantly revised and broadened for 2014 and the HSE engaged external specialist support to review, validate and quality assure the revised review process to ensure that it meets best practice standards.

The review is informed by the following various elements, all of which provide evidence of the effectiveness, or otherwise, of the system of internal control in the HSE:

Internal Control Questionnaire (ICQ)

The ICQ was required to be completed by all staff at Grade VIII (or equivalent) and above, who also sign the annual Controls Assurance Statement. The content and format of the ICQ was extensively redeveloped in 2014, and expanded to 169 questions across 13 key control areas. For the first time, in 2014, the ICQ was hosted online and completed by respondents in electronic format. The migration of the ICQ to electronic format has facilitated the detailed statistical analysis of responses received from over 1,100 senior managers. This analysis will assist with staff training needs assessment and risk management focus in 2015.

Controls Assurance Statement (CAS)

The CAS must also be completed by all senior managers, administrative and clinical, from National Director Level to Grade VIII (or equivalent) level, and returned, along with an up-to-date risk register, to line management. There are a number of enhancements to this year's CAS, including a more detailed section on Circular 40/02 and space for staff to include any other information that they believe is relevant. The risk register documents material risks that could affect the HSE, the methods of managing those risks, the controls that are in place to contain them and the procedures to monitor them. These returns, which were previously paper-based, have also been submitted electronically for 2014, which has facilitated real-time monitoring of completion rates.

The 2014 review also involved reference to:

- Status of the recommendations of previous years' Reports on the Review of the Effectiveness of the System of Internal Control;
- Internal Audit reports, 2014 audit programme;
- Audit Committee and Risk Committee Minutes/Reports;
- Reports and management letters of the Comptroller and Auditor General;
- The 2014 audit programme of the Comptroller and Auditor General and in particular, the audit risks identified therein;
- Assessment of the progress of the implementation of recommendations contained in previous Internal Audit reports and reports of the Comptroller and Auditor General;
- Internal news/media releases;
- HSE Directorate and Leadership Team Minutes;
- Steering Group/Working Group/Implementation Groups etc Minutes;
- External Reviews/Reports;
- Reports of the Committee of Public Accounts;
- Health Information and Quality Authority Reports;
- Quality Patient Safety Audit Reports; and
- Government policy, such as Future Health – A Strategic Framework for Reform of the Health Service 2012-2015 and the Programme for Government.

Compliance by staff with the extended controls assurance process in 2014 has significantly improved versus 2013. The individual National Director Registers identify the staff who have and have not completed a CAS and ICQ, and non-responders will be followed up. The absence of a signed CAS attesting to the operation of controls gives rise to a concern that corporate risks may not be appropriately identified and addressed.

7. Conclusion

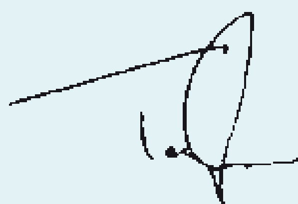
The report of the Review of the System of Internal Control in the HSE was considered by the HSE Leadership Team in February 2015 and subsequently circulated to the Directorate and Audit Committee.

In summary, the review concluded that there is evidence that:

- The HSE has adopted a suite of internal policies and procedures, which form the basis of the internal financial control framework.
- Where high level risks have been identified, mitigating/compensating controls are generally in place.
- A range of instances of non-compliance with these adopted policies and procedures have been identified which exposes the organisation to material risk when not promptly addressed.
- It is clear from the responses received to the online ICQ that most managers indicate high levels of compliance with internal controls in the daily undertaking of their role. However the lack of uniform consistency of responses indicates varying levels of compliance in specific control areas and these will be subject to particular focus for improvement which will be monitored by the National Financial Controls Assurance Group during 2015.
- Reasonable assurance can be placed on the sufficiency of internal controls to mitigate and/or manage key inherent risks to which financial activities are exposed. However the operation of a number of controls remains inconsistent and represents a significant focus area for improvement over the coming year.

As in previous years, the evaluation of the effectiveness of the system of internal control has had regard to the continuous development of the control systems of the HSE as an organisation undergoing significant change, comprising an amalgamation of health bodies and their legacy systems. The extension in scope and depth of the annual controls assurance process in 2014 has had the effect of further increasing awareness and understanding of the control system throughout the organisation. A concerted approach is being adopted to following up the review's recommendations in a consistent way. All recommendations will be grouped into thematic areas so that action plans for implementation will seek to address all recommendations relating to the theme.

The breaches of the control environment of the HSE which are referenced in this statement underline the imperative of specific and sustained focus on compliance at all levels of the organisation. In summary, notwithstanding control breaches which were identified and are being addressed by management as set out above, satisfactory levels of compliance with the control framework are generally observed by the majority of staff. However, persistent instances of non-compliance remain in certain areas such as compliance with procurement rules. Disregard of procurement requirements, and by extension NFRs, are matters for consideration under the HSE's disciplinary procedures. As with recommendations contained in any other report, such as Internal Audit and C&AG reports, structured plans for the implementation of the recommendations of the Review of the Effectiveness of the System of Internal Control in the Health Service Executive are prepared by management. The implementation of these recommendations by management will be co-ordinated by National Financial Controls Assurance Group and progress will be monitored during 2015 by the National Performance Oversight Group and the Audit Committee. The situation will be reassessed in the 2015 Review of the Effectiveness of the System of Internal Control.



Tony O'Brien
Chairman

18 May 2015

Report of the Comptroller and Auditor General

for Presentation to the Houses of the Oireachtas

Health Service Executive

I have audited the financial statements of the Health Service Executive for the year ended 31 December 2014 under Section 36 of the *Health Act 2004*. The financial statements, which have been prepared under the accounting policies set out therein, comprise the accounting policies, the revenue income and expenditure account, the capital income and expenditure account, the balance sheet, the cash flow statement, and the related notes.

The financial statements have been prepared in the form prescribed under Section 36 of the *Health Act 2004* and accounting standards specified by the Minister for Health. The statement on the basis of accounting in the accounting policies explains how the accounting standards specified by the Minister differ from generally accepted accounting practice in Ireland.

The Health Service Executive also produces an appropriation account for transactions reflected in the financial statements. I report separately on that account. Any matters arising out of my audits that I consider merit reporting will be outlined in my Report on the Accounts of the Public Services for 2014.

Responsibilities of the members of the Directorate

The Directorate of the Health Service Executive is responsible for the preparation of the financial statements, for ensuring that they give a true and fair view, in accordance with the accounting standards specified by the Minister for Health, of the state of the Health Service Executive's affairs and of its income and expenditure, and for ensuring the regularity of transactions.

Responsibilities of the Comptroller and Auditor General

My responsibility is to audit the financial statements and report on them in accordance with applicable law.

My audit is conducted by reference to the special considerations which attach to State bodies in relation to their management and operation.

My audit is carried out in accordance with the International Standards on Auditing (UK and Ireland) and in compliance with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements, sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of

- whether the accounting policies are appropriate to the Health Service Executive's circumstances, and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made in the preparation of the financial statements, and
- the overall presentation of the financial statements.

I also seek to obtain evidence about the regularity of financial transactions in the course of audit.

In addition, I read the Health Service Executive's annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies, I consider the implications for my report.

Opinion on the financial statements

In my opinion, the financial statements, which have been properly prepared under the accounting standards specified by the Minister for Health, give a true and fair view in accordance with those standards of the state of the Health Service Executive's affairs at 31 December 2014 and of its income and expenditure for 2014.

In my opinion, proper books of account have been kept by the Health Service Executive. The financial statements are in agreement with the books of account.

Matters on which I report by exception

I report by exception if

- I have not received all the information and explanations I required for my audit, or
- my audit noted any material instance where money has not been applied for the purposes intended or where the transactions did not conform to the authorities governing them, or
- the information given in the Health Service Executive's annual report is not consistent with the related financial statements, or
- the statement on internal financial control does not reflect the Health Service Executive's compliance with the Code of Practice for the Governance of State Bodies, or
- I find there are other material matters relating to the manner in which public business has been conducted.

Non-compliant procurement

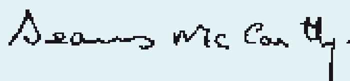
In examining a sample of procurements of goods and services by the Health Service Executive, the audit found a high incidence of failure to comply with relevant guidelines and regulations. The statement on internal financial control discloses steps being taken by the Health Service Executive to address such failures.

Tax compliance

The statement on internal financial control also discloses non-compliance by the Health Service Executive with the tax code, and the steps taken to address these lapses in control.

Non payment of interest and compensation

Legislation which came into effect in March 2013 provides for the payment of interest and compensation to suppliers in respect of late payment of invoices. The HSE has not complied fully with this legislation. In 2014, the HSE has charged an additional €9 million to the income and expenditure account to recognise the expected cost of compensation due to suppliers since the introduction of the legislation in March 2013 (See Note 8).



Seamus McCarthy
Comptroller and Auditor General

19 May 2015

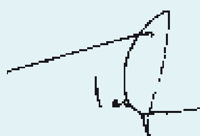
Revenue Income and Expenditure Account

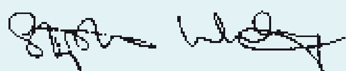
For Year Ended 31 December 2014

	Note	2014 €'000	2013 €'000
Income			
Exchequer Revenue Grant	3	**11,843,214**	12,171,661
Receipts from certain excise duties on tobacco products		**167,605**	167,605
Income from services provided under EU regulations		**171,980**	220,000
Recovery of costs from Social Insurance Fund		**8,808**	14,748
Patient Income	4	**409,922**	371,124
Other Income	5	**627,212**	690,145
		13,228,741	13,635,283
Expenditure – Pay and Pensions			
Clinical	6 & 7	**3,071,120**	3,143,812
Non Clinical	6 & 7	**1,010,825**	1,038,696
Other Client/Patient Services	6 & 7	**713,482**	688,871
		4,795,427	4,871,379
Expenditure – Non Pay			
Clinical	8	**880,780**	856,264
Patient Transport and Ambulance Services	8	**56,892**	56,682
Primary Care and Medical Card Schemes	8	**2,667,502**	2,901,490
Other Client/Patient Services	8	**15,994**	64,866
Grants to Outside Agencies	8	**3,425,454**	3,477,148
Housekeeping	8	**229,193**	232,970
Office and Administration Expenses	8	**403,096**	408,579
Long Stay Charges Repaid to Patients	31	**1,124**	196
Hepatitis C Insurance Scheme	32	**882**	1,198
Payments to State Claims Agency	29	**117,356**	135,874
Nursing Homes Support Scheme (Fair Deal) – Private Nursing Home only	33	**585,511**	591,386
Other Operating Expenses	8	**41,110**	44,399
		8,424,894	8,771,052
Operating Surplus/(Deficit) for the Year before Transfer of Operations		**8,420**	(7,148)
Net Current Liabilities on Transferred Operations	26	**37,095**	0
Net Operating Surplus/(Deficit) for the Year		**45,515**	(7,148)

All gains and losses with the exception of depreciation and amortisation have been dealt with through the Revenue Income and Expenditure Account and the Capital Income and Expenditure Account.

The primary financial statements of the HSE comprise the Revenue Income and Expenditure Account, Capital Income and Expenditure Account, Balance Sheet and Cash Flow Statement on pages 96-99.





Tony O'Brien
Chairman

18 May 2015

Stephen Mulvany
Chief Financial Officer

18 May 2015

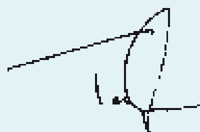
Capital Income and Expenditure Account

For Year Ended 31 December 2014

	Notes	2014 €'000	2013 €'000
Income			
Exchequer Capital Funding		**362,518**	328,736
Revenue Funding Applied to Capital Projects		**1,014**	945
Application of Proceeds of Disposals		**2,871**	2,941
Government Departments and Other Sources		**2,302**	3,086
		368,705	335,708
Expenditure			
Capital Expenditure on HSE Capital Projects	*18(b)*	**303,596**	273,352
Capital Grants to Outside Agencies (Appendix 2)	*18(b)*	**53,292**	68,875
		356,888	342,227
Net Capital Surplus/(Deficit) for the Year		**11,817**	(6,519)

All gains and losses with the exception of depreciation and amortisation have been dealt with through the Revenue Income and Expenditure Account and the Capital Income and Expenditure Account.

The primary financial statements of the HSE comprise the Revenue Income and Expenditure Account, Capital Income and Expenditure Account, Balance Sheet and Cash Flow Statement on pages 96-99.



Tony O'Brien
Chairman

18 May 2015

Stephen Mulvany
Chief Financial Officer

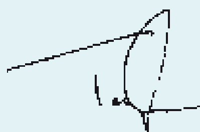
18 May 2015

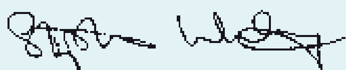
Balance Sheet

As at 31 December 2014

	Notes	2014 €'000	2013 €'000
Fixed Assets			
Tangible Fixed Assets			
Land and Buildings	*9*	**4,633,826**	4,661,118
Other Tangible Fixed Assets	*10*	**227,846**	249,120
Investments			
Financial Assets – unquoted shares		**3**	3
Total Fixed Assets		**4,861,675**	4,910,241
Current Assets			
Stocks	*11*	**137,133**	122,852
Debtors	*12*	**339,321**	262,794
Paymaster General and Exchequer Balance	*13*	**92,016**	77,721
Cash at Bank or in Hand		**53,379**	49,043
Current Liabilities			
Creditors	*14*	**(1,644,820)**	(1,600,020)
Net Current Liabilities		**(1,022,971)**	(1,087,610)
Creditors (amounts falling due after more than one year)	*15*	**(41,334)**	(49,248)
Deferred income	*16*	**(25,724)**	(10,440)
Total Assets		**3,771,646**	3,762,943
Capitalisation Account	*17(a)*	**4,861,672**	4,910,238
Capital Reserves	*17(b)*	**(139,025)**	(150,779)
Revenue Reserves	*17(c)*	**(951,001)**	(996,516)
Capital and Reserves		**3,771,646**	3,762,943

The primary financial statements of the HSE comprise the Revenue Income and Expenditure Account, Capital Income and Expenditure Account, Balance Sheet and Cash Flow Statement on pages 96-99.





Tony O'Brien
Chairman

18 May 2015

Stephen Mulvany
Chief Financial Officer

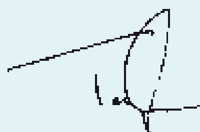
18 May 2015

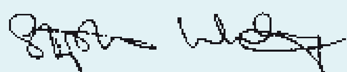
Cash Flow Statement

For Year Ended 31 December 2014

	Notes	**2014 €'000**	**2013 €'000**
Net Cash Inflow/(Outflow) from Operating Activities	*19*	**21,437**	54,371
Net Cash Inflow/(Outflow) from Returns on Investments and Servicing of Finance			
Interest paid on loans and overdrafts		**(2)**	(3)
Interest paid on finance leases		**(1,106)**	(1,175)
Equity dividends received		**0**	0
Interest received		**31**	257
Net Cash Outflow from Returns on Investments and Servicing of Finance		**(1,077)**	(921)
Capital Expenditure			
Capital expenditure funded from Capital Vote – capitalised	*18(b)*	**(206,424)**	(151,133)
Capital expenditure funded from Capital Vote – not capitalised	*18(b)*	**(150,464)**	(191,094)
		(356,888)	(342,227)
Payments from revenue re: acquisition of fixed assets (net of trade-ins)	*18(a)*	**(13,285)**	(29,939)
Revenue funding applied to Capital		**1,014**	945
Receipts from sale of fixed assets (excluding trade-ins)		**3,624**	2,465
Net Cash Outflow from Capital Expenditure		**(365,535)**	(368,756)
Net Cash Outflow before Financing		**(345,175)**	(315,306)
Financing			
Capital grant received		**362,518**	328,736
Capital receipts from other sources		**2,302**	3,086
Payment of capital element of finance lease and loan repayments		**(1,014)**	(945)
Net Cash Inflow from Financing		**363,806**	330,877
Increase/(Decrease) in cash in hand, bank and PMG balances in the year	*20*	**18,631**	15,571

The primary financial statements of the HSE comprise the Revenue Income and Expenditure Account, Capital Income and Expenditure Account, Balance Sheet and Cash Flow Statement on pages 96-99.





Tony O'Brien
Chairman

18 May 2015

Stephen Mulvany
Chief Financial Officer

18 May 2015

Accounting Policies

Basis of Accounting

The financial statements have been prepared on an accruals basis, in accordance with the historical cost convention. Under the *Health Act 2004*, the Minister for Health specifies the accounting standards to be followed by the HSE. The HSE has adopted Generally Accepted Accounting Principles (GAAP) in accordance with the accounting standards issued by the Financial Reporting Council subject to the following exceptions specified by the Minister:

1. Depreciation is not charged to the Revenue Income and Expenditure Account, rather it is charged to a reserve account: the Capitalisation Account. Reserve accounting is not permitted under Generally Accepted Accounting Principles (GAAP). Under those principles, depreciation must be charged in the revenue income and expenditure account.
2. Grants received from the State to fund the purchase of fixed assets are recorded in a Capital Income and Expenditure Account. Under Generally Accepted Accounting Principles (GAAP), capital grants are recorded as deferred income and amortised over the useful life of the related fixed asset, in order to match the accounting treatment of the grant against the related depreciation charge on the fixed asset.
3. Pensions are accounted for on a pay-as-you go basis. The provisions of FRS 17 *Retirement Benefits* are not applied and the liability for future pension benefits accrued in the year has not been recognised in the financial statements.
4. Claims under the Clinical Indemnity Scheme which are paid by the HSE, and administered by the State Claims Agency on the HSE's behalf, are accounted for on a pay-as-you go basis, and the accruals basis of accounting required by FRS 18 *Accounting Policies* is not applied. The charge to the Revenue Income and Expenditure Account in 2014 was €117.3m (2013: €135.9m). The actuarially estimated future liability attaching to this scheme at 31 December 2014 is €1,277m (2013: €1,084m) (see Note 29 to the financial statements).

Basis of Preparation

The Programme for Government commits to the HSE ceasing to exist over time but for 2014 the HSE continued as before, except for the transfer of childcare services to the new Child and Family Agency on 1 January 2014 as provided for in the *Child and Family Agency Act, 2013*. The Directorate assumes that all existing HSE activities will continue to be carried out by the new entities established in the restructuring of health services, with all assets and liabilities likely to be transferred to those new bodies. In the circumstances, it does not believe that any adjustment to the carrying value of assets or liabilities is warranted in these financial statements to reflect any possible restructuring and it has prepared these accounts on a going concern basis.

The Child and Family Agency was established on 1 January 2014 under the *Child and Family Agency Act, 2013*. The new Agency brings together three key services which play a role in the welfare of children and families:

- Children and Family Services previously operated by HSE
- The Family Support Agency
- The National Educational Welfare Board

The assets, liabilities and reserves of the HSE's Child and Family Services were transferred to the Child and Family Agency at net book value on 1 January 2014. Please refer to Note 26 to the financial statements for further information.

Income Recognition

(i) The HSE is funded mainly by monies voted annually by Dáil Éireann in respect of administration, capital and non-capital services. The amount recognised as income in respect of voted monies represents the net recourse to the Exchequer to fund payments made during the year. Income in respect of administration and non-capital services is accounted for in the Revenue Income and Expenditure Account. Income in respect of capital services is accounted for in the Capital Income and Expenditure Account. Revenue funding applied to meet the repayment of monies borrowed by predecessor agencies and which were used to fund capital expenditure is accounted for in the Capital Income and Expenditure under the heading Revenue Funding Applied to Capital Projects.

(ii) Patient and service income is recognised at the time service is provided.

(iii) Superannuation contributions from staff are recognised when the deduction is made (see pensions accounting policy below).

(iv) Income from all other sources is recognised on a receipts basis.

(v) The amount of income, other than Exchequer grant, which the HSE is entitled to apply in meeting its expenditure is limited to the amount voted to it as 'Appropriations-in-Aid' in the annual estimate. Appropriations in aid are receipts that may, under section 2 of the *Public Accounts and Charges Act, 1891*, be used to meet expenditure to the extent authorised by the annual Appropriation Act. In general, these are receipts arising in the normal course of business under the Vote. Other income received in the year in excess of this amount must be surrendered to the Exchequer. Other income is shown net of this surrender.

The income recognition policy as set out above continued to apply in 2014. However, under the new arrangements set out under the *Health Service Executive (Financial Matters) Act 2014*, the HSE will be funded from 1st January 2015 by way of a net determination funded by grants from the Department of Health. The 2015 letter of determination was received on 31st October 2014.

Section 10 of the Act requires the HSE to manage/deliver services in a manner that is in accordance with the approved Service Plan. It also requires the HSE to manage the services within the net determination notified by the Minister. If the HSE exceeds its budget in one year that deficit is a first charge against the following year's approved budget. If the HSE has a surplus it can carry over the surplus into the following year, subject to the approval of the Minister with the consent of the Department of Public Expenditure and Reform.

The Nursing Homes Support Scheme (A Fair Deal)

Payments received from eligible people are accounted for as long stay charges within patient income. The scheme provides that in certain circumstances a portion of the amount payable may be deferred and collected at a point in the future by the Revenue Commissioners. Charges so deferred are not accounted for in the financial statements of the HSE.

Capital Income and Expenditure Account

A Capital Income and Expenditure Account is maintained in accordance with the accounting standards laid down by the Minister for Health. Exchequer Capital Funding is the net recourse to the Exchequer to fund payments made during the year in respect of expenditure charged against the Capital Services subheads in the HSE's Vote. Capital funding is provided in the HSE's Vote for construction/purchase of major assets, capital maintenance and miscellaneous capital expenditure not capitalised on the balance sheet. In addition, capital funding is provided in the HSE's Vote for payment of capital grants to outside agencies. An analysis of capital expenditure by these categories is provided in Note 18 to the financial statements.

Balance on Income and Expenditure Accounts

Most of the income in both the Revenue and Capital Income and Expenditure Accounts is Exchequer Grant which is provided to meet liabilities maturing during the year as opposed to expenditure incurred during the year. A significant part of the remaining income is accounted for on a receipts basis. However, expenditure is recorded on an accruals basis. As a result, the balances on the income and expenditure accounts do not represent normal operating surpluses or deficits, as they are largely attributable to the difference between accruals expenditure and cash-based funding.

Grants to Outside Agencies

The HSE funds a number of service providers and bodies for the provision of health and personal social services on its behalf, in accordance with the provisions of Sections 38 and 39 of the *Health Act 2004*. Before entering into such an arrangement, the HSE determines the maximum amount of funding that it proposes to make available in the financial year under the arrangement and the level of service it expects to be provided for that funding. This information is set out in nationally standardised documentation which is required to be signed by both parties to the arrangement. This funding is charged, in the year of account to the income and expenditure account at the maximum determined level for the year, although a certain element may not actually be disbursed until the following year.

Leases

Rentals payable under operating leases are dealt with in the financial statements as they fall due. The HSE is not permitted to enter into finance lease obligations under the Department of Public Expenditure and Reform's Public Financial Procedures, without prior sanction or approval from the HSE Directorate. However, where assets of predecessor bodies have been acquired under finance leases, these leases have been taken over by the HSE on establishment. For these leases, the capital element of the asset is included in fixed assets and is depreciated over its useful life. In addition to the normal GAAP treatment for assets acquired under finance leases, the cost of the asset is charged to the Capital Income and Expenditure Account and the Capitalisation (Reserve) Account is credited with an equivalent amount. The outstanding capital element of the leasing obligation is included in creditors. Interest is charged to the income and expenditure account over the period of the lease.

Capital Grants

Capital grant funding is recorded in the Capital Income and Expenditure Account. In addition to capital grant funding, some minor capital expenditure is funded from revenue. The amount of this revenue funding expended in the year in respect of minor capital is charged in full in the Revenue Income and Expenditure Account in the year. This accounting treatment, which does not comply with Generally Accepted Accounting Principles, is a consequence of the exceptions to Generally Accepted Accounting Principles specified by the Minister.

Tangible Fixed Assets and Capitalisation Account

Tangible fixed assets comprise Land, Buildings, Work in Progress, Equipment and Motor Vehicles. Tangible fixed asset additions since 1 January 2005 are stated at historic cost less accumulated depreciation. The carrying values of tangible fixed assets taken over from predecessor bodies by the HSE were included in the opening balance sheet on establishment day, 1 January 2005, at their original cost/valuation. Where lands had been revalued prior to transfer to the HSE, Department of Health valuation rates were used. The related aggregate depreciation account balance was also included in the opening balance sheet. The HSE has adopted a policy of not revaluing fixed assets.

Lands owned by the HSE are held for the provision of health and personal social services. The HSE does not hold land for commercial purposes.

In accordance with the accounting standards prescribed by the Minister, expenditure on fixed asset additions is charged to the Revenue Income and Expenditure Account or the Capital Income and Expenditure Account, depending on whether the asset is funded by capital or revenue funding. Capital funded assets and Revenue funded assets are capitalised if the cost exceeds certain value thresholds; €2,000 for computer equipment and €7,000 for all other asset classes. Asset additions below this threshold and funded from revenue are written off in the year of purchase. Asset additions below this threshold funded from Capital are included in Note 18(b) under 'Expenditure on HSE projects not resulting in Fixed Asset additions'. A breakdown of asset additions by funding source is provided in Note 18(a) to the Accounts. Depreciation is not charged to the income and expenditure account over the useful life of the asset. Instead, a balance sheet reserve account, the Capitalisation Account, is the reciprocal entry to the fixed asset account. Depreciation is charged to the Fixed Assets and Capitalisation Accounts over the useful economic life of the asset.

Depreciation is calculated to write-off the original cost/valuation of each tangible fixed asset over its useful economic life on a straight line basis at the following rates:

- Land: land is not depreciated.
- Buildings: depreciated at 2.5% per annum.
- Modular buildings (i.e. prefabricated buildings): depreciated at 10% per annum.
- Work in progress: no depreciation.
- Equipment – computers and ICT systems: depreciated at 33.33% per annum.
- Equipment – other: depreciated at 10% per annum.
- Motor vehicles: depreciated at 20% per annum.

On disposal of a fixed asset, both the fixed assets and capitalisation accounts are reduced by the net book value of the asset disposal. An analysis of the movement on the Capitalisation Account is provided in Note 17 to the accounts.

Proceeds of disposal of fixed assets are considered as Exchequer Extra Receipts (EERs) under the Department of Expenditure and Reform's Public Financial Procedures. The HSE is not entitled to retain these sales proceeds for its own use and must surrender them to the Exchequer, except in the case of proceeds applied for Mental Health and other projects as sanctioned, subject to a maximum threshold of €8m in 2014 (2013: €8m). The application of any additional proceeds of disposal from surplus assets over and above €8m is subject to the approval of the Department of Public Expenditure and Reform.

Stocks

Stocks are stated at the lower of cost and net realisable value. Net realisable value is the estimated proceeds of sale less costs to be incurred in the sale of stock.

Accounting for Bad and Doubtful Debts

Known bad debts are written off in the period in which they are identified. Specific provision is made for any amount which is considered doubtful. General provision is made for patient debts which are outstanding for more than one year.

Pensions

Eligible HSE employees are members of various defined benefit superannuation schemes. Pensions are paid to former employees by the HSE. The HSE is funded by the State on a pay-as-you-go basis for this purpose. The Vote from the State in respect of pensions is included in income. Pension payments under the schemes are charged to the income and expenditure account when paid, as follows:

i. Superannuation paid to retired HSE employees is accounted for within the pay classification (see Note 6);

ii. Superannuation paid to retirees from the voluntary health service providers is accounted for under grants to outside agencies within the non-pay classification (see Note 8 and Appendix 1).

Contributions from HSE employees who are members of the schemes are credited to the income and expenditure account when received. Contributions from employees of the voluntary health service providers who are members of the scheme are retained as income of the health service provider.

No provision has been made in respect of pension benefits earned by employees and payable in future years under the pension scheme, consistent with the accounting treatment in previous years. This continues to be the treatment adopted by the HSE following the accounting specifications of the Minister.

Pension Related Deduction

Under the *Financial Emergency Measures in the Public Interest Act 2009*, a pension levy was introduced for all staff who are members of a public service pension scheme, including staff of certain HSE-funded service providers. Pension levy collected by service providers as well as pension levy deducted from HSE staff is accounted for as income by the HSE. Details of amount deducted in respect of the pension levy are set out in Note 5(a) to the Financial Statements.

Patients' Private Property

Monies received for safe-keeping by the HSE from or on behalf of patients are kept in special accounts separate and apart from the HSE's own accounts. Such accounts are collectively called Patients' Private Property accounts. The HSE is responsible for the administration of these accounts. However, as this money is not the property of the HSE, these accounts are not included on the HSE's balance sheet. The HSE acts as trustee of the funds. Patients' Private Property accounts are independently audited each year.

Notes to the Financial Statements

Note 1(a) Segmental Analysis by Area of Operation

	Hospitals Division (incl. Ambulance)	Primary Care Division	Mental Health Division	Social Care Division	Health and Wellbeing Division	Corporate Support Services Division	Total	Total
	2014	2014	2014	2014	2014	2014	2014	2013
	€'000	€'000	€'000	€'000	€'000	€'000	€'000	€'000
Expenditure								
Pay and Pensions								
Clinical	1,458,766	373,872	452,485	346,357	54,318	385,322	**3,071,120**	3,143,812
Non Clinical	343,158	140,211	70,611	145,218	33,394	278,233	**1,010,825**	1,038,696
Other Client/Patient Services	214,427	32,604	44,329	335,845	1,897	84,380	**713,482**	688,871
	2,016,351	546,687	567,425	827,420	89,609	747,935	**4,795,427**	4,871,379
Non Pay								
Clinical	564,430	154,725	17,770	52,958	49,896	41,001	**880,780**	856,264
Patient Transport and Ambulance Services	36,238	6,688	4,106	9,028	375	457	**56,892**	56,682
Primary Care and Medical Card Schemes	20,209	2,462,765	28,106	132,871	12,664	10,887	**2,667,502**	2,901,490
Other Client/Patient Services	853	1,990	1,752	11,022	70	307	**15,994**	64,866
Grants to Outside Agencies	2,346,018	128,752	30,026	905,266	10,628	4,764	**3,425,454**	3,477,148
Housekeeping	112,832	23,840	26,263	61,091	1,239	3,928	**229,193**	232,970
Office & Administrative Expenses	114,253	85,583	33,123	39,457	22,863	107,817	**403,096**	408,579
Long Stay Charges Repaid to Patients	0	0	0	0	0	1,124	**1,124**	196
Hepatitis C Insurance Scheme	0	0	0	0	0	882	**882**	1,198
Payments to State Claims Agency	0	0	0	0	0	117,356	**117,356**	135,874
Nursing Homes Support Scheme (Fair Deal) – Private Nursing Home only	0	0	0	585,511	0	0	**585,511**	591,386
Other Operating Expenses	14,190	5,797	7,323	9,058	2,785	1,957	**41,110**	44,399
	3,209,023	2,870,140	148,469	1,806,262	100,520	290,480	**8,424,894**	8,771,052
Gross expenditure for the year	5,225,374	3,416,827	715,894	2,633,682	190,129	1,038,415	**13,220,321**	13,642,431

Note 1(b) Prior Year Comparatives excluding Child and Family Agency (CFA)

	Total HSE 2013 €'000	Total CFA 2013 €'000	Total HSE (excl. CFA) 2013 €'000	Total HSE 2014 €'000
Expenditure				
Pay and Pensions				
Clinical	3,143,812	153,453	2,990,359	3,071,120
Non Clinical	1,038,696	64,119	974,577	1,010,825
Other Client/Patient Services	688,871	0	688,871	713,482
	4,871,379	217,572	4,653,807	4,795,427
Non Pay				
Clinical	856,264	44,356	811,908	880,780
Patient Transport and Ambulance Services	56,682	1,565	55,117	56,892
Primary Care and Medical Card Schemes	2,901,490	150,185	2,751,305	2,667,502
Other Client/Patient Services	64,866	0	64,866	15,994
Grants to Outside Agencies	3,477,148	90,571	3,386,577	3,425,454
Housekeeping	232,970	3,881	229,089	229,193
Office & Administrative Expenses	408,579	49,064	359,515	403,096
Long Stay Charges Repaid to Patients	196	0	230	196
Hepatitis C Insurance Scheme	1,198	0	1,198	0
Payments to State Claims Agency	135,874	0	135,874	135,874
Nursing Homes Support Scheme (Fair Deal) – Private Nursing Home only	591,386	0	591,386	591,386
Other Operating Expenses	44,399	9,224	35,175	41,110
	8,771,052	348,846	8,422,206	8,424,894
Gross expenditure for the year	13,642,431	566,418	13,076,013	13,220,321

Note 2 Net Operating Surplus/(Deficit)

	2014 €'000	2013 €'000
Net operating surplus/(deficit) for the year is arrived at after charging:		
Audit fees	**520**	547
Remuneration	**185**	190
Remuneration comprises the following elements:		
Director General Designate/Deputy CEO basic pay – post existed from 20/8/2012 to 23/7/2013	**0**	109
Director General basic pay*	**185**	81
	185	190

* The Director General's remuneration package comprises basic pay only. No allowances, bonuses or perquisites apply to the post. The Director General is a member of the HSE pension scheme and his pension entitlements do not extend beyond the standard entitlements of the public sector model scheme.

Note 2 Net Operating Surplus/(Deficit) contd.

	2014 €	2013 €
Directorate members' expenses**		
Tony O'Brien	**7,603**	2,332
Laverne Mc Guinness	**4,912**	880
Stephen Mulvany	**3,886**	3,009
John Hennessy	**780**	919
Stephanie O' Keeffe	**857**	917
Ian Carter – (resigned 12 May 2014)	**730**	1,842
Pat Healy	**9,531**	1,001
Tom Byrne – (resigned 19 May 2014)	**215**	3,641
Anne O'Connor – (appointed 11 July 2014)	**1,355**	0
Dr Tony O'Connell – (appointed 12 May 2014)	**10,418**	0
	40,287	14,541

** Directorate members expenses for 2013 are shown from the date of appointment on 24 July 2013.

2013 Directorate members' expenses have been re-stated to include expenses which were incurred in 2013 but reimbursed in 2014.

The Directorate comprises senior executives from the HSE. In accordance with Government pay policy, public servants who sit on State boards or who may be nominated to such boards independently of their public service employment are not paid remuneration in the form of board fees and their remuneration applies to their HSE executive roles only. No fees are paid to members of the Directorate.

Note 3 Exchequer Revenue Grant

	2014 €'000	2013 €'000
Net Estimate voted to HSE (HSE Vote 39)	**12,232,496**	12,531,471
Less net Surplus to be surrendered (Note 21)	**(26,764)**	(31,074)
Net recourse to Exchequer	**12,205,732**	12,500,397
Less: Capital services funding from the State (HSE Vote 39)	**(362,518)**	(328,736)
Exchequer Revenue Grant	**11,843,214**	12,171,661

Note 4 Patient Income

	2014 €'000	2013 €'000
Private Charges*	**298,010**	239,187
Inpatient Charges*	**18,011**	36,613
Emergency Department Charges	**9,225**	9,225
Road Traffic Accident Charges	**4,841**	4,841
Long Stay Charges	**79,820**	80,140
EU Income – E111 Claims	**15**	15
	409,922	371,124

* A revised charging structure was introduced for Inpatient Services provided under Section 55 of the Health Act 1970 (as amended by Health (Amendment) Act 2013.) These include charging for private patients accommodated in a non-designated bed, which could not be billed for previously, and a reduction in statutory charges for private patients for the Public Inpatient Charge.

Note 5 Other Income

	2014 €'000	2013 €'000
(a) Other Income		
Superannuation Income	**169,373**	181,655
Pension levy deductions from HSE own staff	**212,743**	234,848
Pension levy deductions from service providers	**106,427**	109,604
Other Payroll Deductions	**8,303**	8,359
Agency/Services – provided to Local Authorities and other organisations	**7,279**	7,282
Canteen Receipts	**11,693**	11,109
Income from other Agencies (See Note 5(b) analysis below)**	**4,339**	31,686
Miscellaneous Income (See Note 5(c) analysis below)**	**107,055**	105,602
	627,212	690,145

	2014 €'000	2013 €'000
(b) Income from Other Agencies		
National Council for Professional Development of Nursing & Midwifery	**0**	670
Department of Health (Drugs Program Unit)*	**0**	21,770
Department of Arts, Heritage & the Gaeltacht (Helicopter Emergency Services)	**53**	32
Department of Children & Youth Affairs (Young Peoples Facilities and Services – transferred to CFA in 2014)	**0**	1,074
All Ireland Cooperative Clinical Research Group (ICORG)/Health Research Board (Academic fellowship programmes, clinical research trials)	**1,289**	2,083
Department of Justice (Traveller Conflict Mediation Initiative)	**100**	35
EU Income – CAWT (Co-operation and Working Together – EU cross border initiative)	**921**	3,130
Genio Trust (Mental Health Projects)	**182**	83
Limerick City Council (formerly Limerick Regeneration Agencies – transferred to CFA in 2014)	**0**	150
Employment Response (employment initiatives for persons with a disability)	**136**	129
SOLAS Further Education and Training Authority	**281**	771
Department of Social Protection (Education & Training Boards)	**877**	437
National Treatment Purchase Fund	**0**	943
Limerick City Children's Service Committee (to enhance collaboration across services for children and families in Limerick – transferred to CFA in 2014)	**0**	216
Elton John AIDS Foundation	**158**	159
The Atlantic Philanthropies (single assessment tool for the elderly)**	**92**	4
Irish Cancer Society (colonoscopy for the Bowel Screen Programme)	**250**	0
	4,339	31,686

* Department of Health (Drugs Program Unit) is funded directly to the HSE via the Department of Health with effect from 1 January 2014.

** Miscellaneous Income in 2013 and 2014 has been re-stated to separately disclose income from The Atlantic Philanthropies which is detailed in 5(b) Income from Other Agencies. In addition, Department of Social Protection (Money Advice & Budgeting Service) is included in Other Miscellaneous Income.

Note 5 Other Income contd.

	2014 €'000	2013 €'000
(c) Miscellaneous Income		
Rebate from Pharmaceutical Manufacturers*	**41,192**	38,418
Certificates and Registration Income (Births, Deaths and Marriages)	**11,654**	11,388
Parking	**12,408**	11,732
Insurance Claim re: flood damage** (Note 29)	**14,000**	1,566
Other Miscellaneous Income (e.g. refunds, rental income, donations, training)**	**27,801**	42,498
	107,055	105,602

* In respect of 2010 IPHA Agreement and special arrangements for specific drugs and medicines.

** 2013 Other Miscellaneous Income has been re-stated to exclude Letterkenny General Hospital Insurance proceeds re: flood damage of €1.56m, which is now separately disclosed.

Note 6 Pay and Pensions

	2014 €'000	2013 €'000
Clinical HSE Staff		
Medical/Dental	**656,096**	678,183
Nursing	**1,359,186**	1,358,040
Health & Social Care Professional	**483,371**	602,273
Superannuation	**371,222**	353,913
	2,869,875	2,992,409
Clinical Agency Staff		
Medical/Dental	**109,880**	64,217
Nursing	**63,172**	57,427
Health & Social Care Professional	**28,193**	29,759
	201,245	151,403
Non Clinical HSE Staff		
Management/Administration	**515,307**	564,367
General Support Staff	**318,416**	313,856
Superannuation	**147,706**	137,628
	981,429	1,015,851
Non Clinical Agency Staff		
Management/Administration	**15,926**	10,388
General Support Staff	**13,470**	12,457
	29,396	22,845
Other Client/Patient Services HSE Staff		
Other Patient & Client Care	**585,692**	575,514
Superannuation	**80,925**	74,663
	666,617	650,177
Other Client/Patient Services Agency Staff		
Other Patient & Client Care	**46,865**	38,694
	46,865	38,694
Total Pay Expenditure	**4,795,427**	4,871,379

Note 6 Pay and Pensions contd.

	Clinical	Non Clinical	Other Client/ Patient Services	Total	Total
	2014	2014	2014	2014	2013
	€'000	€'000	€'000	€'000	€'000
Summary Analysis of Pay Costs					
Basic Pay	1,933,429	706,245	446,866	**3,086,540**	3,226,840
Allowances	70,205	12,485	18,948	**101,638**	115,546
Overtime	94,352	19,059	14,632	**128,043**	134,519
Night duty	54,254	5,667	9,693	**69,614**	67,547
Weekends	90,021	23,622	43,098	**156,741**	166,819
On-Call	48,852	1,322	434	**50,608**	48,248
Arrears	13,984	2,070	956	**17,010**	17,229
Wages and Salaries	2,305,097	770,470	534,627	**3,610,194**	3,776,748
Employer PRSI	193,556	63,253	51,065	**307,874**	315,486
Superannuation*	371,222	147,706	80,925	**599,853**	566,203
Total HSE Pay	2,869,875	981,429	666,617	**4,517,921**	4,658,437
Agency Pay	201,245	29,396	46,865	**277,506**	212,942
Total Pay	3,071,120	1,010,825	713,482	**4,795,427**	4,871,379

Total Pay Costs above relate to HSE services only. Pay costs for employees in the voluntary sector are accounted for under Non-Pay Expenditure (Revenue Grants to Outside Agencies). See Note 8 and Appendix 1.

	2014	2013
	€'000	€'000
***Analysis of Superannuation**		
On-going superannuation payments to pensioners	**508,496**	495,086
Once-off lump sums and gratuity payments	**91,357**	71,117
	599,853	566,203

Note 7 Employment

The number of employees at 31 December by Area of Operation was as follows (in whole time equivalents (WTEs)):

	2014	**2013**
Acute Services	**26,900**	26,196
Mental Health	**8,526**	8,478
Primary Care	**9,317**	9,250
Social Care	**11,776**	12,034
Health & Wellbeing	**1,233**	1,266
Ambulance Services	**1,623**	1,615
Corporate & HBS	**2,599**	2,619
Children & Family Services*	**0**	3,465
Total HSE employees**	**61,974**	64,923
Voluntary Sector – Acute Services	**22,267**	21,619
Voluntary Sector – Non Acute Services	**13,550**	13,417
Total Voluntary Sector employees	**35,817**	35,036
Total Employees per Department of Health methodology as encompassed in the Employment Control Framework (ECF)	**97,791**	**99,959**
Other directly employed non ECF personnel***	**5,239**	4,123
Total Employees	**103,030**	104,082

Employment numbers as shown above are calculated in accordance with a methodology agreed with the Department of Health for the purpose of monitoring compliance with the employment ceiling laid down by the Department as encompassed by the Employment Control Framework (ECF).

* The HSE's Child and Family Services transferred to the Child and Family Agency under the aegis of the Department of Children and Youth Affairs on 1 January 2014.

** Comparative employment numbers have been restated to reflect changes to the HSE's organisational directorate structure.

*** Grades excluded from the Employment Control Framework are: General Support Interns, Graduate Nurse/Midwife Placements, Home Helps, Other Care Interns.

Note 8 Non Pay Expenditure

	2014 €'000	**2013 €'000**
Clinical		
Drugs & Medicines (excl. demand led schemes)	**229,863**	221,592
Blood/Blood Products	**28,309**	27,629
Medical Gases	**8,573**	8,223
Medical/Surgical Supplies	**245,047**	235,376
Other Medical Equipment	**90,113**	85,369
X-Ray/Imaging	**30,078**	28,868
Laboratory	**108,199**	108,660
Professional Services (e.g. therapy costs, radiology etc.)	**87,314**	90,459
Education & Training	**53,284**	50,088
	880,780	856,264
Patient Transport and Ambulance Services		
Patient Transport	**42,613**	41,520
Vehicles Running Costs	**14,279**	15,162
	56,892	56,682

Note 8 Non Pay Expenditure contd.

	2014 €'000	2013 €'000
Primary Care and Medical Card Schemes		
Pharmaceutical Services	**1,987,042**	2,019,123
Less Prescription Levy Charges	**(117,646)**	(85,504)
Net Cost Pharmaceutical Services	**1,869,396**	1,933,619
Doctors' Fees & Allowances	**462,211**	487,760
Pension payments to Former District Medical Officers/Dependents	**3,695**	3,927
Dental Treatment Services Scheme	**69,936**	70,109
Community Ophthalmic Services Scheme	**31,723**	31,562
Cash Allowances (Blind Welfare, Domiciliary Care etc.)	**34,080**	46,550
Fostering Payments	**0**	110,522
Capitation Payments	**196,461**	217,441
	2,667,502	2,901,490
Other Client/Patient Services		
Professional Services (e.g. care assistants, childcare contracted services, guardian ad litem costs etc.)	**13,468**	58,586
Education & Training	**2,526**	6,280
	15,994	64,866
Grants to Outside Agencies		
Revenue Grants to Outside Agencies (Appendix 1)	**3,425,304**	3,458,633
Grants funded from other Government Departments/State Agencies (Appendix 1)	**150**	18,515
	3,425,454	3,477,148
Housekeeping		
Catering	**54,789**	54,116
Heat, Power & Light	**72,875**	79,791
Cleaning & Washing	**81,434**	79,975
Furniture, Crockery & Hardware	**7,848**	6,735
Bedding & Clothing	**12,247**	12,353
	229,193	232,970
Office and Administration Expenses*		
Maintenance	**60,903**	51,806
Lease Interest, Bank Interest & Charges	**2,779**	2,731
Prompt Payment Interest & Compensation	**9,336**	197
Insurance	**6,081**	4,034
Audit	**520**	547
Legal & Professional Fees	**40,474**	66,237
Bad & Doubtful Debts	**15,609**	28,250
Education & Training	**8,181**	6,915
Travel & Subsistence	**50,865**	52,054
Vehicle Costs	**829**	678
Office Expenses/Rent & Rates	**159,101**	153,112
Computers & Systems Maintenance	**48,418**	42,018
	403,096	408,579

Note 8 Non Pay Expenditure contd.

	2014 €'000	2013 €'000
Other Operating Expenses		
Maintenance Farm and Grounds	**2,253**	2,053
Security	**18,427**	18,027
Fluoridation	**2,394**	2,219
Memberships	**154**	344
Licences	**2,767**	629
Subscriptions	**712**	601
Sundry Expenses	**7,723**	12,147
Burial Expenses	**106**	123
Secondment Charges	**2,128**	2,418
Recreation (Residential Units)	**650**	1,159
Materials for Workshops	**1,653**	1,707
Home Adaptations	**0**	756
Meals on Wheels Subsidisation	**1,813**	1,838
Refunds	**330**	378
	41,110	44,399

In accordance with the provisions of the 2013 *Child and Family Agency Act*, the HSE's Children and Families programmes were disaggregated and transferred to the Child and Family Agency (CFA) on 1 January 2014. The transfer of staff and other operational resources contributed to the reduction in income, pay and non-pay expenditure in 2014, when compared to prior year. See also Note 1(b) and Note 26.

* Office and Administration Expenses in relation to the Hepatitis C Insurance Scheme and the *Health (Repayment Scheme) Act, 2006* are disclosed under the relevant HSE expenditure heading in 2014. Similar expenditure for 2013 was itemised separately and has been reanalysed to include this expenditure under the appropriate headings, such as Legal and Professional Fees, Computers and Systems Maintenance, and Office Expenses/Rent & Rates.

Note 9 Tangible Fixed Assets – Land and Buildings

	Land* €'000	Buildings** €'000	Work in Progress €'000	Total 2014 €'000
Cost/Valuation				
At 1 January 2014	1,721,684	3,779,324	112,229	5,613,237
Additions	2,003	13,602	137,944	153,549
Transfers from Work in Progress	0	18,570	(18,570)	0
Disposals (CFA)***	(16,276)	(78,996)	0	(95,272)
Disposals (Non-CFA)	(9,687)	(2,402)	(1,136)	(13,225)
At 31 December 2014	1,697,724	3,730,098	230,467	5,658,289
Depreciation				
Accumulated Depreciation at 1 January 2014	0	952,119	0	952,119
Charge for the Year	0	92,445	0	92,445
Disposals (CFA)***	0	(19,372)	0	(19,372)
Disposals (Non-CFA)	0	(729)	0	(729)
At 31 December 2014	0	1,024,463	0	1,024,463
Net Book Values				
At 1 January 2014	1,721,684	2,827,205	112,229	4,661,118
At 31 December 2014	1,697,724	2,705,635	230,467	4,633,826

Note 9 Tangible Fixed Assets contd.

* Land with a value of €2.121bn was transferred to the HSE on establishment at the carrying value on 1 January 2005. This land was valued in 2002 by the then Health Boards in accordance with the Department of Health's revaluation policy and based on valuation rates issued by the Department of Health. Recent disposals of land surplus to HSE requirements, at open market value, have realised losses on disposal indicating that the Department of Health's 2002 valuation rates may exceed the current use or open market value of such land.

** The net book value of fixed assets above includes €29.8m (2013: €31.6m) in respect of buildings held under finance leases; the depreciation charged for the year above includes €1.8m (2013: €1.8m) on those buildings.

*** Land and Buildings were transferred to the Child and Family Agency on 1 January 2014 in accordance with the asset schedule contained within the Deed of Agreement entered into between the Minister for Health and the Minister for Children and Youth Affairs, dated 23 December 2013. Please refer to Note 26 for further detail.

Note 10 Tangible Fixed Assets – Other than Land and Buildings

	Motor Vehicles €'000	Equipment €'000	Work in Progress €'000	Total 2014 €'000
Cost/Valuation				
At 1 January 2014	92,075	1,261,651	6,226	1,359,952
Additions	5,559	48,609	11,992	66,160
Transfers from Work in Progress	524	16,272	(16,796)	0
Disposals (CFA)*	(1,746)	0	0	(1,746)
Disposals (Non-CFA)	(9,146)	(14,933)	(483)	(24,562)
At 31 December 2014	87,266	1,311,599	939	1,399,804
Depreciation				
Accumulated Depreciation at 1 January 2014	79,435	1,031,397	0	1,110,832
Charge for the Year	5,958	79,455	0	85,413
Disposals (CFA)*	(1,495)	0	0	(1,495)
Disposals (Non-CFA)	(9,061)	(13,731)	0	(22,792)
At 31 December 2014	74,837	1,097,121	0	1,171,958
Net Book Values				
At 1 January 2014	12,640	230,254	6,226	249,120
At 31 December 2014	12,429	214,478	939	227,846

* Motor vehicles transferred were subject to a formal identification process and transferred to the Child and Family Agency on 1 January 2014 upon agreement between the HSE and the Child and Family Agency. Please refer to Note 26 for further detail.

Note 11 Stocks

	2014 €'000	2013 €'000
Medical, Dental and Surgical Supplies	**31,745**	31,719
Laboratory Supplies	**6,166**	6,449
Pharmacy Supplies	**18,751**	18,179
High Tech Pharmacy Stocks	**44,814**	33,780
Pharmacy Dispensing Stocks	**968**	1,066
Blood and Blood Products	**1,120**	1,250
Vaccine Stocks	**23,319**	19,638
Household Services	**7,684**	8,074
Stationery and Office Supplies	**2,021**	2,016
Sundries	**545**	681
	137,133	122,852

Note 12 Debtors

	2014 €'000	2013 €'000
Patient Debtors – Private Facilities in Public Hospitals*	**158,068**	110,783
Patient Debtors – Public Inpatient Charges*	**5,587**	13,840
Patient Debtors – Long Stay Charges	**8,998**	8,200
Prepayments and Accrued Income	**19,784**	18,598
Other Debtors:		
Pharmaceutical Manufacturers	**18,428**	15,294
Payroll Technical Adjustment	**27,228**	30,350
Pension Levy Deductions from Staff/Service Providers	**9,981**	10,549
Statutory Redundancy Claim	**3,720**	6,021
Local Authorities	**1,007**	2,292
National Treatment Purchase Fund/Special Delivery Unit	**–**	94
Payroll Advances & Overpayments**	**30,247**	4,275
Voluntary Hospitals re: National Medical Device Service Contracts	**16,313**	11,145
Sundry Debtors	**39,960**	31,353
	339,321	262,794

* Patient Debtors – Private Facilities in Public Hospitals has increased significantly year on year and Patient Debtors – Public Inpatient Charges has fallen. A revised charging structure was introduced for Inpatient Services provided under Section 55 of the Health Act 1970 (as amended by *Health (Amendment) Act 2013*). These include charging for private patients accommodated in a non-designated bed, which could not be billed for previously, and a reduction in statutory charges for private patients for the Public Inpatient Charge.

** Payroll payments to fortnightly paid staff due on 1st January 2015 were paid on 31st December 2014 as current banking arrangements are unable to credit accounts on Bank Holidays. The Department of Public Expenditure and Reform advised that these payments were to be treated as an advance in the 2014 accounts.

Note 13 Paymaster General and Exchequer Balance

	2014 €'000	2013 €'000
Paymaster General Bank Account	**97,780**	94,946
Net Liability to the Exchequer	**(5,764)**	(17,225)
Paymaster General and Exchequer Balance	**92,016**	77,721

Note 14 Creditors (amounts falling due within one year)

	2014 €'000	2013 €'000
Finance Leases	**2,083**	2,014
Trade Creditors – Revenue	**149,726**	133,540
Trade Creditors – Capital	**4,140**	14,513
Accruals Non Pay – Revenue	**657,346**	653,765
Accruals Non Pay – Capital	**5,340**	4,199
Accruals – Grants to Voluntary Hospitals & Outside Agencies	**270,790**	286,072
Accruals Pay	**374,173**	348,980
Taxes and Social Welfare	**125,654**	139,126
Local Property Tax (LPT)	**339**	147
Department of Public Expenditure & Reform – Single Public Service Pension Scheme	**771**	288
Lottery Grants Payable*	**1,513**	1,708
Department of Health (Payroll Advances)**	**36,733**	0
Sundry Creditors	**16,212**	15,668
	1,644,820	1,600,020

* The HSE administers the disbursement of National Lottery grants for local programmes under the National Lottery's Health and Welfare Funded Schemes. The balance represents funding approved but not yet disbursed to grant recipients at year end.

** Arising from the disestablishment of the Vote from 1st January 2015 the Department of Health funded the payroll advance paid on the 31st December 2014. The net amount received from the Department of Health is accounted for as an advance of 2015 grant funding from the Department of Health.

Note 15 Creditors (amounts falling due after more than one year)

	2014 €'000	2013 €'000
Finance lease obligations – buildings		
After one but within five years	**5,984**	5,227
After five years	**28,968**	30,808
Total Finance Lease obligations	**34,952**	36,035
Liability to the Exchequer in respect of Exchequer Extra Receipts*	**6,382**	13,213
Total Creditors (amounts falling due after more than one year)	**41,334**	49,248

* **Liability to the Exchequer in respect of Exchequer Extra Receipts**
Proceeds of disposal of fixed assets are considered as Exchequer Extra Receipts (EERs) under the Department of Public Expenditure and Reform's Public Financial Procedures. The HSE is not entitled to retain these sales proceeds for its own use and must surrender them to the Exchequer except in the case of proceeds used for Mental Health and other projects as sanctioned.

	2014 €'000	2013 €'000
Gross Proceeds of all disposals in year	**3,830**	2,554
Less: Net expenses incurred on disposals	**(207)**	(89)
Net proceeds of disposal	**3,623**	2,465
Less Application of Proceeds	**(2,871)**	(2,941)
At 1 January	**244**	720
Balance at 31 December	**996**	244
Liability to the Exchequer Sale Proceeds – Other Sales/Capital Grant Refunds	**1,665**	1,665
Liability to the Exchequer – Statutory Rebate Claim	**3,721**	11,304
Total Liability to the Exchequer	**6,382**	13,213

Note 16 Deferred Income

	2014 €'000	2013 €'000
Deferred income comprises the following:		
Donations and bequests*	**9,280**	5,126
Income from sales of land which have not been concluded	**739**	807
Grant Funding from the State and other bodies	**7,923**	2,793
Funding from specific capital projects	**1,782**	1,714
Letterkenny General Hospital – Note 29	**6,000**	–
	25,724	10,440

* Unspent income arising from donations and bequests where the purposes to which money may be applied has been specified but the related expenditure has not been incurred. Donations and bequests for 2013 have been re-stated to provide further analysis consistent with 2014.

Note 17 Capital and Reserves

	2014 €'000	2013 €'000
(a) Capitalisation Account		
At 1 January	**4,910,238**	4,919,766
Additions to fixed assets in the year	**219,709**	181,073
Less: Net book value of fixed assets disposed in year – CFA	**(76,151)**	0
Less: Net book value of fixed assets disposed in year – Non CFA	**(14,266)**	(11,172)
Less: Depreciation charge in year	**(177,858)**	(179,429)
Balance at 31 December	**4,861,672**	4,910,238
(b) Capital Reserves		
At 1 January	**(150,779)**	(144,260)
Opening Reserve – bequest transferred to Child and Family Agency – Rathmines Women's Refuge Bequest	**(63)**	0
Net Capital Surplus/(Deficit) for the year	**11,817**	(6,519)
Balance at 31 December	**(139,025)**	(150,779)
(c) Revenue Reserves		
At 1 January	**(996,516)**	(990,626)
Revenue Reserves Aontacht Phobail Teoranta (see Note 27)	**0**	70
Revenue Reserves from the Drug Treatment Centre Board	**0**	1,188
At 1 January Opening Reserves restated	**(996,516)**	(989,368)
Net Operating Surplus/(Deficit) for the year*	**45,515**	(7,148)
Balance at 31 December	**(951,001)**	(996,516)

* The net operating surplus for 2014 is shown after the transfer of net current liabilities of HSE Children and Family Services to the Child and Family Agency on 1 January 2014. See Note 26 for further detail.

Note 17 Capital and Reserves contd.

	2014 €'000	2013 €'000
(d) Reconciliation of Movement on Reserves		
Closing Creditors at 31 December	**(1,686,154)**	(1,649,268)
Less Opening Creditors at 1 January	**(1,649,268)**	(1,574,596)
	(36,886)	(74,672)
Less Increase in Current Assets	**109,439**	62,948
(Increase) in Deferred Income	**(15,284)**	(685)
	57,269	(12,409)
Net Operating Surplus/(Deficit) after Transfer of Operations	**45,515**	(7,148)
Revenue Reserves from subsumed agencies	**0**	1,258
Net Capital Surplus/(Deficit)	**11,817**	(6,519)
Capital Reserves	**(63)**	0
	57,269	(12,409)

Note 18 Capital Income and Expenditure

	2014 €'000	2013 €'000
(a) Additions to Fixed Assets		
Additions to Fixed Assets (Note 9) Land and Buildings	**153,549**	93,765
Additions to Fixed Assets (Note 10) Other than Land and Buildings	**66,160**	87,308
	219,709	181,073
Funded from Capital Vote of HSE	**206,424**	151,134
Funded from Revenue Vote of HSE	**13,285**	29,939
	219,709	181,073
(b) Analysis of expenditure charged to Capital Income and Expenditure Account		
Expenditure on HSE's own assets (Capitalised)	**206,424**	151,133
Expenditure on HSE projects not resulting in Fixed Asset additions*	**97,172**	122,219
Total expenditure on HSE Projects charged to capital**	**303,596**	273,352
Capital grants to outside agencies (Appendix 2)*	**53,292**	68,875
Account	**356,888**	342,227

* Total capital expenditure not capitalised amounts to €150.5m (2013; €191.1m).

** Capital funded assets and Revenue funded assets are capitalised if the cost exceeds certain value thresholds: €2,000 for computer equipment and €7,000 for all other asset classes.

Note 18 Capital Income and Expenditure contd.

	2014 €'000	2013 €'000
(c) Analysis of Capital Income from Other Sources		
Income from Government Depts. and Other Sources in respect of capital projects:		
Sustainable Energy Ireland (SEI) – energy saving in acute hospitals	**268**	134
St. Coleman's Care Centre Ltd. – Care Centre Achill	**0**	72
Insurance Proceeds – Letterkenny General Hospital flood damage	**0**	2,434
Other Insurance Proceeds	**394**	102
Irish Hospice Foundation – Donation for Design and Dignity Projects	**0**	250
Children's Leukaemia Association Donation	**600**	0
Friends of Ennistymon Hospital – donation towards en-suite units	**397**	0
Friends of St. Ita's Hospital – Rehab Unit Project	**160**	0
Cystic Fibrosis Galway Donation to UCHG	**250**	0
St. Vincent's Hospital contribution to the HSE	**125**	0
Other Miscellaneous Income	**108**	94
Total Capital Income from Other Sources	**2,302**	3,086

Note 19 Net Cash Inflow/(Outflow) from Operating Activities

	2014 €'000	2013 €'000
Surplus/(Deficit) for the current year	**45,515**	(7,148)
Capital Reserves – transferred to the Child and Family Agency	**(63)**	0
Capital element of lease payments charged to revenue	**1,014**	945
Less: Interest received	**(31)**	(257)
Purchase of equipment charged to Revenue Income and Expenditure	**13,285**	29,939
All interest charged to Revenue Income and Expenditure	**1,108**	1,178
(Increase) in Stock	**(14,281)**	(4,587)
(Increase) in Debtors	**(76,527)**	(42,790)
Increase in Creditors	**44,800**	76,231
Revenue Reserves from Subsumed Agencies	**0**	1,258
(Decrease) in Creditors falling due in more than one year	**(8,667)**	(1,013)
Increase in Deferred Income	**15,284**	685
(Decrease in Long Term Loan) – Note 27	**0**	(70)
Net Cash Inflow from Operating Activities	**21,437**	54,371

Note 20 Reconciliation of Net Cash Flow to Movement in Net Funds

	2014 €'000	2013 €'000
Change in net funds resulting from cash flows		
Net Cash and PMG Balance at 1 January	**126,764**	111,193
Movement in net funds for the year from cash flow statement	**18,631**	15,571
Net Cash and PMG Balance at 31 December*	**145,395**	126,764
*Analysis of Net Cash and PMG Balance		
Paymaster General Bank Account (Note 13)	**92,016**	77,721
Cash at Bank or in Hand	**53,379**	49,043
	145,395	126,764

Note 21 Vote Accounting

(a) Exchequer disbursements during the year are based on annual amounts voted by Dáil Éireann. Any part of the amount voted which has not been expended by 31 December in accordance with Government accounting rules must be surrendered to the Exchequer.

It is a statutory requirement of the Accounting Officer of the HSE that no overspending of the Vote takes place. The surplus to be surrendered in 2014 amounts to €27m, which represents 0.22% of the total Vote of the HSE.

The HSE is required under the Health Act 2004 to produce two sets of financial statements, the Annual Financial Statements and the Appropriation Account. The Annual Financial Statements are prepared using the accruals basis of accounting (with specific exceptions as outlined under Accounting Policies) while the Appropriation Account is prepared on a cash basis.

While the Appropriation Account shows a surplus to be surrendered based on cash accounting principles, the Annual Financial Statements prepared under the accruals basis of accounting show a different surplus for the year. A summary of the Appropriation Account is shown below and a detailed reconciliation between the two accounts is available on the HSE website www.hse.ie.

(b) Summary Appropriation Account, prepared under Government Accounting rules:

	Estimate 2014 €'000	Outturn 2014 €'000	Outturn 2013 €'000
HSE Vote 39 Gross Expenditure	**13,587,809**	**13,542,476**	13,872,830
Less: Appropriations-in-Aid	**(1,355,313)**	**(1,337,185)**	(1,372,433)
Net Vote Expenditure	**12,232,496**	**12,205,291**	12,500,397

	2014 €'000	2013 €'000
Surplus to be Surrendered	**26,764**	31,074
Analysis of Surrender:		
Surplus Appropriations-in-Aid	**0**	10,281
Surplus Gross Vote	**26,764**	20,793
Net surplus to be surrendered	**26,764**	31,074

Note 21 Vote Accounting contd.

(c) Extract from HSE Appropriation Account (unaudited) for the year ended 31 December:

	2014 €'000	2013 €'000
Balance Sheet as at 31 December		
Capital Assets	**4,861,672**	4,910,238
Financial Assets	**3**	3
	4,861,675	4,910,241
Current Assets		
Bank and cash and PMG	**151,159**	143,989
Stocks	**137,133**	122,852
Debtors and Prepayments	**333,924**	217,526
Other debit balances	**5,397**	45,268
Total Current Assets	**627,613**	529,635
Less Current Liabilities		
Creditors	**153,866**	148,053
Accrued expenses	**1,381,496**	1,329,183
Deferred Income	**25,724**	10,440
Other credit balances	**150,792**	172,032
Net Liability to the Exchequer	**5,764**	17,225
Total Current Liabilities	**1,717,642**	1,676,933
Net Current Liabilities	**(1,090,029)**	(1,147,298)
Net Assets	**3,771,646**	3,762,943
Represented by:		
State Funding Account	**3,771,646**	3,762,943

(d) Extract from HSE Appropriation Account (unaudited) for the year ended 31 December:

	2014 €'000	2013 €'000
Net Liability to the Exchequer at 31 December		
Surplus to be surrendered	**26,764**	31,074
Exchequer grant undrawn	**(21,000)**	(13,849)
Net liability to the Exchequer	**5,764**	17,225
Represented by:		
Debtors		
Bank and cash and PMG	**151,159**	143,989
Other debit balances	**5,397**	45,268
	156,556	189,257

Note 21 Vote Accounting contd.

	2014 €'000	2013 €'000
Creditors		
Due to State	**(126,764)**	(122,126)
Special Income & Expenditure balances	**(6,000)**	(32,393)
Payroll deductions and other credit balances	**(18,028)**	(17,513)
	(150,792)	(172,032)
Net liability to the Exchequer	**5,764**	17,225

Note 22 Pensions

Eligible staff employed in the HSE are members of a variety of defined benefit superannuation schemes.

Superannuation entitlements (i.e. pensions) of retired staff are paid out of current income and are charged to the income and expenditure account in the year in which they become payable. In accordance with a directive from the Minister for Health, no provision is made in the financial statements in respect of future pension benefits and no charge is made to the Income & Expenditure Account in respect of this. Superannuation contributions from employees who are members of these schemes are credited to the income and expenditure account when received. No formal actuarial valuations of the HSE's pension liabilities are carried out. The Pension charge to the Revenue Income & Expenditure Account for 2014 was €599m (2013: €566m), which included payments in respect of once-off lump sums and gratuity payments on retirement of €91m (2013: €71m).

Note 23 Capital Commitments

Future tangible fixed assets purchase commitments:

	2014 €'000	2013 €'000
Within one year	**297,011**	306,472
After one but within five years	**856,620**	625,990
After five years	**0**	0
	1,153,631	932,462
Contracted for but not provided in the financial statements	**357,161**	277,694
Included in the Capital Plan but not contracted for	**796,470**	654,768
	1,153,631	932,462

The HSE has a multi-annual capital investment plan which prioritises expenditure on capital projects in line with goals in the Corporate Plan and the Annual Service Plan. The commitments identified above are in respect of the total cost of projects for which specific funding budgets have been approved at year end. These commitments may involve costs in years after 2014 for which budgets have yet to be approved.

Note 24 Property

	2014 Number of Properties	2013 Number of Properties
The HSE estate comprises 2,449 properties. Title to the properties can be analysed as follows:		
Freehold	**1,559**	1,640
Leasehold	**890**	954
Total Properties	**2,449**	2,594
Primary utilisation of the properties can be analysed as follows:		
Delivery of health and personal social services	**2,371**	2,512
Health Business Services & Support (including medical card processing etc.)	**78**	82
Total Properties	**2,449**	2,594

The reduction in the number of properties is as a result of the removal of properties from the estate during the year through property disposals, the transfer of 67 owned and 48 leased properties to the Child and Family Agency, the Lease Cost Reduction Initiative and the Mental Health Disposals Initiative.

Note 25 Operating Leases

	2014 €'000	2013 €'000
Operating lease rentals (charged to the Revenue Income and Expenditure Account)		
Land and buildings	**39,456**	39,613
Motor Vehicles	**79**	73
Equipment	**433**	621
	39,968	40,307

The HSE has the following annual lease commitments under operating leases which expire:

	Land and Buildings 2014 €'000	Other 2014 €'000	Total 2014 €'000	Total 2013 €'000
Within one year	**7,374**	**351**	**7,725**	6,873
In the second to fifth years inclusive	**6,853**	**66**	**6,919**	8,610
In over five years	**27,990**	**0**	**27,990**	25,556
	42,217	**417**	**42,634**	41,039

Note 26 The Child and Family Agency (CFA)

The *Child and Family Agency Act, 2013* led to the creation of a single dedicated State agency focused on providing services committed to children's wellbeing and protection. The Child and Family Agency (CFA), was established and began operation on 1 January 2014.

As a result, the HSE's Child and Family Services were disaggregated from the organisation and transferred, without the payment of consideration, to CFA. This formal process of separation commenced in the HSE in 2013, and focused on the transfer of services, assets and liabilities as at 31 December 2013 from the HSE to CFA on 1 January 2014.

Part 11 of the *Child and Family Agency Act 2013*, sets out the legislative criteria adopted by both organisations with respect to the transfer and maintenance of certain functions, employees, assets, and liabilities.

In addition, the Deed of Agreement entered into between the Minster for Health and the Minister for Children and Youth Affairs, dated 23 December 2013, included a detailed schedule of the property assets to be transferred to CFA on 1 January 2014.

In accordance with the provisions of the *Child and Family Agency Act 2013*, the HSE's Child and Family Services were transferred to the Child and Family Agency (CFA) on 1 January 2014. The transfer of staff and other operational resources contributed to the reduction in income, pay and non-pay expenditure in 2014, when compared to prior year. The Net Current Liabilities on Transfer of Operations on the face of the Revenue Income and Expenditure Account in 2014 represents the transfer of net current liabilities relating to HSE Child and Family Services at 1 January 2014 to the agency. Please refer to Note 1(b) for further information.

The transfer of services gave rise to balance sheet transfers without consideration, as follows:

	2014 €'000	Total 2014 €'000
Tangible Assets		
Buildings	**59,624**	
Land	**16,276**	
Motor Vehicles	**251**	76,151
Current Assets		
Debtors and Prepayments	**4,984**	
Cash at Bank or in Hand	**109**	5,093
Current Liabilities		
Trade Creditors	**(6,421)**	
Accruals	**(35,516)**	(41,937)
Creditors (amounts falling due after more than one year)		
Deferred Income	**(188)**	(188)
Net Assets and Liabilities transferred		39,119

	2014 €'000
Represented by:	
Capital and Reserves – Capitalisation account (see Note 17(a))	**76,151**
Capital and Reserves – Capital Reserves (see Note 17(b))	**63**
Capital and Reserves – Revenue Reserves (see Note 17(c))	**(37,095)**
Total Capital and Reserves	**39,119**

Note 26 The Child and Family Agency (CFA) contd.

The Revenue Reserves entry noted above relates to the transfer of net current liabilities to CFA in the Revenue Income and Expenditure Account in 2014.

In addition to the statutory separation of services, the HSE provides general administrative assistance to CFA which are subject to legal agreement and transacted on an arms-length basis. For example, the recharge of rental and related utility costs for the proportion of HSE properties jointly occupied by CFA services.

Note 27 Subsidiary Undertakings

Aontacht Phobail Teoranta was partially subsumed into the HSE at 31 December 2010 and the transfer of the remaining balances is expected be completed in 2015.

The HSE has no other subsidiary undertakings. The Department of the Environment and Local Government, through the relevant local authorities, previously provided Aontacht Phobail Teoranta with subsidised loans on the purchase price of properties secured by mortgages and the value of the loan at the date it was subsumed was €1,062,042. The relevant councils on behalf of the Department of the Environment agreed the redemption value on the mortgages on 31 December 2012 at €70,062, a reduction of €991,980 as under the terms of the agreement loans are non repayable provided they are used to accommodate homeless people. No mortgages were redeemed by the HSE from the various local authorities during the year. There are no mortgages outstanding at 31 December 2014.

Note 28 Taxation

The HSE has been granted an exemption in accordance with the provisions of Section 207 (as applied to companies by Section 76), Section 609 (Capital Gains Tax) and Section 266 (Deposit Interest Retention Tax) of the *Taxes Consolidation Act, 1997*. This exemption, which applies to Income Tax/Corporation Tax, Capital Gains Tax and Deposit Interest Retention Tax, extends to the income and property of the HSE. The exemption is subject to review by the Revenue Commissioners and, if conditions as specified are not met, the exemption may be withdrawn from the date originally granted.

A comprehensive self-review of tax compliance which was initiated in 2013 was completed in 2014, with external specialist tax assistance. The self-review was conducted across all tax heads for which the HSE needs to account and focussed in particular on those risk areas identified by a formal tax risk assessment completed in 2012. Details of the underpayment of tax identified in the course of the self-review were set out in an unprompted voluntary disclosure submitted to the Revenue Commissioners (including interest and penalties) in December 2014 and full provision has been made in the 2014 financial statements. The Revenue Commissioners are auditing the unprompted voluntary disclosure submitted in accordance with their procedures. An in-house specialist tax function for the HSE was established at the end of 2013. The HSE remains committed to exemplary compliance with taxation laws.

Note 29 Insurance

Prior to 1 January 2001, HSE insurance premium was subject to retro-rating. Under the retro-rating basis, the final premium is not determined until the end of the coverage period and is based on the HSE's loss experience for that same period. The retro-rated adjustment payable by the HSE is subject to maximum and minimum limits. At 31 December 2014 it was not possible to accurately quantify the liability, if any, which may arise as a result of future retro-rating. The maximum liabilities for retro-rated claims still outstanding, based on agreed levels of each insurable risk is €5,000 and €980,500 for employers liability and public liability respectively. All insurance premiums from 1 January 2001 have been paid on a flat basis only and no retro-rating applies to cover from this date forward. Until the transfer to State indemnity on 1 January 2010, the HSE was insured against employer's liability and public liability risks up to an indemnity limit, under both retro-rated and flat-rated bases.

Insurance – Flood Damage at Letterkenny General Hospital

Letterkenny General Hospital suffered catastrophic damage following flooding on 26 July 2013. The flood affected the Emergency Department, Coronary Care Unit, Radiology Department, Haematology Oncology Ward, Laboratory, main Out-Patient Department, Cardiac Investigations, kitchen facilities, medical records and office accommodation. Letterkenny General Hospital continued to operate services, and has worked closely with insurers to restore services, repair the damage caused by the flood and take measures to prevent a recurrence. Full buildings and contents and business interruption insurance cover was in place to cover the claim of €34.05m and there were no uninsured losses as a result of the flood damage.

Note 29 Insurance contd.

There is however a shortfall between the insurance settlement and the estimated cost of €40.6m to rebuild the hospital. This is because insurers' liability is limited to reinstatement of the infrastructure. The rebuild programme includes enhancements over and above reinstatement, such as the development of an interventional radiology suite and other developments which are being incorporated at this time to avoid disruption to service in future years. Insurance claim proceeds of €20m were received in 2014 (2013: €4m). These proceeds are to be allocated against expenditure in both revenue and capital to fund the rebuild programme. Of the €20m insurance claim proceeds received in 2014, €14m was recognised in respect of revenue expenditure in 2014. The balance of insurance proceeds of €6m is held as deferred income on the balance sheet for distribution against expenditure in future accounting periods when it is incurred. Further claim proceeds will be receivable in future accounting periods and, in accordance with HSE accounting policies, will be recognised and matched against expenditure or transferred to deferred income in the year they are received.

State Claims Agency

Since 1 July 2009 the HSE is funded for claims processed by the State Claims Agency under the terms of the Clinical Indemnity Scheme. From 1 January 2010 the National Treasury Management Agency (Delegation of Functions) Order 2009 extended the State indemnity to personal injury and third party property damage claims against the HSE. Awards paid to claimants under the terms of the scheme are accounted for on a pay-as-you-go basis. At 31 December 2014, the estimated liability incurred to that date under the Clinical Indemnity Scheme and State indemnity was €1,277m (2013: €1,084m). Of this €1,277m, approximately €1,139m relates to active claims in respect of clinical care, with the balance of the estimated liability relating to non-clinical care claims. In 2014, the charge to the Revenue Income and Expenditure Account was €117.3m (2013: €135.9m). Based on actuarial estimates, the charge to the Income and Expenditure Account is expected to increase significantly in future years. In accordance with the directions of the Minister for Health, no provision has been made for this liability in the financial statements.

Note 30 Contingent Liabilities

The HSE is involved in a number of claims involving legal proceedings which may generate liabilities, depending on the outcome of the litigation. The HSE has insurance cover for professional indemnity, fire and specific all risk claims. In most cases such insurance would be sufficient to cover all costs, but this cannot be certain due to indemnity limits and certain policy conditions. The financial effects of any uninsured contingencies have not been provided in the financial statements.

The HSE is currently involved in a legal dispute with a number of drugs importing companies with respect to the implementation of cost savings and other initiatives outlined as part of a framework agreement between the Irish Pharmaceutical Healthcare Association (IPHA), the Department of Health, and the HSE, which came into effect on 1 November 2012. The outcome from the dispute process based on the current stage of legal proceedings remains uncertain and therefore difficult to quantify any potential liability which may arise. Consequently, no provision for any potential future liability has been made in the financial statements.

Note 31 The Health (Repayment Scheme) Act, 2006

The *Health (Repayment Scheme) Act 2006* provides the legislative basis for the repayment of what has been referred to as 'long stay charges' which were incorrectly levied on persons with full medical card eligibility prior to 14 July 2005. The Scheme allows for the repayment of charges to the following people:

- Living people who were wrongly charged at any time since 1976
- The estates of people who were wrongly charged and died on or after 9 December 1998

A special account is set up which is funded by monies provided by the Oireachtas and from which repayments are made. An amount of €8m was set aside in 2014 for this purpose. The majority of this funding refers to a provision for payments that will arise as a result of appeals. The best estimate of the total cost of repayments, at the inception of the Scheme based on the terms as set out in the Act was up to €1bn. Repayments were expected to be made to approximately 20,000 living patients and to the estates of approximately 40,000 to 50,000 deceased former patients.

The Scheme closed to new applicants on the 31 December 2007 and nearly 14,000 claims were received in respect of living patients and nearly 27,000 claims in respect of estates. Up to 31 December 2014, 20,045 claims were paid. As at December 2014, there were a total of 211 outstanding claims being processed to offer stage under the scheme. These claims refer to the 499 applications made under the scheme which were the subject of an appeal to the High Court. The appeal to the High Court was subsequently withdrawn by the State and as a result, these claims are now being processed. It is expected that all claims will be processed by the end of Quarter 2 2015. €4m has been provided in the HSE's 2015 budget to fund repayments and outstanding claims and associated administrative costs.

The cumulative total expenditure of the scheme (including administrative costs) to 31 December 2014 was €483.022m.

Note 31 The Health (Repayment Scheme) Act, 2006 contd.

In 2014, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Repayments Scheme:

	2014 €'000	2013 €'000
Pay	**146**	158
Non Pay		
Repayments to Patients	**1,124**	196
Payments to Third Party Scheme Administrator	**0**	0
	1,124	196
Legal and Professional Fees	**17**	29
Office Expenses*	**48**	5
Total Non Pay	**1,189**	230
Total	**1,335**	388

* Office and Administration Expenses in relation to the *Health (Repayment Scheme) Act 2006* are included in HSE expenditure in 2014. Similar expenditure for 2013 was not included and has been re-stated to include this expenditure under the appropriate headings which include Legal and Professional Fees and Office Expenses.

Note 32 Hepatitis C Compensation Tribunal (Amendment) Act, 2006

The *Hepatitis C Compensation Tribunal (Amendment) Act, 2006* established a statutory scheme to address insurance difficulties experienced by persons infected with Hepatitis C and HIV through the administration within the State of blood and blood products. This scheme addresses the problems faced by these persons due to their inability to purchase mortgage protection and life assurance policies as a result of contaminated blood products being administered to them. The scheme will cover the insurance risk for the 1,700 or more people entitled to avail of assurance products, regardless of any other medical conditions these people may have, once they pay the standard premium that an uninfected person of the same age and gender would pay. The life assurance element of the scheme was launched by the HSE in September 2007. A further element, providing for travel insurance cover, was introduced in March 2009.

The overall cost over the lifetime of the scheme was originally estimated at €90m. The cumulative expenditure on the insurance scheme to 31 December 2014 was €7.2m.

In 2014, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Insurance Scheme:

	2014 €'000	2013 €'000
Pay	**79**	83
Non Pay		
Payments of premium loadings	**442**	522
Payments of benefits underwritten by HSE	**440**	676
	882	1,198
Office Expenses*	**5**	11
Total Non Pay	**887**	1,209
Total	**966**	1,292

* Office Expenses in relation to the Hepatitis C Insurance Scheme are included in HSE expenditure in 2014. Similar expenditure for 2013 was not included and has been re-stated to include this expenditure under the appropriate headings which include Computers and Systems Maintenance and Office Expenses/Rent & Rates.

Note 33 Long Term Residential Care (incorporating Nursing Homes Support Scheme/Fair Deal)

The Nursing Homes Support Scheme (Fair Deal) commenced in 2009 and phases out the former Nursing Home Subvention Scheme and the 'contract beds' system for older persons. Under the Scheme, people who need long term residential care services have their income and assets assessed, and then contribute up to 80% of assessable income and up to 7.5% of the value of the assets they own towards the cost of their care. The HSE pays the balance, if any, of the costs of their care in both public and registered private nursing homes covered under the scheme.

Costs of Long term Residential Care (Nursing Homes Support Scheme/Fair Deal):

	2014 €'000	**2013 €'000**
Payments to Private Nursing Homes	**529,496**	512,765
Private Nursing Homes Contract Beds and Subvention Payments	**56,015**	78,621
Nursing Homes Support Scheme (Fair Deal) – Private Nursing Homes only	**585,511**	591,386
Cost of Public Nursing Homes*	**320,218**	329,312
Revenue Grants to Outside Agencies (Appendix 1)	**24,589**	25,625
Nursing Home Fixed and other unit costs	**23,775**	20,001
Total Long Term Residential Care	**954,093**	966,324

* Public nursing homes costs are included under the relevant expenditure headings in the Revenue Income and Expenditure Account.

Patient contributions

Fair Deal patient contributions for those patients in public homes amounted to €54.079m (2013: €53.038m) and are included in the Revenue Income and Expenditure Account under Patient Income.

Fair Deal patient contributions for those patients in voluntary homes (Section 38 organisations) amounted to €6.431m (2013: €6.097m) and are retained by those homes and do not constitute income for the HSE.

Contract beds, Subvention beds

In 2014, payments of €56.0m (2013: €78.6m) were made in relation to contract beds and nursing home subvention. These schemes are being phased out having had no new entrants since the Nursing Homes Support Scheme began in 2009.

Expenditure within public facilities

Within the public homes in 2014 there was an additional €23.8m (2013: €20.0m) of costs relating to long term care. These costs related to fixed unit costs and other costs incurred which were in excess of the reimbursed 'money follows the patient' rate paid under the Nursing Homes Support Scheme.

Note 34 Ancillary State Support

Ancillary State Support is an optional extra feature of the Nursing Homes Support Scheme for people who own property or assets in the State. Instead of paying the full weekly contribution for care from their own means, a client can choose to apply for a Nursing Home Loan, to cover the portion of their contribution, which is based on property or land-based assets within the State. The HSE then pays that portion of the cost of care on top of the State Support payment. The loan is paid back to the State after the sale of the asset or on the death of the client, whichever occurs first. Repayment of the loan is made to the Revenue Commissioners. In certain cases, repayment of the loan can be deferred. This part of the scheme is designed to protect people from having to sell their home during their lifetime to pay for nursing home care.

The total gross amount of Ancillary State Support advised to Revenue as at 31 December 2014 for recoupment from the commencement of the Nursing Homes Support Scheme was €34.839 million representing 2,143 client loans and the Revenue Commissioners have confirmed to the HSE that they had received €21.378 million of loan repayments representing 1,466 client loans.

Note 35 Post Balance Sheet Events

No circumstances have arisen or events occurred, between the balance sheet date and the date of approval of the financial statements by the Directorate, which would require adjustment or disclosure in the financial statements.

Note 36 Related Party Transactions

In the normal course of business the Health Service Executive may approve grants and may also enter into other contractual arrangements with undertakings in which Health Service Directorate members are employed or otherwise interested. The Health Service Executive adopts procedures in accordance with the Department of Finance's Code of Practice for the Governance of State Bodies, the Ethics in Public Office Act 1995 and the Standards in Public Office Act 2001, in relation to the disclosure of interests of Health Service Directorate members. These procedures have been adhered to by the Health Service Directorate members and the HSE during the year. During 2014 no Directorate members held a direct interest within any related parties. However, indirect interests were noted by two Directorate members via their spousal relationship in the Medical Council of Ireland and Digital Eye Limited. The HSE Service Directorate members concerned did not participate in, receive any documentation, or attend any meetings or discussions in relation to these organisations.

Note 37 Approval of Financial Statements

The financial statements were approved by the Directorate on 18 May 2015.

Appendix 1: Revenue Grants and Grants Funded by Other Government Departments/State Agencies

Analysis of Grants to Outside Agencies in Note 8

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Total Grants under €100,000 (1,822 Grants)	**36,232**	**31**	**36,263**

* Other grants originate from a variety of sources. The funding is paid to the HSE in the first instance and then distributed to the relevant voluntary body along with their HSE Vote funded grant.

** Additional payments may have been made to some grantees related to services provided, and are not shown here.

Grants €100,000 or more each

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
A Ghrá Homecare Services Ltd.	378		378
Ability West Ltd.	22,214		22,214
Abode Hostel and Day Centre	1,000		1,000
Acquired Brain Injury Ireland (Formerly Peter Bradley Foundation)	9,382		9,382
Active Retirement Ireland	251		251
Adapt Community Drugs Team	554		554
Addiction Response Crumlin (ARC)	865		865
Aftercare Recovery Group	105		105
Age Action Ireland	513		513
Age and Opportunity	526		526
AIDS Fund Housing Project (Centenary House)	364		364
AIDS Help West	250		250
Áiseanna Tacaíochta	655		655
Aiséirí	281		281
Aislinn Centre, Kilkenny	742		742
Alcohol Action Ireland	152		152
All About Healthcare t/a The Care Team	348		348
All In Care	9,781		9,781
Alliance	227		227
Alpha One Foundation	120		120
Alzheimer Society of Ireland	10,510		10,510
AMEN	147		147
Ana Liffey Drug Project	1,669		1,669
Arabella Counselling, t/a Here2Help	203		203
Áras Mhuire Day Care Centre (North Tipperary Community Services)	297		297
ARC Cancer Support Centre	171		171

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Ard Aoibhinn Centre	3,143		3,143
Ardee Day Care Centre	274		274
Arlington Novas Ireland	2,259		2,259
Arthritis Ireland	185		185
Asperger Syndrome Association of Ireland (ASPIRE)	472		472
Associated Charities Trust	167		167
Association for the Healing of Institutional Abuse (AHIA) (Previously known as the Aislinn Centre, Dublin).	223		223
Association of Parents and Friends of the Mentally Handicapped	627		627
Athlone Community Services Council Ltd.	280		280
Autism Initiatives Group	4,163		4,163
Autism West Ltd.	567		567
Aware	162		162
Baile Mhuire Recuperative Unit for the Elderly	217		217
Ballinasloe Social Services	132		132
Ballincollig Senior Citizens Club Ltd.	356		356
Ballyfermot Advanced Project Ltd.	525		525
Ballyfermot Home Help	2,159		2,159
Ballyfermot Star Ltd.	376		376
Ballymun Local Drugs Task Force	303		303
Ballymun Youth Action Project (YAP)	663		663
Ballyphehane and Togher Community Resource Centre	162		162
Barnardos	782		782
Barretstown Camp	151		151
Barrow Valley Enterprises for Adult Members with Special Needs Ltd. (BEAM)	444		444
Beaufort Day Care Centre	177		177
Beaumont Hospital	266,692		266,692
Belong to Youth Services Ltd.	192		192
Bergerie Trust	285		285
Blakestown and Mountview Youth Initiative (BMYI)	480		480
Blanchardstown and Inner City Home Helps	3,459		3,459
Blanchardstown Local Drugs Task Force	294		294
Blanchardstown Youth Service	192		192
Bluebird Care	7,269		7,269
Bodywhys The Eating Disorder Association of Ireland	289		289
Bon Secours Sisters	829		829
Brainwave – Irish Epilepsy Association	728		728
Bray Community Addiction Team	706		706

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Bray Lakers Social and Recreational Club Ltd.	137		137
Bray Travellers Group	111		111
Brothers of Charity Services Ireland	163,383		163,383
Cabra Resource Centre	217		217
Cairde	495		495
Cairdeas Centre Carlow	274		274
Camphill Communities of Ireland	1,066		1,066
Cancer Care West	500		500
Cappagh National Orthopaedic Hospital	26,290		26,290
Care About You	147		147
Care at Home Services	295		295
Care of the Aged West Kerry	129		129
CareBright	2,750		2,750
Caredoc GP Co-operative	7,855		7,855
Caremark Ireland	3,286		3,286
Carers Association Ltd.	5,439		5,439
Careworld	1,021		1,021
Caring and Sharing Association (CASA)	199		199
Caring For Carers Ireland	654		654
Caritas	2,026		2,026
Carlow Day Care Centre (Askea Community Services)	106		106
Carlow Institute of Technology	107		107
Carlow/Kilkenny Home Care Team	218		218
Carnew Community Care Centre	140		140
Carrickmacross Parent and Friends Association	348		348
Carriglea Cairde Services Ltd. (formerly Sisters of the Bon Sauveur)	8,639		8,639
Casadh	195		195
Casla Home Care Ltd.	303		303
Castle Homecare	700		700
Catholic Institute for Deaf People (CIDP)	1,084		1,084
CDA Trust Ltd. (Cavan Drug Awareness)	213		213
Central Remedial Clinic	15,695		15,695
Centres for Independent Living (CIL)	10,581		10,581
Charleville Care Project Ltd.	175		175
Cheeverstown House Ltd.	22,736		22,736
Cheshire Ireland	21,487		21,487
Children's Sunshine Home	3,907		3,907
ChildVision (St. Joseph's School For The Visually Impaired)	4,043		4,043

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Chrysalis Community Drug Project	255		255
Cill Dara Ar Aghaidh	202		202
Clann Mór	1,121		1,121
Clannad Care	281		281
Clarecare Ltd. Incorporating Clare Social Service Council	5,133	29	5,162
Clarecastle Daycare Centre	389		389
Clareville Court Day Centre	168		168
CLASP (Community of Lough Arrow Social Project)	126		126
Clondalkin Addiction Support Programme (CASP)	842		842
Clondalkin Drugs Task Force	203		203
Clondalkin Tus Nua Ltd.	451		451
Clonmel Community Resource Centre	195		195
Clontarf Home Help	1,538		1,538
CLR Home Help	1,827		1,827
CLUB 91 (Formerly Chez Nous Service), Sligo	125		125
Co-Action West Cork	6,421		6,421
Cobh General Hospital	760		760
Comfort Keepers Ltd.	14,104		14,104
Communicare Healthcare Ltd.	1,338		1,338
Community Creations Ltd.	156		156
Community Games	200		200
Community Nursing Unit NW	662		662
Community Response, Dublin	311		311
Community Substance Misuse Team Limerick	417		417
Console (Living with Suicide)	925		925
Contact Care	842		842
Coolmine Therapeutic Community Ltd.	1,516		1,516
Coombe Women's Hospital	51,223		51,223
COPE Foundation	45,059		45,059
COPE Galway	2,033		2,033
Cork Arc Cancer Support House	105		105
Cork Association for Autism	4,020		4,020
Cork Family Planning Clinic	267		267
Cork Foyer Project	287		287
Cork Mental Health Association	240		240
Cork Social and Health Education Project (CSHEP)	686		686
Cork University Dental School and Hospital	1,867		1,867
County Limerick VEC	105		105

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
County Wexford Community Workshop, Enniscorthy/New Ross Ltd.	3,843		3,843
CPL Healthcare	2,178		2,178
CROI (West of Ireland Cardiology Foundation)	166		166
Crosscare	2,311		2,311
Crumlin Home Help	2,824		2,824
Cuan Mhuire	1,543		1,543
Cumas Teo	488		488
Cunamh	105		105
Cura	814		814
Cystic Fibrosis Registry of Ireland	140		140
Dara Residential Services	1,676		1,676
Darndale Belcamp Drug Awareness	202		202
Daughters of Charity	100,898		100,898
Deafhear.ie	4,559		4,559
Delta Centre Carlow	2,774		2,774
Depaul Ireland	2,260		2,260
Diabetes Federation of Ireland	304		304
Disability Federation of Ireland (DFI)	1,545		1,545
Dóchas	101		101
Dolmen Clubhouse Ltd.	143		143
Donnycarney and Beaumont Home Help Services Ltd.	1,208		1,208
Donnycarney Youth Project Ltd.	263		263
Donnycarney/Beaumont Local Care	218		218
Donore Community Development	178		178
Down Syndrome Ireland	183		183
Drogheda Community Services	106		106
Drogheda Homeless Aid Association	151		151
Dromcollogher and District Respite Care Centre	402		402
Drumcondra Home Help	1,325		1,325
Drumkeerin Care Of The Elderly	196		196
Drumlin House	162		162
Dublin AIDS Alliance (DAA) Ltd.	393		393
Dublin City University	200		200
Dublin Dental Hospital	6,147		6,147
Dublin North East Drugs Task Force	358		358
Dublin Region Homeless Executive	754		754
Dun Laoghaire Home Help	831		831
Dun Laoghaire Rathdown Community Addiction Team	466		466

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Dun Laoghaire Rathdown Local Drugs Task Force	81	26	107
Dun Laoghaire Rathdown Outreach Project	377		377
Edward Worth Library	135		135
Enable Ireland	36,027		36,027
Ennis Community Development Project	161		161
Errigal Truagh Special Needs Parents and Friends Ltd.	154		154
Extern Ireland	113		113
Extra Care (ROI)	356		356
Father McGrath Multimedia Centre (Family Resource Centre)	130		130
Fatima Home, Tralee	229		229
Ferns Diocesan Youth Services (FDYS)	246		246
Festina Lente Foundation	360		360
Fettercairn Drug Rehabilitation Project	110		110
Fighting Blindness Ireland	111		111
Fingal Home Care	4,912		4,912
Finglas Addiction Support Team	454		454
Finglas Home Help/Care Organisation	2,382		2,382
Focus Ireland	1,490		1,490
Fold Ireland	1,880		1,880
Foróige	328		328
Friedreich's Ataxia Society in Ireland	111		111
FRS Homecare	307		307
Fusion CPL Ltd.	111		111
Gaelic Athletic Association (Alcohol and Substance Abuse Prevention Programme)	125		125
Galway Hospice Foundation	3,356		3,356
Genio Trust	5,590		5,590
Gheel Autism Services Ltd.	5,883		5,883
GLEN – Gay and Lesbian Equality Network	146		146
Good Shepherd Sisters	982		982
Graiguenamanagh Elderly Association	160		160
GROW	1,220		1,220
Guardian Ad Litem and Rehabilitation Office (GALRO)	2,275		2,275
Hail Housing Association for Integrated Living	382		382
Hands On Peer Education (HOPE)	149		149
Headstrong	2,156		2,156
Headway the National Association for Acquired Brain Injury	2,356		2,356
Hesed House	241		241
Holy Angels Carlow Special Needs Day Care Centre	680		680

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Holy Family School	111		111
Holy Ghost Hospital	172		172
Home Care Plus	156		156
Home Help Services Ballymun	1,868		1,868
Home Instead Senior Care	12,930		12,930
Homecare Independent Living Ltd.	3,150		3,150
Homecare Solutions Ltd.	435		435
Hope House	104		104
IADP Inter-Agency Drugs Project UISCE	139		139
Immigrant Counselling and Psychotherapy (ICAP)	268		268
Inchicore Community Drugs Team	480		480
Inchicore Home Help	1,161		1,161
Inclusion Ireland	430		430
Incorporated Orthopaedic Hospital of Ireland	9,195		9,195
Inspire Ireland Foundation Ltd.	210		210
Ire Services	166		166
Irish Advocacy Network	799		799
Irish Association for Spina Bifida and Hydrocephalus (IASBH)	1,018		1,018
Irish Cancer Society	300		300
Irish College of General Practitioners	125		125
Irish Family Planning Association (IFPA)	1,240		1,240
Irish Guide Dogs for the Blind	776		776
Irish Haemophilia Society (IHS)	534		534
Irish Heart Foundation	314		314
Irish Homecare Services	8,506		8,506
Irish Kidney Association (IKA)	217		217
Irish Motor Neurone Disease Association	256		256
Irish Prison Service	256		256
Irish Society for Autism	3,813		3,813
Irish Society for the Prevention of Cruelty to Children (ISPCC)	355		355
Irish Travellers Movement (ITM)	6,152		6,152
Irish Wheelchair Association (IWA)	35,569		35,569
Jack and Jill Children's Foundation	642		642
Jobstown Assisting Drug Dependency Project (JAAD Project)	266		266
K Doc (GP Out of Hours Service)	1,876		1,876
Kalbay Ltd.	2,040		2,040
KARE Plan Ltd.	1,216		1,216
KARE Newbridge	15,986		15,986

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Kerry Parents and Friends Association	7,932		7,932
Kilbarrack Coast Community Programme Ltd. (KCCP)	351		351
Kildare and West Wicklow Community Addiction Team Ltd.	368		368
Kildare Youth Services (KYS)	243		243
Killinarden (KARP)	148		148
Kilmaley Voluntary Housing Association	152		152
Kingsriver Community	309		309
Knocknaheeny Hollyhill Special Justice Project	268		268
L'Arche Ireland	2,636		2,636
Leitrim Association of People with Disabilities (LAPWD)	532		532
Leitrim Development Company	220		220
Leopardstown Park Hospital	13,117		13,117
Letterkenny Women's Centre	209		209
Liberties and Rialto Home Help	1,355		1,355
Life Pregnancy Care Service	477		477
Lifford Clonleigh Resource Centre	145		145
Limerick Social Services Council	307		307
Link (Galway) Ltd.	155		155
Liscarne Court Senior Citizens	115		115
Little Angels Hostel Letterkenny	172		172
Lochrann Ireland Ltd.	133		133
Longford Community Resources Ltd.	229		229
Longford Social Services Committee	156		156
Lourdes Day Care Centre	187		187
Mahon Community Creche	155		155
Marian Court Welfare Home Clonmel	150		150
Marino/Fairview Home Help	1,018		1,018
Mater Misericordiae University Hospital Ltd.	238,723		238,723
Matt Talbot Adolescent Services	1,434		1,434
Meath Accessible Transport t/a Flexi Bus	139		139
Meath Partnership	461		461
Mental Health Associations (MHAs)	1,380		1,380
Mental Health Ireland	137		137
Merchant's Quay Ireland (MQI)	2,425		2,425
Mercy University Hospital Cork	68,485		68,485
MIDOC	853		853
MIDWAY – Meath Intellectual Disability Work Advocacy and You Ltd.	2,238		2,238
Mid-West Regional Drugs Task Force	448	64	512

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Migraine Association of Ireland	142		142
Milford Care Centre	11,589		11,589
Mná Feasa	107		107
Moorehaven Centre Tipperary Ltd.	1,040		1,040
Mount Carmel Home, Callan, Co Kilkenny	116		116
MS Ireland – Multiple Sclerosis Society of Ireland	2,677		2,677
Muintir na Tíre Ltd.	125		125
Mulhuddart/Corduff Community Drugs Team	385		385
Multiple Sclerosis North West Therapy Centre Ltd.	256		256
Muscular Dystrophy Ireland	1,251		1,251
National Association of Housing for the Visually Impaired Ltd.	486		486
National Council for the Blind of Ireland (NCBI)	6,305		6,305
National Federation of Voluntary Bodies in Ireland	280		280
National Maternity Hospital	48,429		48,429
National Office of Victims of Abuse (NOVA)	882		882
National Rehabilitation Hospital	27,085		27,085
National Suicide Research Foundation (NSRF)	650		650
National Youth Council of Ireland	154		154
Nazareth House, Mallow	1,430		1,430
Nazareth House, Sligo	673		673
New Ross Community Hospital	232		232
Newbridge and Dun Laoghaire Community Training Centre	125		125
Newbury House Family Centre, Mayfield, Cork	485		485
Newport Social Services, Day Care Centre	228		228
No Name Youth Club Ltd.	165		165
North Dublin Inner City Homecare and Home Help Services	1,879		1,879
North Tipperary Community and Voluntary Association (CAVA)	172		172
North Tipperary Disability Support Services Ltd.	636		636
North Tipperary Leader Partnership	234		234
North West Alcohol Forum	510		510
North West Parents and Friends Association	1,911		1,911
North West Regional Drugs Task Force	292		292
Northside Community Health Initiative (NICHE)	377		377
Northside Homecare Services Ltd.	2,242		2,242
Northside Partnership	131		131
Northstar Family Support Project	160		160
Northwest Hospice	1,042		1,042
Nua Healthcare Services	1,823		1,823

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Nurse on Call – Homecare Package	3,661		3,661
O'Connell Court Residential and Day Care	258		258
Offaly Local Development Company	115		115
One Family	416		416
One in Four	515		515
Open Door Day Centre	400		400
Open Heart House	186		186
Order of Malta	431		431
Ossory Youth Services	115		115
Our Lady's Children's Hospital, Crumlin	122,362		122,362
Our Lady's Hospice, Harold's Cross	27,734		27,734
Outhouse Ltd.	187		187
Parentstop Ltd.	109		109
Patient Focus	197		197
Peacehaven Trust	632		632
Peamount Hospital	24,261		24,261
Peter McVerry Trust (previously known as the Arrupe Society)	1,239		1,239
PHC Care Management Ltd.	1,556		1,556
Pieta House	817		817
Positive Age Ltd.	105		105
Post Polio Support Group (PPSG)	364		364
Prague House	133		133
Praxis Care Group	3,682		3,682
Prosper Fingal Ltd.	6,546		6,546
RAH Home Care Ltd. t/a Right At Home	283		283
Rathmines Home Help Services	204		204
Rathmines Pembroke Community Partnership	138		138
Red Ribbon Project	303		303
Regional and Local Drugs Task Forces	4,208		4,208
Rehab Group	42,991		42,991
Resilience Ireland (Resilience Healthcare Ltd.)	950		950
Respond! Housing Association	644		644
Rialto Community Development	123		123
Rialto Community Drugs Team	368		368
Rialto Partnership Company	713		713
Right of Place Second Chance Group	167		167
Ringsend and District Response to Drugs	343		343
Roscommon Home Services Co-op	2,972		2,972

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Roscommon Partnership Company Ltd.	229		229
Roscommon Support Group Ltd.	1,097		1,097
Rosedale Residential Home	115		115
Rotunda Hospital	47,398		47,398
Royal College of Physicians	1,481		1,481
Royal College of Surgeons in Ireland	1,947		1,947
Royal Hospital Donnybrook	17,666		17,666
Royal Victoria Eye and Ear Hospital	24,205		24,205
Ruhama Women's Project	220		220
SHARE	208		208
Salesian Youth Enterprises Ltd.	387		387
Salvation Army	1,483		1,483
Samaritans	622		622
Sandra Cooney's Homecare	656		656
Sandymount Home Help	309		309
Sankalpa	236		236
SAOL Project	310		310
SCJMS/Muiriosa Foundation	41,938		41,938
SDC South Dublin County Partnership (formerly Dodder Valley Partnership)	490		490
Servisource Recruitment	678		678
Shalamar Finiskilin Housing Association	184		184
Shannondoc Ltd. (GP Out Of Hours Service)	4,786		4,786
SHINE	1,819		1,819
Simon Communities of Ireland	7,491		7,491
Sisters of Charity	16,029		16,029
Sisters of Charity St. Mary's Centre for the Blind and Visually Impaired	3,181		3,181
Sisters of Mercy	310		310
Slí Eile Support Services Ltd.	222		222
Sligo Family Centre	140		140
Sligo Social Services Council Ltd.	560		560
Sligo Sport and Recreation Partnership	115		115
Snug Community Counselling	148		148
Society of St. Vincent De Paul (SVDP)	3,096		3,096
Sonas Housing Association	113		113
Sophia Housing Association	695		695
South Doc GP Co-operative	8,247		8,247
South Infirmary Victoria University Hospital	53,389		53,389
South West Mayo Development Company	124		124

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Spinal Injuries Ireland	300		300
Spiritan Asylum Services Initiative (SPIRASI)	404		404
Springboard Projects	145		145
St. Aengus' Community Action Group	141		141
St. Aidan's Services	3,732		3,732
St. Andrew's Resource Centre	405		405
St. Bridget's Day Care Centre	162		162
St. Carthage's House Lismore	173		173
St. Catherine's Association Ltd.	5,562		5,562
St. Christopher's Services, Longford	8,344		8,344
St. Cronan's Association	800		800
St. Dominic's Community Response Project	274		274
St. Fiacc's House, Graiguecullen	326		326
St. Francis' Hospice	7,868		7,868
St. Gabriel's School and Centre	1,926		1,926
St. Hilda's Services For The Mentally Handicapped, Athlone	4,181		4,181
St. James' Hospital	327,782		327,782
St. James' Hospital, Jonathan Swift Hostels	4,439		4,439
St. John Bosco Youth Centre	159		159
St. John of God Hospitaller Services	130,300		130,300
St. John's Hospital	20,921		20,921
St. Joseph's Foundation	12,826		12,826
St. Joseph's Home For The Elderly	789		789
St. Joseph's Home, Kilmoganny, Co.Kilkenny	127		127
St. Joseph's School For The Deaf	1,762		1,762
St. Kevin's Home Help Service	415		415
St. Laurence O' Toole SSC	982		982
St. Lazarian's House, Bagenalstown	246		246
St. Luke's Home	2,425		2,425
St. Luke's Hospital (UK)	166		166
St. Mary's School For The Deaf	1,143		1,143
St. Michael's Hospital, Dun Laoghaire	25,518		25,518
St. Michael's House	73,082		73,082
St. Michael's Day Care Centre	170		170
St. Monica's Community Development Committee	259		259
St. Monica's Nursing Home	124		124
St. Patrick's Hospital	184		184
St. Patrick's Special School	170		170

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
St. Patrick's Wellington Road	8,751		8,751
St. Vincent's Hospital Fairview	14,130		14,130
St. Vincent's University Hospital, Elm Park	216,349		216,349
Star Project Ballymun Ltd.	244		244
Stella Maris Facility	146		146
Stewart's Hospital	44,122		44,122
Stillorgan Home Help	560		560
Suicide or Survive (SOS)	144		144
Sunbeam House Services	19,803		19,803
Tabor House, Navan	108		108
Tabor Lodge	501		501
Talbot Grove Treatment Centre	169		169
Tallaght Home Help	1,212		1,212
Tallaght Hospital	190,965		190,965
Tallaght Rehabilitation Project	108		108
Tallaght Travellers Youth Service	115		115
Teach Mhuire Day Care Centre	136		136
Teen Challenge Ireland Ltd.	392		392
Temple Street Children's University Hospital	93,487		93,487
Templemore Day Care Centre	163		163
Terenure Home Care Service Ltd.	981		981
The Avalon Centre, Sligo	254		254
The Beeches Residential Home	147		147
The Birches Alzheimer Day Centre	192		192
The Gateway Project	100		100
The Glen Neighbourhood Youth Project	170		170
The Oasis Centre	164		164
The Sexual Health Centre	355		355
The TCP Group	340		340
Third Age	529		529
Thurles Community Social Services	314		314
Tinteán Housing Association Ltd.	108		108
Tipperary Association for Special Needs	130		130
Tipperary Hospice Movement	220		220
Tralee Women's Forum	127		127
Transfusion Positive	138		138
Transgender Equality Network Ireland	112		112
Treoir	420		420

Name of Agency	Revenue Grants 2014 €000's	Other Grants* 2014 €000's	Total Grants** 2014 €000's
Tribli Limited, t/a Exchange House National Travellers Service	714		714
Trinity College Dublin	140		140
Tullow Day Care Centre	166		166
Turas Counselling Services Ltd.	370		370
Turners Cross Social Services Ltd.	157		157
Valentia Community Hospital	557		557
Village Counselling Service	140		140
Walkinstown Association For Handicapped People Ltd.	3,973		3,973
Walkinstown Greenhills Resource Centre	233		233
Wallaroo Pre-School	107		107
Waterford and South Tipperary Community Youth Service	1,201		1,201
Waterford Association for the Mentally Handicapped	2,102		2,102
Waterford Hospice Movement	237		237
Waterford Institute of Technology	114		114
Well Woman Clinics	548		548
West Cork Carers Support Group Ltd.	130		130
West Limerick Resources Ltd.	157		157
West Of Ireland Alzheimer Foundation	961		961
Westdoc (GP Out Of Hours Service)	1,409		1,409
Western Care Association	28,575		28,575
Western Region Drugs Task Force	300		300
Westmeath Community Development Ltd.	177		177
Wexford Homecare Service	202		202
White Oaks Housing Association Ltd.	304		304
Wicklow Community Care Home Help Services	5,386		5,386
Windmill Therapeutic Training Unit	359		359
Young Men's Christian Association (YMCA)	162		162
Young Social Innovators Ltd.	142		142
Youth For Peace Ltd.	139		139
Total Grants to Outside Agencies (see Note 8)	**3,425,304**	**150**	**3,425,454**

Appendix 2: Analysis of Capital Grants to Outside Agencies

Capital Income and Expenditure Account

Name of Agency	Capital Grants 2014 €000's
Beaumont Hospital	3,483
Cappagh National Orthopaedic Hospital	425
Coombe Women's Hospital	386
Cystic Fibrosis Association of Ireland	200
Dublin Dental Hospital	391
Mater and Children's Hospital Development Ltd.	1,281
Mater Misericordiae University Hospital Ltd.	2,248
Mercy University Hospital Cork	1,741
National Maternity Hospital	4,879
National Paediatric Hospital	7,259
National Rehabilitation Hospital	1,171
Our Lady's Children's Hospital, Crumlin	1,090
Rotunda Hospital	1,531
Royal Victoria Eye and Ear Hospital	121
South Infirmary Victoria University Hospital	425
St. Francis' Hospice	900
St. James' Hospital	13,806
St. John's Hospital	19
St. Vincent's University Hospital, Elm Park	1,086
Tallaght Hospital	5,185
Temple Street Children's University Hospital	934
University College Galway	1,731
Western Health Social Care Trust Northern Ireland	3,000
Total Capital Grants to Outside Agencies (Note 18(b))	**53,292**

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