Health Service Executive

Annual Report and Financial Statements 2013

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

4.59m People lived in Ireland

1.43m People received either inpatient or day case treatment

People attended a hospital outpatient department **2.4m**

Patients were seen in an Emergency Department **1m**

68,000 Babies were born

1.8m People have a Medical Card

Prescriptions were filled for 62 million items **20m**

Home Help Hours delivered to 46,454 people **9.74m**

281,000 Emergency calls were made to the Ambulance Service

93% Children in care lived with Foster Carers

Women attended BreastCheck **140,000**

People contacted a GP out of hours **978,000**

1.32m Treatments provided under the Dental Scheme

92% Children were immunised against MMR

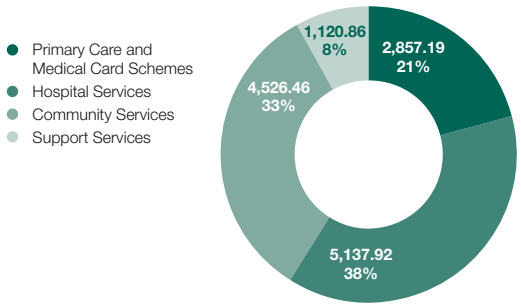
Adults and children seen by the mental health services **15,300**

Homeless people admitted to emergency accommodation each quarter **2,000**

Facts and Figures in 2013 Finance

- Total HSE expenditure in 2013 was €13.642bn
- Gross expenditure on hospital services was €5.1bn
- Gross expenditure on primary and community care services was €7.4bn
- The total budget reduction to date since 2008 is €3.3bn

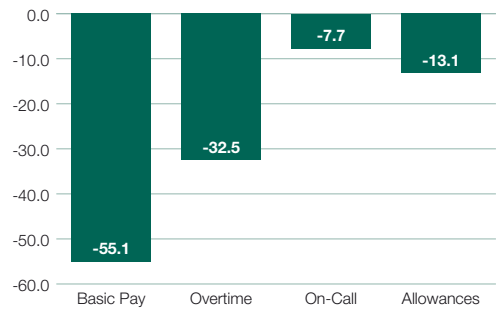
Breakdown of total expenditure 2013 (€m)



Data source: HSE Corporate Finance

- In 2013, basic pay expenditure (statutory and non-statutory) reduced by €55.1m (1.2%)
- There was a 12.8% reduction in overtime payments (statutory and non-statutory)
- There was a 20.8% increase in agency expenditure
- Agency costs amounted to 4.2% of all pay costs
- Non-pay costs remained the same as in 2012

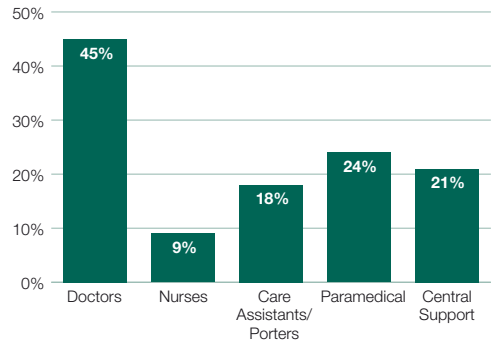
Pay cost change (statutory and non-statutory, excluding superannuation) 2013 v 2012 (€m)



Data source: HSE Corporate Finance

- 2,616 non-statutory agencies were funded, through service arrangements or grant aid agreements
- €1.813bn funding was provided to acute voluntary hospitals
- €1.664bn funding was provided to non-acute voluntary agencies
- Total capital expenditure in 2013 was €342m

Variance in 2013 agency costs against 2012



Data source: HSE Corporate Finance

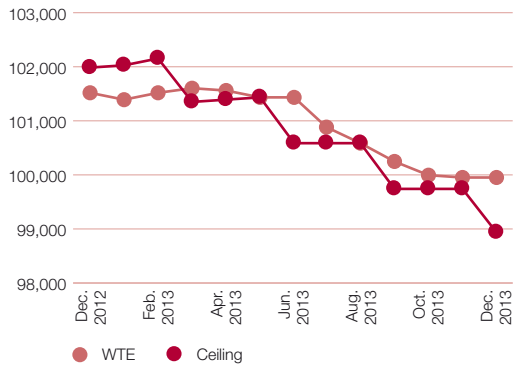
Facts and Figures in 2013 Workforce

- At the end of 2013, there were 99,959 WTEs employed
- This was a reduction of 1,574 WTEs on the previous year
- Since 2007 there has been an overall reduction of 11% in staff numbers
- There were 3,693 new starters, 60% of whom were in acute services
- There were 340 new development posts

- There were 409 appointments to the new Nurse Graduate Programme
- 2,670 public sector consultants were in post
- 48% of staff in 2013 worked in hospitals
- 43% of staff worked in community services
- Just 2.6% of staff worked in corporate services
- Since 2007, there has been a 16% reduction in the number of management/ administration staff

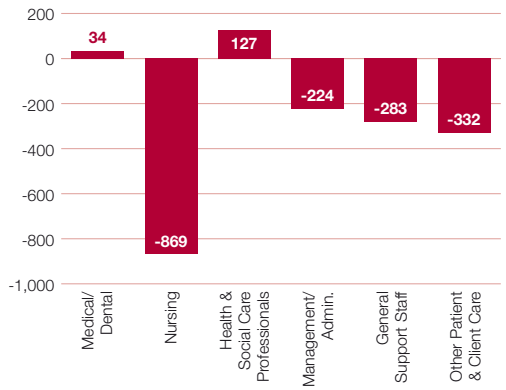
- 22% of staff worked in voluntary hospitals
- 13% of staff worked in voluntary community services
- There has been a 30.8% increase in the number of GPs trained
- The number of intern places has increased from 570 to 640
- Absenteeism rates are continuing to improve, down from 5.76% in 2008 to 4.73% in 2013

Employment ceiling and WTEs 2012-2013



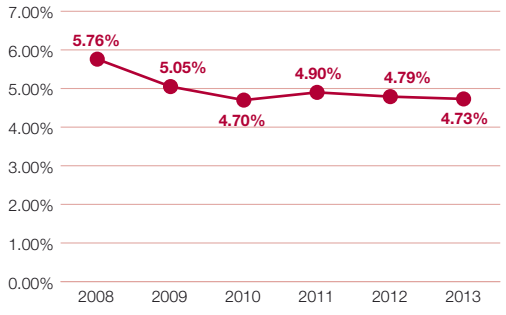
Data source: Health Service Personnel Census

WTE change December 2012 – December 2013



Data source: Health Service Personnel Census

Absenteeism rates 2008-2013



Data source: Health Service Personnel Census

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Part I

Part II

In appreciation of the late Gerry Collins and his family, who led a powerful series of HSE QUIT campaign adverts in 2013, discussing his terminal lung cancer caused by smoking. Gerry passed away on March 2, 2014.

Statement from the Director General

2013 was a year of significant challenge and change for the Health Services in Ireland. Demand for health services increases each year and this was no different in 2013. Our population is growing and ageing (it has grown by 8% since 2006, and the number of those aged over 65 years increased by 14% in the same period) more people than ever before have medical cards (over 1.8 million people or 40% of the population) and advances in new medical technologies while improving patient outcomes, are highly cost intensive.

Since 2008 there has been a budget reduction of €3.3 billion or 22% in the Health Service. Staffing levels reduced by over 12,812 whole-time equivalents or 11% since the peak employment levels in 2007. Understandably, providing high quality effective services, within these increasing demands and a reduced budgetary framework, has been a significant challenge during the year. Despite these challenges we remain fully committed to excellence in service delivery – throughout this report you will read examples of solid achievements and where we will be focusing our attention in the future.

There is a focus on quality and patient safety and in parallel, the foundations for implementation of the Health Service Reform Programme continue to be strengthened. These will change how health services will be delivered and include structural reform, financial reform and reform of primary care and hospital services, and a special emphasis on health and wellbeing. The work of the national clinical programmes is progressing, ensuring real improvements in the way services are delivered. These important work streams are supported by the continued implementation of the Haddington Road Agreement, providing opportunities to achieve greater efficiencies across all services.

We do not always get everything right and when we do not we must learn from our mistakes. We continue to implement learning from report findings including the Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (The Francis Report) and the investigation into the death of Ms. Halappanavar at Galway University Hospital. In addition, during the year a review of health and safety performance was undertaken across the Health Services in order to assure that current occupational health and safety policies, procedures and resources are fit for purpose. Our Open Disclosure: National Policy and National Guidelines represent a significant advancement in the change in culture towards ensuring openness and transparency between patients, service users and health and social care providers. Our continued focus on implementing best practice recommendations provides a renewed collective commitment to providing the highest quality care in the safest of healthcare environments.

Health Reform

2013 saw significant key building blocks laid on the path to realising the vision of *Future Health*, the framework for health reform, based on Government commitments in its *Programme for Government*. The vision for developing a universal, single-tier health service which guarantees access to medical care based on need not income, is a radical and far reaching reform which requires significant change across the spectrum of our health system. *Future Health* is about prioritising the needs of the patient as difficult decisions on future health financing are made.

The *Health Service Executive (Governance) Act 2013* was enacted in July which fundamentally changed the management and governance of health services in Ireland. This is a transition step to the establishment of the Healthcare Commissioning Agency.

A post of Chief Operating Officer/Deputy Director General has been established and a Chief Finance Officer post has been put in place. Five new Divisions and associated structures for Primary Care, Mental Health, Acute Hospitals, Health and Wellbeing and Social Care have also been established. In addition a Director of Shared Services has been put in place.

We are now preparing for the wider introduction of the 'money follows the patient' principle and the ultimate introduction of Universal Health Insurance.

The groundwork for this reform has already commenced and it is vital that we effectively transition towards the new organisational model while ensuring that the quality of services we provide is at the highest level.

Three new hospital groups were in place at the end of 2013 and more will come on stream in 2014. This will ensure that services can be organised in an optimum way across a number of hospitals in these groups and will strengthen accountability. The report on future hospital trusts and the small hospitals framework provides a necessary strategic guidance to build our modern acute hospital infrastructure and networks.

At the end of the year, after significant preparatory ground work was undertaken, the disaggregation from the HSE of children and family services to the new Child and Family Support Agency (TUSLA) was completed. The HSE will continue to work closely with the agency and with the Minister for Children and Youth Affairs to ensure the health and welfare of our children.

Responding to our challenges

Future projected increases in chronic disease are largely attributable to behavioural factors that can be modified such as smoking, regular physical activity, diet, alcohol misuse. *Healthy Ireland* was published in 2013 and is a cross-government framework for improved health and wellbeing. A priority for the Health Service is the development of a three year plan for its implementation and this will commence in 2014.

Enhanced governance arrangements were put in place with section 38 agencies. Engagement took place with the chairpersons of the boards of all section 38 agencies following which additional measures were put in place to strengthen the governance relationships between the Boards of these agencies and the Executive. These measures included the introduction of a new compliance statement process based on best practice and an enhancement of Board and Corporate Governance Standards. From 31st May, 2014, the Board of each section 38 agency will be required to submit a signed compliance statement together with their annual financial statements to the Health Service, in respect of the previous financial year.

Improving access and supporting service delivery

Acute Services

Over 1.43 million people received inpatient or day case treatment in 2013, 58% of which were on a day case basis. Over 2.4 million people attended an outpatient department. A key priority during the year was to ensure improved access to services.

- The number of people waiting over eight months for an elective procedure was reduced to four people, in one hospital, at the end of December.
- 95% of all children waiting on the paediatric elective waiting list (excluding gastrointestinal (GI) scopes) were waiting less than 20 weeks. A total of 193 children waited over 20 weeks for a procedure by the end of December in three hospitals.
- 99% of people on the GI endoscopy waiting list were waiting less than 13 weeks with 96 patients waiting greater than 13 weeks by the end of December.
- No patient waited longer than 28 days for an urgent colonoscopy at the end of December.
- 98% of those waiting for an outpatient appointment (295,815 people) waited less than 52 weeks at the end of December. 4,937 waited over 52 weeks. There was a 96% reduction (over 100,000 people) in the number of patients waiting more than12 months for an outpatient appointment and a 55% reduction (over 105,000 people) in those waiting more than six months.

The reorganisation of our ambulance service continued. All emergency responses are now attended by qualified paramedics and advanced paramedics who can deliver immediate lifesaving techniques directly to the patients, before arrival at hospital. The move to one national Control Centre over two sites was progressed. 25 intermediate care vehicles were brought into service in 2013 and over 70% of all inter-hospital transfers were carried out by intermediate care vehicles in December.

Community Services

1.8 million people or 40.3% of the population are covered by a medical card. The number of people with eligibility has increased by 61% since January 2005.

Throughout the year, nearly 46,500 people received home help services, with 11,873 people benefiting from a home care package. In total we provided 9.74m home help hours. 2.56m home support hours were delivered to adults and children who have a disability.

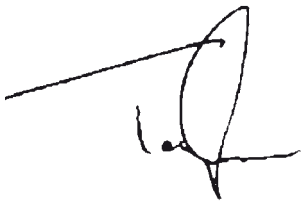
Investment in our mental health services has supported the 17% increase in referrals to the child and adolescent service in 2013 and an increase in capacity in child and adolescent inpatient units.

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, older people services and acute hospital services.

Thank You

On behalf of the Directorate, I would like to thank my colleagues on the Leadership Team, all former members of the HSE Board, Dr. Ambrose McLoughlin, Secretary General of the Department of Health, and his officials who supported the HSE during the year. I would also like to acknowledge the leadership of the Minister for Health, Dr. James Reilly TD who along with his Ministers of State Alex White TD and Kathleen Lynch TD, are steering policy at Government level to fundamentally change the health services for the people of Ireland.

I also wish to take the opportunity to thank all the dedicated and committed staff who work day and night striving to deliver a vast range of quality services for our service users in what was a particularly challenging year given the ongoing reductions in staff numbers and funding.



Mr. Tony O'Brien
Director General
Health Service Executive

Health Reform

Progressing the Health Reform Programme

Significant progress has been made on health reform as set out in *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015*. An integrated portfolio of reform programmes has been developed to ensure the core objectives of delivering safe and effective health and social care services for patients, services users, carers and families, in multiple settings, are met. This will be driven by:

- A sustained emphasis on quality and patient safety.
- Integration of Health and Wellbeing and prevention to service delivery models and reform programmes.
- Integrated models of care within and across all divisions, supported by a governance model for Clinical Programmes.
- Hospital Groups as a transition to Hospital Trusts.
- Integrated Service Area (ISA) Review and development of Community Services.
- Performance Assurance Model.
- Money Follows the Patient.
- Incremental transitioning to a commissioning model.
- Strategic Human Resource Management.
- Leadership and Management Development Programme.
- Strategic communications/Information and Communication Technology Strategy/Informatics.
- Finance Operating Model Reform.
- Shared Services Reform.

Health and Wellbeing is an overarching theme of the reform programme. Many of the key reform programmes initiated, including financial reforms (Money Follows the Patient), service reforms (a new strategy for integrated clinical programmes) and structural reforms (Community Healthcare Organisations, Hospital Groups and the Health and Wellbeing Division), all contribute to the incremental creation of a health service that rewards and prioritises health promotion, early diagnosis and self-care.

Structural Reform

The Health Service Executive (Governance) Act, 2013 was passed which gave the legislative basis for the change in governance and management structures for the Health Service. The HSE Board was replaced with the HSE Directorate, under the leadership of a Director General. Further details in relation to this can be found in the Annual Financial Statements section of this report.

A new national divisional structure was established for five main service domains: Hospitals, Primary Care, Mental Health, Social Care and Health and Wellbeing. A new division for Shared Services was established to lead transformation in areas such as procurement, estates, ICT, accounts and payroll functions. A Chief Operating Officer for planning, commissioning and performance management and a Chief Financial Officer to lead on the financial reform agenda were also appointed.

An organisational chart as of 31st December 2013 can be seen in Appendix 3.

Financial Reform

Phase 1 of the financial reform programme was implemented which included the development of a new financial operating model, with new governance structures. The programme aims to develop more effective financial planning and management, and build a more cost conscious culture across the Health Service. In addition, the *Health Service Executive (Financial Matters) Bill 2013*, which relates to the disestablishment of the HSE Vote and the establishment of a new statutory governance framework for the Executive, was published.

Reform of Primary Care

A review of Integrated Service Areas (ISAs) took place to progress the development of Community Healthcare Organisations which will be established during 2014.

The Department of Health (DoH), announced steps to facilitate the introduction of a universal GP service without fees for all children aged five years and under. This included consultation on the content and scope of a new contract and the drafting of enabling legislation.

The *Health (Pricing and Supply of Medical Goods) Act 2013* sets out responsibility for the Irish Medicines Board to establish the list of interchangeable medicines, with the HSE responsible for setting reference prices.

Reform of Hospital Services

The structural reform for hospital services continued with the establishment of seven Hospital Groups (six plus Paediatric Group). Chairpersons were appointed to all groups with Board members now in place for three groups. Recruitment of Group CEOs took place.

The foundations for the phased approach to 'money follows the patient' (MFTP) were put in place to plan for, initially, the acute hospital sector linking funding to actual activity. Progress in relation to other programmes can be seen throughout this report in their respective chapters

Quality and Patient Safety

Underpinning the delivery of all our services is the commitment to ensuring that the quality and patient safety agenda is at the forefront of what we do. It is the responsibility of all staff, is core to service provision, and our priority is that it will be embedded in service delivery across all our services. A culture of continuous quality improvement through effective governance structures, clinical effectiveness, outcome measurements and evaluation, remains at the centre of our approach to improving services.

Our Organisation

Introduction

The core purpose of the Health Service is to:

- Keep people healthy
- Deliver safe healthcare and better outcomes
- Provide the healthcare people need, and
- Achieve best value from health system resources.

This Annual Report describes what the Health Service did in 2013 to meet our objectives. It sets out progress against the *HSE National Service Plan 2013 (NSP2013)* 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 Sections 36 and 37 of the *Health Act 2004*, the Annual Report also reports progress against the *HSE Capital Plan* and provides detailed financial statements for the organisation.

Our Workforce

The staff of the Health Service, nurses, clinicians, health and social care professionals, clerical, administrative, care staff and support staff, continue to be its most valuable resource. Without them, it would not be possible to deliver the wide range of services every day across the country. Our staff trend continues downward, with overall numbers falling by 1.5% (-1,547 WTE) over 2012, against a backdrop of significant challenges facing the public health sector workforce in the context of a reducing workforce, increased working hours, reduced take-home pay, reduced budget allocations and higher service delivery demands. Nonetheless, we are committed to ensuring a culture where the work of staff is valued and understood by the communities served. Fundamental to the reform of the Health Service is the requirement to continue building the expertise and skills of staff at all levels in leadership, process change and management.

Workforce Planning

The delivery of high quality healthcare is heavily dependent upon the staff who work in the Health Service. The effective management of human resources in 2013 required an approach to workforce planning and development that included recruiting and retaining the right mix of staff, training and up skilling, providing for professional and career development through leadership and succession management, and creating supportive and healthy workplaces.

Public Service Agreement – Haddington Road

The Public Service Agreements (PSAs), initially *Croke Park*, followed by the *Haddington Road Agreement* (HRA), provided significant enablers to increase productivity, extract costs, reduce the overall payroll base and support the reform and reorganisation agenda for the Health Service.

In relation to the range of pay and productivity measures under the Agreement, all Health Service managers are required to review their service delivery models to maximise the provisions of the Agreement to ensure that services are delivered in the most cost effective and efficient manner. Hospital CEOs, Area Managers, CEOs of voluntary agencies and service managers at all levels have responsibility to directly engage with their staff, and be accountable for the delivery of the Agreement within their own organisations and workforce.

Employment Control Framework

At the end of December 2013, the health sector employed 99,959 whole-time equivalent (WTE) staff, 1,021 WTEs (1%) above the end of year approved employment ceiling. The majority of this variance is in the voluntary hospital sector. This was a reduction of 1,574 WTEs (1.5%) compared to the end of 2012 (Table 1). In total, since employment levels peaked in 2007, the health sector has reduced its numbers by just over 11% (12,812 WTEs).

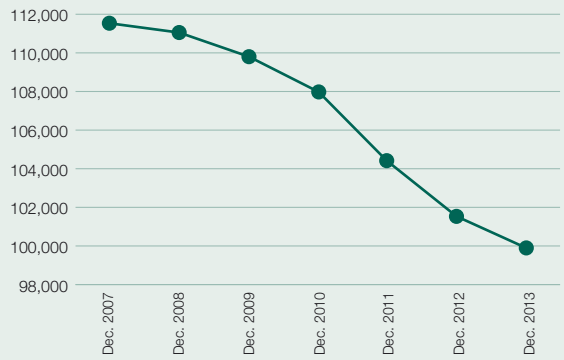
Table 1: Health Service Personnel 2012-2013

Division	WTE Dec. '12	% of Total	WTE Dec. '13	% of Total	% Variance 2012-2013
Acute	48,904	48.2%	48,255	48.3%	-1.3%
Primary Care	9,016	8.9%	9,476	9.5%	+5.1%
Health and Wellbeing	1,230	1.2%	1,232	1.2%	+0.2%
Mental Health	8,909	8.8%	8,904	8.9%	-0.1%
Social Care	25,724	25.3%	24,393	24.4%	-5.2%
Children and Families Services	3,501	3.5%	3,465	3.5%	-1.0%
National Ambulance Service	1,551	1.5%	1,615	1.6%	+4.1%
Other	2,671	2.6%	2,619	2.6%	-2.0%
Total	**101,506**	**100%**	**99,959**	**100%**	**-1.5%**

Data source: Health Service Personnel Census

Note: Due to the move of staff in Children and Family Services to the new agency at year end, the WTE opening position from 1st January 2014 was 94,600.

Figure 1: WTEs December 2007 – December 2013

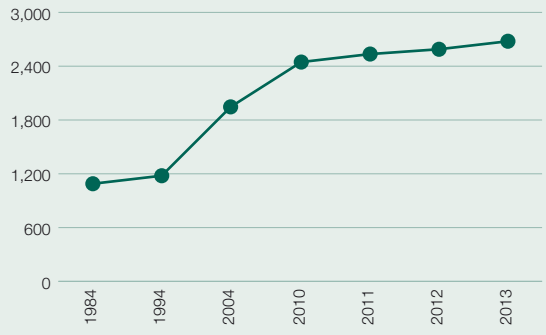


Data source: Health Service Personnel Census

At the end of 2013:

- 3,693 new starters were appointed, 60% of whom are in the acute hospital services.
- 340 WTEs were new development posts as set out in NSP2013.
- 409 WTEs were appointed to the new Nurse Graduate Programme (target 1,000).
- In December the first five appointments to the new Support Staff Intern Programme were recruited (target 1,000).
- 2,670 public sector consultants in post (33% increase since 2005). This equates to one consultant per 1,761 population (Figure 2).

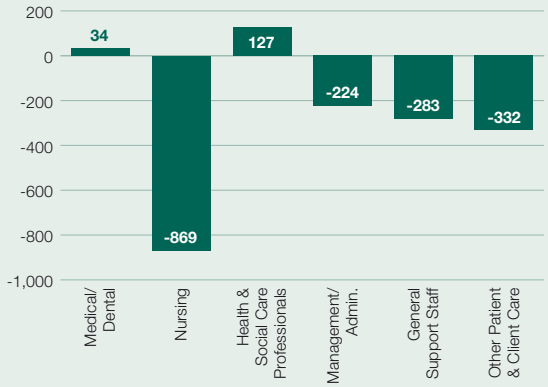
Figure 2: Trend in approved consultants establishment in selected years from 1984 to 2013



Data source: Health Service Personnel Census

- 48% of staff worked in hospitals.
- 43% of staff worked in community services.
- Nearly 9% worked in other areas such as the ambulance service, health and wellbeing, children and families services, national corporate and shared services (finance, procurement, HR, etc).
- Management/administration staff category reduced by nearly 16% (nearly 3,000 WTEs) since their peak in 2007.
- 65% of staff worked in the HSE, 22% in voluntary hospitals and 13% in voluntary primary and community service agencies.

Figure 3: WTE change December 2012 – December 2013



Data source: Health Service Personnel Census

European Working Time Directive

Non-consultant hospital doctors (NCHDs) play a very important and fundamental role in our hospitals. In 2013, there was a focus 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 4,351 NCHDs (including 601 interns, 1,642 Senior House Officers, 1,479 Registrars and 629 Specialist/Senior Registrars):

- 40.4% were compliant with the 48 hour average working week.
- Average weekly working hours were 51.1.
- 76.6% did not work more than 24 hours on-site on call.
- 53.3% received documented daily breaks.
- 75.9% received 11 hour daily rest breaks or equivalent compensatory rest.
- 86.4% 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. While some larger hospitals have shown significant progress, the medium to smaller hospitals remain challenged. Plans to expedite compliance have been developed for implementation in 2014, linked with the hospital reform rogramme.

Medical Education and Training

As a priority area for 2013, approximately €14m was invested which resulted in:

- Implementation of two scholarship programmes specifically targeting NCHDs in their latter stages of training.
- Direct funding of cost of the Basic Specialist Training and Higher Specialist Training Programmes.
- Increase in the numbers of GPs trained, from 120 per year to 157.
- Increase in the number of medical intern places from 570 to 640.

The increase in medical intern posts is one element of the self-sufficiency medical workforce model which is central to the development of medical education and training in Ireland.

As part of the HSE's commitment to medical career planning, an annual Careers Day was launched in September 2013 for final year medical students and current interns. This initiative was undertaken in cooperation with the Forum of Postgraduate Training Bodies.

Absenteeism

The annual rate for 2013 was 4.73% (90.3% of which was medically certified) and was down from the 2012 annual recorded rate of 4.79% (88.4% certified). These figures put the Health Service generally in-line with the figure reported by the Irish Small and Medium Enterprises Association (ISME) for large organisations in the private sector and available information for other large public sector organisations both in Ireland and internationally.

Table 2: Absenteeism by staff category 2012-2013

Staff Category	2012	2013
Medical/Dental	1.20%	1.30%
Nursing	5.31%	5.28%
Health and Social Care Professionals	4.27%	3.99%
Management/Administration	4.74%	4.64%
General Support Staff	5.52%	5.36%
Other Patient and Client Care	5.44%	5.33%
Total	**4.79%**	**4.73%**

Data source: Health Service Personnel Census

Table 3: Absenteeism by sector 2012-2013

Sector HSE/S38	2012	2013
Health Service Executive	5.28%	5.28%
Voluntary Hospitals	3.68%	3.58%
Voluntary Agencies P&C Services	4.24%	4.09%
Total	**4.79%**	**4.73%**

Data source: Health Service Personnel Census

Table 4: Absenteeism by service area 2012-2013

Service Area	2012	2013
Acute Services	4.54%	4.49%
Non-Acute Services	5.05%	5.01%
Ambulance Services	5.73%	5.27%
Corporate and Shared Services	4.41%	4.62%
Health and Wellbeing	4.30%	3.56%
Total	**4.79%**	**4.73%**

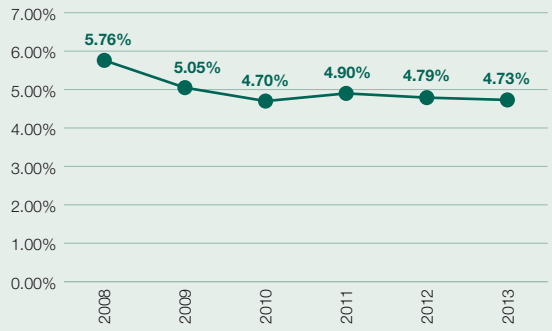
Data source: Health Service Personnel Census

Table 5: Absenteeism by HSE region 2012-2013

Region	2012	2013
Dublin Mid-Leinster	4.41%	4.38%
Dublin North East	4.50%	4.54%
South	5.01%	4.81%
West	5.25%	5.22%
National	5.47%	5.17%
Total	**4.79%**	**4.73%**

Data source: Health Service Personnel Census

Figure 4: Absenteeism rates 2008-2013

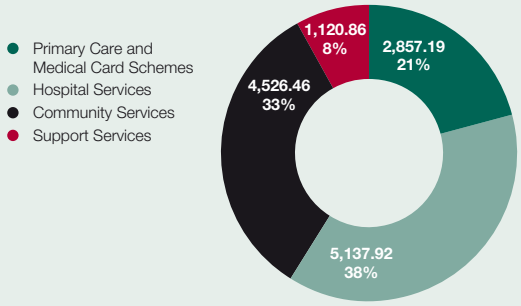


Data source: Health Service Personnel Census

Finance

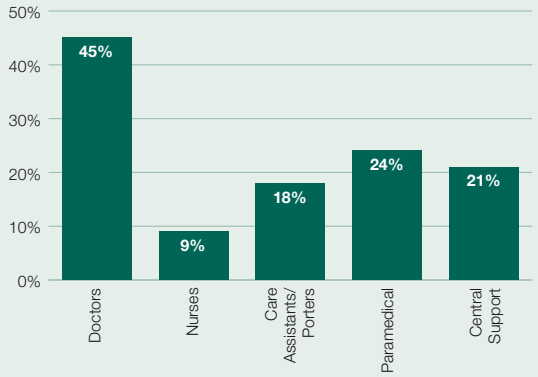
The total HSE expenditure in 2013 was €13.642 billion (bn) for the delivery and contracting of health and personal social services. A supplementary estimate of €219m was voted by Government to the HSE at the end of the year to address pressures in the Primary Care Reimbursement Service (PCRS) and demand led schemes. It was also used to address pressures in the acute hospital sector resulting from the non-achievement of income targets, due to delayed implementation of the legislation until January 2014. The main areas of expenditure are set out in Figure 5.

Figure 5: Breakdown of total expenditure 2013 (€m)



Data source: HSE Corporate Finance

Figure 6: Variance in 2013 agency costs against 2012



Data source: HSE Corporate Finance

In progressing the **HSE Capital Plan** for 2013, the total capital expenditure was €342m, which included capital grants to voluntary agencies of €69m. Further information on capital and ICT infrastructure developments can be found on page 47.

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

Payroll (Statutory and Non-Statutory)

The 2013 service plan required a reduction in the gross pay bill of €286m, and €69m of this reduction was linked to forecasted staff reductions of 3,400 WTEs. Critical to the achievement of this payroll reduction was the efficient management of payroll costs during the year, particularly agency usage, overtime and premium payments, and delivery of the required number of staff reductions.

The overall pay bill of the Health Service, including voluntary service providers and excluding superannuation, reduced by €85.05m (1.4%) in 2013. Basic pay reduced by €55.06m (1.2%), overtime payments by €32.53m (12.8%), on call by €7.66m (9%), and allowances by €13.09m (8.1%). However, there was a 20.8% increase in agency expenditure compared to 2012. The acute sector accounted for a 27% increase with a 9% increase in the non-acute sector. The greatest increase compared to 2012 was in relation to medical/dental at nearly 45%. This increase has been driven by difficulties in recruitment of NCHDs in some hospitals.

- Overtime amounted to 3.6% of all pay costs (excluding superannuation).
- Agency costs amounted to 4.2% of all pay costs (excluding superannuation).

Governance Arrangements with the Non-Statutory Sector

The HSE provided funding of €3.477bn to non-statutory agencies to deliver health and personal social services.

- Acute Voluntary Hospitals €1.813bn (52%)
- Non-Acute Agencies €1.664bn (48%)

In total, 2,616 agencies were funded, with over 4,234 separate funding arrangements in place. Nine agencies accounted for over 51% of the funding and ninety agencies accounted for over 90% of the funding.

- 100% of hospital agencies (16) had both Part 1 and 2 Schedules of a Service Agreement in place at the end of 2013.
- Nearly 94% of non-acute agencies had both Part 1 and 2 Schedules of a Service Agreement in place at the end of 2013.

Additional measures were introduced between the Boards of Section 38 agencies and the HSE to strengthen governance arrangements.

Given the level of investment by the State in services provided by the non-statutory sector, the Health Service has from the 1st January 2014 enhanced its governance framework with each Section 38 Provider. This means that each Section 38 agency will be required annually to furnish the Executive with a Compliance Statement. This Compliance Statement will be completed by the Board of the agency, having reviewed the compliance of their organisation in respect of the previous financial year, with specific requirements set out in their Service Arrangement. As part of the Compliance Statement process, Section 38 agencies are also required to adopt and implement a set of core governance standards for their organisation.

Listening to Our Service Users

It is essential for any organisation to hear the views of its service users. Consumer Affairs and the National Advocacy Unit have responsibility for promoting service user involvement across the organisation through the concept of *Your Service Your Say* and developing and implementing good practice in collecting and managing service user feedback.

The National Healthcare Charter *You and Your Health Service* is a statement of commitment by the Health Service, which describes what can be expected when using health services in Ireland and what the individual service user can do to help health services deliver services safer and more effectively. The charter is based on eight principles: access, dignity and respect, safe and effective services, communication and information, participation, privacy, improving health and accountability.

Initiatives in 2013

- A report *Emergency Departments: Taking Patient Feedback Seriously* was developed as a collaboration between the National Advocacy Unit and the National Emergency Medicine Programme, to provide patient feedback to emergency department (ED) teams to assist them in improving the safety, quality and patient experience of care in EDs.
- 16 people received World Health Organisation designation as Patients for Patient Safety Ireland, a global initiative aimed at improving patient safety in health care. The purpose of setting up a network of Patients for Patient Safety is to promote understanding and dialogue around patient safety and the role patients themselves can play.
- The principles of the National Children's Charter were developed and launched in conjunction with the Ombudsman for Children. These principles will form the basis of a full charter and work on it will continue next year.
- A staff guide *Using Patient Feedback* was published to support services to achieve a real measure of the patient experience during their journey through the health system.
- Analysis of complaints made by maternity services patients post-discharge was carried out to identify trends and provide feedback that can be used for service improvement and to inform the development of the National Charter for Maternity Services.

Compliments and Complaints

Health Service Executive

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 2013, there were 4,019 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 6,823 complaints recorded and examined by complaints officers, an increase of 0.15% on the number received in 2012. Of the total number of complaints received this year, 4,651 or 68% were dealt with within 30 working days.

Table 6: HSE complaints received and % dealt with within 30 working days

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

Data source: HSE National Advocacy Unit

Table 7: HSE complaints by region

Region	2012	2013
Dublin Mid-Leinster	1,153	971
Dublin North East	1,427	1,447
South	2,069	1,583
West	1,632	1,680
Primary Care Reimbursement Service	532	1,142
Total	**6,813**	**6,823**

Data source: HSE National Advocacy Unit

Complaints are now broken down into 16 categories in line with the eight principles of the National Healthcare Charter which were piloted by Dublin Academic Teaching Hospitals in 2012. As this is the first time complaints are being reported under the new categorisation, it is not possible to compare the new complaints data with the data reported in 2012.

Table 8: Categories of complaints received in 2013

Category	2013
Access	1,622
Dignity and Respect	720
Safe and Effective Care	1,631
Communication and Information	1,046
Participation	60
Privacy	68
Improving Health	84
Accountability	217
Other	1,512
Clinical Judgment	113
Vexatious Complaints	20
Nursing Homes/residential care for older people (65 and over)	30
Nursing Homes/residential care (aged 64 and under)	2
Pre-School inspection services	162
Trust in Care	29
Children First	34

Data source: HSE National Advocacy Unit

Note: Some complaints contain multiple issues and therefore fall under a number of categories

Voluntary Hospitals and Agencies

There were 9,110 compliments recorded by voluntary hospitals and agencies and 5,573 complaints. Of the total number of complaints received and managed by voluntary hospitals and agencies, 4,711 or 85% were dealt with within 30 working days.

Table 9: Categorisation of complaints received by voluntary hospitals and agencies, 2013

Category	2013
Access	1,410
Dignity and Respect	441
Safe and Effective Care	1,505
Communication and Information	1,622
Participation	47
Privacy	83
Improving Health	88
Accountability	71
Other	1,320

Data source: HSE National Advocacy Unit

Note: 1) Some complaints contain multiple issues and therefore fall under a number of categories

2) A nil return recorded for Tallaght Hospital and Rotunda Hospital

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

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

Reviews

There were 210 requests for review received. This represents a decrease of 12.5% 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 1.7% of complaints that were made.

National Information Line

A total number of 114,801 calls were received by the National Information Line. This represents a decrease of 15,995 calls or 12% compared with 2012. Limerick Customer Service Centre, which is part of the National Information Line and provides a walk-in service, received 5,450 visitors and 2,125 postal queries during the year.

How to make a comment, compliment or complaint

- Talk to any member of Health Service staff, service manager or Complaints Officer
- Fill in the 'Your Service Your Say, Information on how to make Comments, Compliments and Complaints' leaflet and place it in provided feedback boxes
- Email yoursay@hse.ie with your feedback
- Send a letter or fax to any HSE location
- Ring 1890 737343 where your call will be answered by a staff member from Consumer Affairs

Our Population

Key Facts and Figures

- 4.589 million (m) people live in Ireland, an 8% increase since 2006 Census.
- Ireland's population is increasing at the third highest rate in the EU and has the highest proportion of young people (0-14) and the second lowest proportion of old people (65 and over) in the EU.
- However, Ireland's rate of ageing is considerably higher than the average for EU countries.
- Each year, the population continues to grow overall with an expected increase of around 20,000 persons in the number of people over the age of 65. This will impact significantly on the age distribution of the Irish population. It is projected that there will be a 66% increase in those aged over 65 years by 2026 and almost a 160% increase by 2046.
- The employment rate increased slightly in 2013 to 60.2% from 58.8% in 2012.
- Ireland has the highest fertility rate in the EU.
- 69,088 births and 31,191 deaths were registered in 2013.
- 21,541 marriages and 338 civil partnerships were registered in 2013.

Life Expectancy and Mortality Rates

- Life expectancy in Ireland has increased by a full four years since 2000 to reach 80.6 today, over the Organisation for Economic Co-operation and Development (OECD) average of 80.1.
- Male life expectancy at birth is 78.3 years while for females it is 83 years.
- The death rate per 1,000 for over 65s has fallen from 46 to just under 42.
- Mortality for circulatory system diseases in 2012 was virtually the same as that for cancer whereas it was 35% higher ten years previously.
- Both circulatory system disease and cancer accounted for 62% of all deaths registered in 2012.
- Health at a Glance 2013: OECD Indicators shows that:
  - Ireland continues to make substantive headway in improving health outcomes.
  - Mortality due to cancer fell by 21%, ischemic heart disease by 59% and cerebrovascular disease by 54% between 1990 and 2011.
  - In all three instances, the rate of decline was greater than the OECD average.

Health Inequalities

Although Ireland has experienced a downward trend in mortality since the 1980s and 1990s, significant health inequalities persist.

- From 2000-2006 the rate of mortality in the lower social class was 300% higher for all causes of death compared with the higher social class.
- The rate of mortality for cardiovascular disease was 368% higher in the lower social class.
- Males in the unskilled manual social class had a standardised mortality rate 1.8 times higher than professional males.

Health inequalities in Ireland are largely avoidable and require concerted efforts through the development of specific initiatives for vulnerable groups and the implementation of the recommendations and actions outlined in ***Healthy Ireland***.

Healthy Ireland

During 2013 ***Healthy Ireland, a Framework for Improved Health and Wellbeing 2013-2025*** was published. It sets out a whole of government and cross sectoral approach to addressing the challenges of an ageing population, together with the demands being placed on health services resulting from the growth in the incidence of chronic illness. This agenda is further supported by reform commitments in ***Future Health***, with Health and Wellbeing being one of the pillars.

Chronic diseases such as cancer, cardiovascular and chronic respiratory disease and diabetes are the leading cause of mortality, accounting for 60% of deaths worldwide and 76% of deaths in Ireland.

Managing ill health resulting from chronic conditions, including obesity and their risk factors, is expensive and is a major driver of healthcare costs. Chronic disease is generally preventable and its increase is largely attributable to behavioural factors that can be addressed and modified. At least 30% of cancers and 80% of heart disease, stroke and Type 2 diabetes can be prevented through regular physical activity, a healthy diet and non-use of tobacco products.

Healthy Ireland supports actions to:

- Increase the proportion of people who are healthy at all stages of life.
- Reduce health inequalities.
- Protect the public from threats to health and wellbeing.
- Create an environment where individuals and sectors of society can play their part in achieving a healthy Ireland.

A priority for the Health Service is the development of a three year implementation plan for ***Healthy Ireland***.

Improving Quality and Delivering Safe Services

We remain focused on the development and implementation of safe quality healthcare, where all service users attending our services receive high quality care and treatment at all times, are treated as individuals with respect and dignity, are involved in decisions about their own care, have their individual needs taken into account, are kept fully informed, have their concerns addressed, and are treated/cared for in a safe environment based on best international practice. Our patient charter, *You and Your Health Service*, is an indication of our commitment to inform and empower service users to actively look after their own health, and to influence the quality of healthcare in Ireland.

The quality and patient safety agenda covers a wide range of areas, including clinical governance and clinical leadership, ensuring safe services, monitoring the quality and patient safety performance of the system, integrated risk management and embedding national standards and recommended practices.

Priorities in 2013 included:

- Strengthening patient and service user input and advocacy.
- Promoting risk management as everyday practice across all services, and enhancing the way we manage and learn from incidents. Reporting on National Clinical Audits.
- Building leadership capacity for quality improvement in healthcare and developing a strong system of integrated corporate and clinical governance.
- Supporting implementation of the *National Standards for Safer Better Healthcare*.

Progressing Our Strategic Priorities

- A number of initiatives were implemented to build leadership capacity and strengthen governance:
  - Guidance documents and specific support were given to hospitals and services.
  - Workshops, training sessions, and on site support in hospitals delivered via the Clinical Directors' programme.
  - Leadership development through two Quality Improvement Diplomas for senior managers and clinicians on methodologies and processes for quality improvement. Fifty participants started training in Q4.
- Training competent investigators to investigate adverse events to ensure that the key causes and contributory factors are identified, quality reports produced and recommendations made to drive improvement.
- Quality and Patient Safety Audits (QPSA) to independently audit sites and services on the application and use of policies, procedures and guidelines in the delivery of services continued. Seventeen audits commenced, including in primary care, mental health, intellectual disability, acute and pre-hospital services.
- Work continued with the DoH on approving national clinical guidelines through the National Clinical Effectiveness Committee. Information on the first National Clinical Guideline, the National Early Warning Score (NEWS), can be found on page 18.

Improving the Way We Manage and Learn from Serious Incidents

When incidents occur, the Health Service has a responsibility to ensure there are systematic measures in place for safeguarding people, property, resources and reputation. This includes responsibility to learn from these incidents to identify and address the causes so that the risk of future harm arising from these causes is reduced as much as possible.

When a serious incident occurs it can have a devastating and far reaching effect. It can have an impact on those directly involved, patients, relatives, staff or visitors, and also on the reputation of the healthcare organisation.

During 2013 a number of serious incident investigation reports were published by the Health Service, including the Report of the investigation into a maternal death at University Hospital Galway in October 2012, and the report on the Midleton ambulance emergency call (6th May 2013). Reports of the National Review Panel for Serious Incidents and Child Deaths were also published. Investigations help us to learn from what happened. Implementing the recommendations from these reports is critical to ensuring safer services for the future.

In summer 2013, QPS commenced delivering training on incident management for senior managers, and training on systems analysis investigations for investigators.

Further information on serious incidents can be found at *http://www.hse.ie/eng/about/qps*

- A joint initiative, Research Collaborative for Quality and Patient Safety, was announced by the Minister for Health, Dr. James Reilly, TD at the 3rd National Patient Safety Conference. The collaboration between the Health Service, the Royal College of Physicians of Ireland and the Health Research Board aims to generate new research evidence in response to specific emerging quality and patient safety issues in health care, particularly arising from the HSE National Clinical Programmes.
- The measurement of patient experience and the culture of staff to patient safety have been initiated.

A Focus On… Open Disclosure

The launch of the HSE **Open Disclosure: National Policy and National Guidelines** represents a significant advancement in the change in culture required to have an open and transparent relationship between the patients/ service users and health and social care providers, especially after care has been sub-optimal. The policy and guidelines reflect joint work with the State Claims Agency, the feedback from groups and bodies nationally to the draft documents, and the learning from the pilot implementation in two major hospitals.

A Focus On… National Consent Policy

National policy was developed and published in the important area of consent. Consent must be obtained before starting treatment or investigation, or providing personal or social care for a service user, or involving a service user in teaching and research. The legal framework in Ireland regarding informed consent for health interventions, social care interventions, and childcare is fragmented and not very clear. Developed through an advisory group, the policy has companion guides for service users, healthcare professionals and minors. The policy will provide all users and care givers with strong support in following best practice for informed consent throughout the health service.

At the launch of the consent policy at the Patient Safety Forum were (L-R): Dr. James Reilly, TD, Minister for Health; Dr. Deirdre Madden, Chair of the HSE Consent Advisory Group; and Dr. Philip Crowley, National Director, Quality and Patient Safety.

A Focus On… It's Safer to Ask

A new patient empowerment resource **It's Safer To Ask** was launched at the National Patient Safety Conference. The leaflet encourages patients to have a greater say in the decision making about their healthcare and to influence the quality and safety of health care across health services in Ireland.

A Focus On… Safer Better Healthcare Acute Collaboration

The Safer Better Healthcare Acute Care Collaboration and the Quality and Patient Safety Division, developed a **Quality Assessment and Improvement (QA+I) toolkit** to enable hospitals to assess against the ***National Standards for Safer Better Healthcare***. The toolkit also supports the development of quality improvement plans to focus and prioritise areas requiring improvement. The toolkit consists of a web enabled tool complemented by eight individual workbooks to reflect the themes of the National Standards.

A Focus On… Clinical Governance

Three guidance documents designed to be a practical resource for health service providers were launched by the Minister for Health, Dr. James Reilly TD and Minister for Health. **Quality and Safety Committee(s): guidance and sample terms of reference** provides samples for organisations to use and adapt for their own purposes in the establishment of quality and safety board committees and also quality and safety executive committees. The **Quality and Safety Walkround Toolkit** provides a structured process to bring together senior managers and front line staff to discuss quality and patient safety with the intention to prevent, detect and mitigate patient/ staff harm. **The Safety Pause: Information Sheet**, aims to heighten safety awareness and to assist teams in being proactive about the challenges they face in providing safe high-quality care for patients. It focuses on one question – What patient safety issues do we need to be aware of today? All documents can be accessed at *www.hse.ie/go/clinicalgovernance*

Acute Hospitals Division

MAXIMISING HOSPITAL SERVICES

A key priority during the year was the continuation of the reorganisation of hospital resources to ensure that patients can access appropriate treatment in the right setting, to receive the best possible clinical outcomes and to provide sustainability for hospital services into the future.

The reports on hospital trusts (*The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts*) and the small hospitals framework (*Securing the Future of Smaller Hospitals: A Framework for Development*) provide the strategic guidance to build a modern acute hospital infrastructure and networks.

Priorities in 2013 included:

- Establishing hospital groups and associated governance and management arrangements, pending primary legislation to give full effect to establishment of public hospitals as independent not-for-profit trusts.
- Implementing the small hospitals framework ensuring patients receive high quality care in the most appropriate setting resulting in best possible outcomes.
- Commencing implementation of new methods of resourcing in hospitals to drive further efficiencies. This includes working towards implementation of the 'money follows the patient' system of funding provided on a per patient basis.
- Delivering optimal care pathways for different clinical needs enabled by implementation of national clinical programmes.

Key Facts

48 — **Acute hospitals in Irish public hospitals system**

13,576 — **Bed complement in acute hospitals (11,513 inpatient and 2,063 day beds/places)**

1.43m — **People receive either inpatient or day case treatment each year**

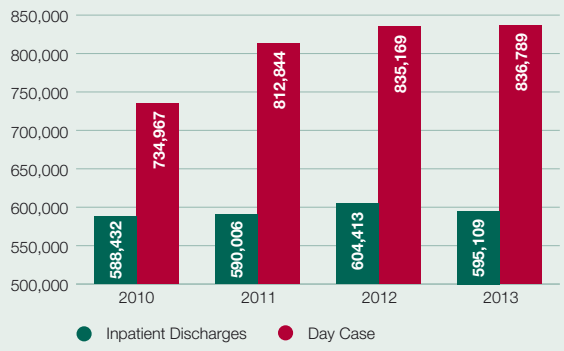
2.4m — **Attendances at hospital outpatient departments each year**

68,000 — **Births in 2013 across 19 maternity units**

Progressing our Strategic Priorities

Scheduled Care

Figure 7: Inpatient and day case activity 2010-2013



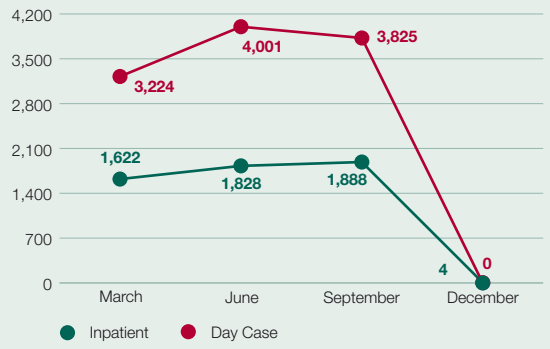
Data source: HSE Performance Reports

- 595,109 people received inpatient treatment (1.5% decrease on 2012).
- 836,789 received day case treatment (0.2% increase on 2012).

There was significant achievement of waiting list targets.

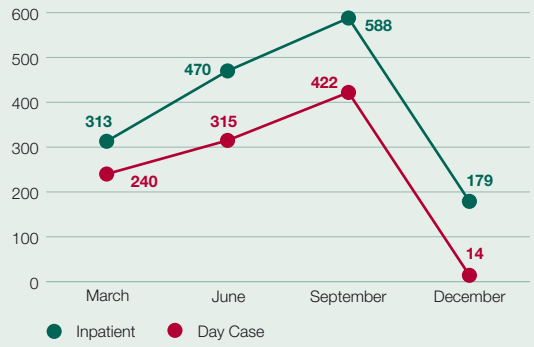
- All except one hospital reached 100% compliance with the eight-month target for elective procedures.
- There were four people waiting more than eight months at the end of December in St. James's Hospital.
- 95% of all children on the paediatric elective waiting list (excluding gastrointestinal (GI) scopes) were waiting less than 20 weeks. 193 children were waiting over 20 weeks for a procedure, at the end of December.
- 99% of people on the GI endoscopy waiting list waited less than 13 weeks. At the end of December, 1% or 96 people were waiting longer than 13 weeks.
- No patient waited longer than 28 days for an urgent colonoscopy at the end of December.

Figure 8: Adults waiting more than eight months in 2013



Data source: HSE Performance Reports

Figure 9: Children waiting more than 20 weeks in 2013



Data source: HSE Performance Reports

Outpatients

- Over 2.4m people attended an outpatient department (OPD).
- 295,815 people (98%) were waiting less than 52 weeks for an outpatient appointment at the end of December. There were 4,937 (2%) waiting over 52 weeks.
- There was a 96% reduction in the number of patients waiting more than 12 months for an outpatient appointment (over 100,000 people) and a 55% reduction in those waiting more than six months (over 105,000 people).
- There has been improved performance in attendance volume, more appropriate chronological booking and effective validation:
  - 100,000 more appointments were provided than in 2012.
  - An increase in the number of patients waiting less than three months (0.5%) and a reduction in those waiting more than 12 months (96%).
  - An additional 42,442 (6%) new attendances at OPD.

Key Targets

	Target 2013	Achieved 2013
Adult elective procedures (either inpatient or day case)	No adult will wait more than eight months	4 waiting for an inpatient procedure; None for day case
Child elective procedures (either inpatient or day case)	No child will wait more than 20 weeks	179 waiting for an inpatient procedure; 14 for day case
Urgent **colonoscopy**	No person will wait more than four weeks	No person waiting
Routine **colonoscopy or OGD**	No person will wait more than 13 weeks following referral	96 waiting
Outpatient appointments	No person will wait longer than 52 weeks	4,937 waiting
Attendance at **EDs**	95% of all attendees will be discharged or admitted within six hours of registration	66% discharged or admitted

Data source: HSE Performance Reports

Non-Scheduled Care

- 66% of patients attending EDs were discharged home or admitted within six hours (target 95%).
- 81% of patients attending EDs were discharged home or admitted within nine hours (target 100%).
- There were 393,846 emergency admissions during the year which is broadly in line with 2012. There were 1,065,571 new attendances at EDs, a 2% reduction on the previous year while elective admissions reduced by 1%.
- There was a 13% reduction in the number of ED patients waiting on trolleys for ward bed accommodation compared to 2012.

Other Indicators of Performance

- 83% of emergency hip fracture surgery was carried out within 48 hours (target of 95%).
- 62% of patients had their principal procedure conducted on day of admission, an improvement against the 56% in 2012, though still below the target of 75%.
- The medical average length of stay in December was 6.7 days, an improvement against 7.2 days in 2012 (target 5.8 days).
- The surgical patient average length of stay was 4.5 days, which exceeded the target set of 5.3 days.
- The overall average length of stay was 5.4 days which was a slight improvement on 5.7 days in 2012 and is an improvement against the target set of 5.6 days.

- A target of < 3% was set for the % of surgical re-admissions to the same hospital within 30 days of discharge. This was a new indicator for 2013 and performance exceeded target.
- There was a 14% reduction in the number of asthma bed days against a target of 10% reduction.
- There was an 18% reduction in the number of bed days for epilepsy inpatient discharges against a target of 10% reduction.
- There were 21 fewer amputations despite a rising prevalence of diabetes in the population. The reduced number of amputations resulted in 1,425 bed days being saved.

Stroke Care

Each of the stroke performance indicators showed improvements against the targets set in 2012.

- 71% acute stroke patients spent all or some of their hospital stay in an acute or combined stroke unit (target 50%).
- 13% of patients with confirmed acute ischaemic stroke in whom thrombolysis is not contraindicated, received thrombolysis (target 9%).
- 59% of hospital stay for acute stroke patients, was in an acute or combined stroke unit (target 50%).

Heart Failure

- 87% of patients with acute decompensated heart failure were seen by a Heart Failure programme during their hospital stay (target 70%).

Acute Coronary Syndrome

- 88% of ST elevation myocardial infarction (STEMI) patients (without contraindication to reperfusion therapy) received primary percutaneous coronary intervention (PPCI) (target 70%).
- 77% of reperfused STEMI patients got timely PPCI (target 70%).
- 23% of reperfused STEMI patients got timely thrombolysis (target 70%).

Preparing for 'Money Follows the Patient' (MFTP)

'Money follows the patient' is an important preparatory step towards implementation of universal health insurance. A phased approach to implementation is being applied in order to minimise the risks associated with the changing of the funding model and ensuring that hospital finances are not destabilised. During 2013:

- A pilot MFTP project was undertaken in the specialty of orthopaedics. Learning from this project is being incorporated into the wider implementation of MFTP.
- A shadow funding exercise commenced in eight hospitals to demonstrate what the financial implications of any variance from activity targets would be in a 'live' MFTP system.
- A patient level costing project was in place in 15 hospitals. This approach underpins the move away from block grants, by giving hospitals a greater understanding of actual costs for different procedures.

Other Highlights

- The Children's Hospital Group Board has been established on a non-statutory or administrative basis and will oversee the operational integration of the three hospitals in advance of the move to the new children's hospital, and a Group CEO has been appointed.
- The National Paediatric Hospital Development Board was established and is responsible for the design, planning and equipping of the new children's hospital. A Programme Director of the National Paediatric Hospital Development Board was appointed.
- As part of the reorganisation of Bantry General Hospital, the Bantry Urgent Care Centre opened and is made up of a local injury unit and a medical assessment unit. The local injury unit is open seven days a week from 8am to 8pm while the medical assessment unit is open five days a week.

A Focus On… Reorganising how we deliver hospital services

Two reports were published in 2013 which transform how acute hospital services will be delivered into the future. These are ***The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts*** and ***The Framework for Development – Securing the Future of Smaller Hospitals***.

The reorganisation of public hospitals into hospital groups and the future organisation of smaller hospitals are designed to ensure patients access appropriate treatment in the right setting, receive the best possible clinical outcomes and provide sustainability for hospital services into the future.

The framework for smaller hospitals outlines the need for smaller hospitals and larger hospitals to operate together and is intrinsically linked to the formation of sustainable hospital groups.

Seven hospital groups will implement a model of integrated care. These Groups are:

- Dublin North East
- Dublin Midlands
- Dublin East
- South/South West

The following are already established:

- West/North West
- University of Limerick Hospitals
- Children's Hospital Group

Each hospital group will comprise between six and eleven hospitals and will include at least one major teaching hospital. Each grouping will also include a primary academic partner in order to stimulate a culture of learning and openness to change within the hospital group. Robust governance and management structures are being put in place at group level.

- A new neurology day unit opened in Beaumont Hospital to treat chronic and ambulatory neurology patients, allowing easier and more timely access to services as well as reducing the number of neurology patients attending the hospital's ED. It provides a follow-up service for those attending the ED with seizures and is a key component in the development of nurse-led services.
- A new ambulatory care and diagnostic centre opened at Roscommon Hospital to provide diagnostic services and day surgery carried out under local anaesthetic.
- Our Lady of Lourdes Hospital Drogheda received gold membership of the European Network of Smoke-free Hospitals (ENSH) Forum which recognises high level implementation of comprehensive tobacco control policy. This is the highest international award achievable by the ENSH Global Network for Tobacco Free Healthcare Services.
- Cork University Maternity Hospital has been designated one of Europe's leading training centres for urogynaecology and pelvic reconstructive surgery. It is one of only seven other centres in Europe with this prestigious accreditation.
- The Rotunda Hospital was awarded maternity hospital of the year at the inaugural Irish Healthcare Centre Awards involving healthcare institutions from across the country.
- CF Matters, an international consortium of cystic fibrosis (CF) clinicians and scientists, led by University College Cork/Cork University Hospital, launched a major EU funded collaboration project focused on the development and trial of personalised antibiotic treatment for patients with CF during respiratory infections.
- As part of the reorganisation of services at Mallow General Hospital, a €4.5m capital investment provided for the following developments:
  - A new endoscopy suite with two procedures rooms, a first stage recovery room and a discharge lounge which replaces the existing endoscopy facility. The new suite has the capacity to do an additional 1,000 endoscopies annually bringing the capacity overall to in excess of 3,000 annually.
  - A new medical assessment unit and a local injury unit opened.
- The first patients moved into the new state of the art €35m critical care unit (CCU) at the University Hospital, Limerick. This CCU is one of the largest public capital projects in the State and is a key element of the development of health services in the mid-west. The new unit will ensure that critical and coronary care services of the highest level will be available and easily accessible to people in the region.
- Within 21 days of being flooded, interim ED and Radiology services reopened at Letterkenny General Hospital and work progressed on a rebuild programme with a view to full reinstatement of all clinical services.
- Emergency services at St. Columcille's Hospital, Loughlinstown were reorganised to secure the future for the hospital, ensuring it remains a vibrant, busy and modern hospital. Over €1m was invested in capital projects to support the reorganisation plan. During the year an urgent care centre was opened. Pre-hospital emergency services in the area were also improved to ensure patient treatment starts even before the patient arrives at hospital. A comprehensive intermediate care service was established to support the successful integration of St. Columcille's with St. Vincent's Hospital.

Dr. Ciara McGlade, Consultant Geriatrician with Dr. John Kiely, General Physician and Mary Owen, Director of Nursing in the new Medical Assessment Unit in Mallow General Hospital.

Quality Initiatives in Acute Hospitals

National Standards for Safer Better Healthcare

- Information sessions were undertaken around the country on the standards and approach to assessment against the *National Standards for Safer Better Healthcare*.
- Quality Assessment and Improvement tools were launched. These resources include a web enabled tool, eight workbooks which complement the web enabled tool and a Practical Guide to undertaking quality assessments. They set out the key principles of quality and safety that should be applied in any healthcare setting.
- Regional Standard Support Groups have been established.

National Transport Medicine Programme

- The National Neonatal Retrieval service extended to a 24/7 service.
- An interim lead has been appointed to the Paediatric Retrieval Service and an outreach education programme to paediatric units nationally has commenced.
- An interim clinical lead has also been appointed to the Adult Retrieval Programme. Critical care trolleys with capability to transport patients on Intra-Aortic Balloon Pump are now in place in Beaumont Hospital, Mater Misericordiae University Hospital, Tallaght Hospital, St Vincent's University Hospital, St James's Hospital, Cork University Hospital, University Hospital Limerick and University Hospital Galway.

Endoscopy Services

Endoscopy Services progressed during the year:

- National Quality Assurance Programme in GI Endoscopy.
- An Endoscopy Reporting System in place in 22 hospitals.
- Reusable Invasive Medical Devices National Track and Trace Project.

Following an audit of endoscopy equipment undertaken in 2012, a capital replacement programme was agreed. An allocation of €16.541m was made which enabled the replacement of some 511 endoscopes and other equipment. This investment will have a significant impact on patient safety and will result in savings of €12m being achieved over the next seven years due to the renegotiation of service contracts and replacement costs.

Implementation of Recommendations

The HSE investigation into the death of Ms. Savita Halappanavar was completed in 2013. The subsequent HIQA investigation into the safety, quality and standards of services provided by the HSE to patients, including pregnant women, at risk of clinical deterioration, including these provided at University Hospital Galway, and as reflected in the care and treatment of Ms. Savita Halappanavar, was published in October 2013.

The Health Service has established a National Implementation Group to oversee and generally ensure recommendations of Health Service/HIQA reports are progressed in a timely and effective manner. The National Director of Acute Hospitals has been assigned responsibility for ensuring arrangements are put in place to implement the findings and recommendations of these reports.

The West/North West Hospital Group has established a Maternity Services Implementation Group to oversee relevant local/national recommendations from Health Service/HIQA reports.

IMPLEMENTING NATIONAL CLINICAL PROGRAMMES

Central to the significant transformation that is underway across the Health Service, is the work of the national clinical programmes. These clinically led programmes provide a strategic approach to the reform of a broad range of services in the acute, community and social care sectors. The programmes are modernising the way in which services are provided through standardising the delivery of high quality, safe and efficient services.

Progressing our Strategic Priorities

- There was continued implementation of clinical programmes and work across all Divisions through:
  - Developing multi-professional, multi-agency partnerships to reduce the number of hospital attendances and admissions at a time of considerable growth in demand.
  - Improving hospital systems, processes and patient flow across organisational boundaries, especially at the arrival, admission and discharge interface.
- Chronic condition management programmes were developed across the spectrum of services from prevention to sustaining services including specific additional investment in diabetes services.
- Savings were delivered in drug expenditure as a result of the quality prescribing project as part of the Medicines Management Clinical Programme.

Some Highlights

- As part of the work of the National Acute Medicine Programme (NAMP), a national clinical guideline and new patient safety initiative was launched, the National Early Warning Score (NEWS) for Ireland. This guideline, based on international best evidence, is designed for adults in acute hospitals to facilitate the early detection and management of patients who are deteriorating clinically. Ireland is the first country to agree such a guideline. NEWS and its associated Education Programme, COMPASS, is now implemented in all 41 acute and single speciality hospitals.
- The Surgery Programme launched the *Model of Care for Acute Surgery*, a companion document to the Model of Care for Elective Surgery. It sets out the principles necessary for separating the flows of acute patients from elective patients, good governance, the need for the early participation of senior decision makers and the provision of dedicated beds, theatres and acute surgical assessment units. This model includes an analysis of the surgical workload by Health Service region.
- The Anaesthesia Programme progressed a number of work streams including the pre-admission programme, anaesthesia nursing education, manpower planning and clinical audit.
- There are currently 13 sites participating in The Productive Operating Theatre (TPOT) process improvement initiative, supported by the Surgery and Anaesthesia Programmes. TPOT utilises Lean methodologies and delivers significant improvements to operating theatres, enabling them to transform the way they work, providing better patient care within a better working environment.

The Productive Ward in Ireland: A Design for Implementation

Mark White, National Programme Lead, and Dr. Áine Carroll, National Director, at the recent all-Ireland Productive Ward conference

This initiative won the 2013 prestigious **Lean Healthcare Academy International Award** for its project structure and implementation to-date. The project highlights the importance of implementation and design planning and provides a framework which can be used by other international healthcare organisations engaged in the roll out of the Productive Ward programme. The aim was to select ground sites, support them to use the Productive Ward to improve, and then to act, as exemplars of improvement to help guide other sites.

Phase 1 included the participation of 17 hospitals (24 wards) countrywide while a further 2 hospitals (13 wards) commenced Phase II in 2013. Results to date include:

- A reduction in unplanned absenteeism
- A reduction in falls
- Saving of thousands of hours of interruption and a saving of thousands of euros in start-up costs because of collective training.

- The Critical Care Programme continues to support implementation of the Hub and Spoke delivery model in hospital groups. A bed stock and manpower census was completed. The national critical care audit data is being collected in 10 ICU centres.
- As part of the National Stroke Programme, the Early Supported Discharge Initiative aims to deliver high-quality care to patients in their homes, reducing cost and hospital stay. It is one of a number of approaches aimed at reducing the hospital stay of stroke patients. There are three early¬ support discharge programmes in place (Mater Misericordiae University Hospital, Tallaght Hospital, and University Hospital Galway).
- As part of the work of the COPD (Chronic Obstructive Pulmonary Disease) Programme, there is access to a structured pulmonary rehabilitation programme in 24 acute hospitals and 14 integrated service areas (ISAs). There is also a structured COPD outreach programme operational in 14 acute hospitals.

A Focus On… Diabetes

Diabetes is a serious metabolic condition in which the body fails to produce enough insulin to regulate blood glucose (sugar). There are approximately 190,000 diabetes patients in Ireland and this figure is expected to rise to almost 280,000 by 2030.

The **National Diabetes Programme** aims to develop a model of care through which all diabetes patients could have access to a structured integrated care package covering all aspects of their diabetic care. In 2013:

- €1.8m funding was provided to implement the Integrated Care Pathway for Diabetes with the approval of 17 integrated care diabetes nurse specialists. By year end ten were in post with the others in process.
- An additional €1.1m was targeted for diabetic retinopathy screening for 30% of eligible population (in six identified sites to people with diagnosed diabetes aged 12 years and over). This target was reached by December 2013.
- €1.8m was also allocated for diabetic treatment.
- A population register was completed and a memorandum of understanding put in place to address treatment in designated locations.
- The national footcare programme is being rolled out and training is ongoing across all areas.

The vast majority of diabetes in childhood is type 1 diabetes. The incidence of type 1 diabetes in children is increasing yearly and is highest in the under five age group.

The provision of insulin pump therapy to children under five years is part of the National Diabetes Programme. It improves blood glucose control and quality of life and reduces the long-term complications associated with diabetes such as blindness, coronary heart disease and kidney failure.

Success at Irish Healthcare Awards

A **diabetic retinopathy screening initiative** was undertaken over a two-year period to provide community based retinopathy screening in Cork and Kerry pending the introduction of the national screening programme. It demonstrated how existing resources in the community and the implementation of the national diabetic retinopathy screening service is the optimum way to detect and treat diabetic eye disease into the future.

- The multi-disciplinary Medicines Management Programme (headed by the National Medicines Information Centre and the National Centre for Pharmacoeconomics, in collaboration with the Primary Care Reimbursement Service) provides national leadership on issues such as the quality of the medicines management process, cost effectiveness of overall drug expenditure and access to other essential (frequently high cost) medicines for all Irish citizens.

  The Programme has identified 'preferred drugs' for prescribers. This is the first time that the State has introduced a preferred drug initiative. These are medicines that the Programme recommends as the drugs of 'first choice' to prescribers.

  This is a large scale behaviour change project where changing prescribing patterns to the preferred drugs can save approximately €17m a year. A large scale education programme for GPs is underway.
- The Acute Coronary Syndrome (ACS) Programme aims to improve and standardise the care of patients who experience heart attacks. Ambulances are equipped with 12 lead electrocardiogram (ECG) machines and paramedics trained to recognise a major heart attack and to transport patients to the best place for appropriate care.
  - An Optimal Reperfusion Service went national at the beginning of the year. Under this service, any patient with an acute heart attack within 90 minutes of travel time to a designated PPCI centre, is brought straight to the centre, where they receive emergency treatment in the cardiac catheter laboratory.
  - The seven designated PPCI centres are: Cork University Hospital, University Hospital Galway, University Hospital Limerick, St. Vincent's University Hospital, St James's Hospital, Mater Misericordiae University Hospital, all on 24/7 basis and Waterford Regional Hospital (9-5 centre).
  - There has been a marked increase in the % of acute heart attack patients receiving PPCI over the clot-busting thrombolytic drug.
  - The PPCI centres, associated network referring hospitals, National Ambulance Service and Emergency Aeromedical Service have all been pivotal to the success of this programme.

ENHANCING CANCER SERVICES

Cancer services are committed to maximising timely access to quality services based on evidence and best practice. The National Cancer Registry projects that the incidence of cancer will more than double over the 30 year period to 2040 and reports that the number of newly diagnosed cancers in Ireland is increasing by 3%-4% annually alongside increased costs, and new and innovative treatments.

Priorities in 2013 included:

- Rolling out of colorectal national cancer screening programme and diabetic retinopathy screening programme.
- Continuing the transfer of major cancer surgeries into designated cancer centres.
- Progressing the expansion of radiation oncology facilities and implement a national medical oncology programme.

Progressing our Strategic Priorities

- €17m was made available to support the cost of new intravenous cancer drugs and to help hospitals address growth in expenditure on existing oncology drugs. National protocols were agreed and published for all new oncology drugs.
- 43,651 patients attended rapid access clinics:
  - 37,891 attendances at breast clinics with 2,042* primary cancers diagnosed.
  - 2,890 attendances at lung clinics with 868 primary cancers diagnosed.
  - 2,870 attendances at prostate clinics with 1,034 primary cancers diagnosed).

*Indicative figure

Key Targets

	Target 2013	Achieved 2013
Breast Cancer: i) Women triaged as urgent offered an appointment within two weeks, and ii) those triaged as non-urgent within 12 weeks	i) 95% ii) 95%	i) 98% ii) 96%
Lung Cancer: patients offered an appointment to attend a lung rapid cancer access clinic within 10 working days of receipt of referral in the cancer centre	95%	91%
Prostate Cancer: patients offered an appointment to attend a prostate cancer rapid access clinic within 20 working days of receipt of referral in the cancer centre	90%	55%**

Data source: HSE Performance Reports

** The Rapid Access Clinics in Waterford, Limerick and Galway are currently experiencing particular pressures. Approval has been given for the appointment of additional urologist posts in the West and South East. All referrals to these centres are triaged and urgent cases are prioritised for appointments.

Key Facts

98% **Urgent breast referrals seen within 2 weeks**

96% **Non-urgent breast referrals seen within 12 weeks**

43,651 **Patients attended rapid access clinics**

91% **People were offered appointments within 10 working days at rapid access lung clinics**

14,978 **Urgent attendances at symptomatic breast cancer services and 22,913 non-urgent**

3,951 **Patients completed radical radiotherapy treatment**

In addition

- The two hereditary cancer clinics in St. James's Hospital and the Mater Misericordiae University Hospital were expanded. There was a 35% increase in numbers of genetic tests from these NCCP funded clinics.
- A new intracranial stereotactic radio-surgery service was launched at St. Luke's Radiation Oncology Unit, Beaumont Hospital, Dublin. This service is designed to treat patients with cancerous and benign brain tumours. The St. Luke's Radiation Oncology network site based in St. James's campus won the Radiation Therapy Department of the Year at the Medray/IIRT X-Ray Awards 2013.
- The transfer of major cancer surgery into eight cancer centres is progressing. Work is ongoing to centralise rectal, prostate and upper gastrointestinal surgeries. Some delays have been encountered due to the acute hospital reconfiguration programme.
- A national oncology medication safety review was completed of all 26 hospitals involved in the administration of systemic cancer therapy in adults and children, to assess the oncology medication policies and practices in day units, from a patient safety and quality perspective.
- National audit, quality and risk events were held for prostate, breast and lung cancer.
- National guidelines for the management of pigmented lesions have been agreed.
- A breast pain application (app) was launched and is available for smart phones to assist in reducing the number of referrals of women under the age of 35 with bilateral cyclical breast pain.

BreastCheck
The National Breast Screening Programme

This is the National Breast Screening Programme which offers women aged 50 to 64 a free mammogram every two years.

- BreastCheck commenced in 2000
- Over 371,200 people have been screened since its introduction
- 144,000 women were screened in 2013, 3% above target
- 74.5% of eligible women invited for screening accepted their invitation, in excess of the programme target of 70%

CervicalCheck
THE NATIONAL CERVICAL SCREENING PROGRAMME

This is the National Cervical Screening Programme which offers free smear tests to women aged 25-60

- CervicalCheck commenced in 2008
- Women aged 25 to 44 should have a smear test every three years and women aged 45 to 60 should have one every five years
- Almost 1.3m smear tests undertaken to date and more than 805,000 women have had at least one test
- Almost 75% of women aged 25-60 availed of their smear test
- Over 344,000 women received at least one smear in 2013

Diabetic RetinaScreen
The National Diabetic Retinal Screening Programme

This is the National Diabetic Retinal Screening Programme

- Diabetic RetinaScreen commenced in Q1 2013
- People with both Type 1 and Type 2 diabetes are at risk of developing diabetic retinopathy (190,000)
- 30% of the eligible population were invited for screening in 2013 as planned
- The programme aims to reduce the risk of sight loss amongst people with diabetes

BowelScreen
The National Bowel Screening Programme

This is the National Bowel Screening Programme for the early detection of bowel cancer in men and women

- BowelScreen commenced in Q4 2012
- Colorectal cancer is the second most commonly diagnosed cancer in Ireland with over 2,000 cases each year and the second most fatal cancer
- Screening is initially being offered to men and women aged 60-69
- The screening test is a FIT (Faeco-Immunochemical Test) which is a simple test done in the home every 2 years
- Over 60,000 people were invited to participate in the programme in 2013
- 12 endoscopy units achieved accreditation, nine of which provide screening colonoscopies for the programme. Additional units will come on stream in 2014

IMPROVING THE PROVISION OF PALLIATIVE CARE

Palliative care services are committed to ensuring that patients with life limiting conditions, and their families, can access a level of palliative care service that is appropriate to their needs, at the right time, in the right place, by the right team.

Priorities in 2013 included:

- Delivery of generalist and specialist palliative care services in line with policy direction, while improving resource utilisation including assessment of need, access and referral to services
- Developing paediatric palliative care services.

Progressing our Strategic Priorities

- A palliative care prospective funding model is being developed which will be submitted to the DoH Universal Health Insurance Group to inform their deliberations.
- As part of the *National Standards for Safer Better Healthcare*, eight specialist palliative care quality assessment and improvement workbooks have been developed for implementation.
- A report on the learning from demonstration projects on COPD, heart failure and dementia is in its final stage and will progress the integration of palliative care into the management of chronic diseases as described in *Palliative Care for All*.
- The development of a best practice model of palliative care in ED settings has commenced in conjunction with the Emergency Medicine Programme. St. Vincent's University Hospital has been awarded a grant and the project will start in 2014.
- Evidence based guidelines/clinical pathways for generalist and specialist palliative care practitioners for cancer pain, constipation, rapid discharge and needs assessment are nearing completion.
- *The Palliative Care Competence Framework*, for 12 healthcare disciplines, has been developed for publication.

Key Targets

	Target 2013	Achieved 2013
Specialist inpatient beds provided within seven days	93%	95%
Home, non-acute hospital, long term residential care delivered by **community teams** within seven days	83%	87%

Data source: HSE Performance Reports

Key Facts

2,894 — **Admissions to specialist palliative care inpatient units**

95% — **Patients were admitted within seven days of referral**

3,149 — **People on average accessed community specialist palliative care services each month**

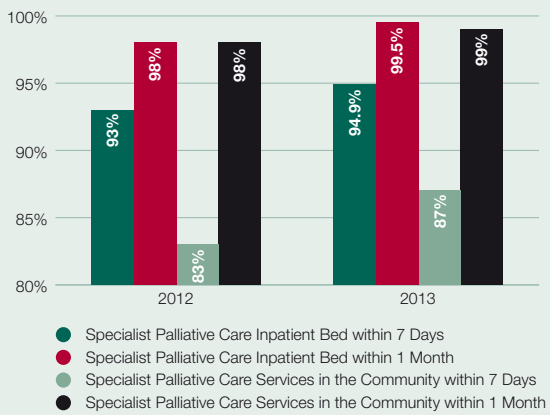
732 — **New patients on average each month received specialist palliative care in the community**

87% — **People were seen with seven days of referral**

946 — **New patients in receipt of specialist palliative day care services**

158 — **Patients on average each month in receipt of care in a designated palliative care bed in a community hospital**

Figure 10: Palliative care wait times



Data source: HSE Performance Reports

- A review of palliative care support beds was completed. A strategic plan for the effective and efficient use of the beds will be developed and implemented in 2014.
- In conjunction with the Irish Hospice Foundation, recommendations in *Palliative Care for Children with Life-Limiting Conditions* in Ireland (2009) are being implemented:
  - Eight nurses have been recruited to extend the provision of co-ordinated care to children and their families.
  - A range of education and training programmes have been developed to support staff across all disciplines to meet the needs of children and their families.
  - A plan for the evaluation of five elements of the Children's Palliative Care Programme has been finalised. The 15 month evaluation will commence early next year.

A Focus On… Design and Dignity

The **Design and Dignity Grants Scheme** brings excellence to the physical environment in which people spend the last days of their lives.

11 projects are supported by the grants scheme which will benefit thousands of our most vulnerable patients and their loved ones.

Under the Scheme initiated by the Irish Hospice Foundation's Hospice Friendly Hospitals Programme, in conjunction with the HSE, a redesigned and refurbished mortuary was opened in the Mercy University Hospital in Cork. In addition, the Standing Committee for End of Life Care co-ordinated the delivery of training for staff and introduced resources such as the End of Life Care symbol, bed and trolley drapes and specially designed handover bags to return patients property to families.

Pictured (L-R) are: Sandra Daly, CEO, Mercy University Hospital; John Buttimer, Lord Mayor of Cork City; Maura Derrane, RTE; and Michael O'Reilly, Chairman of The Irish Hospice Foundation

National Ambulance Service

2013 was a challenging year for the National Ambulance Service (NAS) with significant growth in the number of high acuity emergency calls (ECHO and DELTA). The service also increased the total volume of these calls that it responded to within the 18 minute 59 second target, increasing from just over 4,500 per month to almost 5,000 per month over the course of the year.

All emergency responses are now attended by qualified paramedics and advanced paramedics who deliver lifesaving treatments and therapies to patients, often before the arrival of an ambulance vehicle to carry the patient to hospital.

Priorities in 2013 included:

- Improving response times.
- Putting in place a single National Control Centre over two sites.
- Developing clinical outcome indicators to support the enhancement of patient safety and quality improvement.
- Rolling out a national Mobile Data and electronic Patient Care Record (ePCR).
- Delivering separate Pre-Hospital Emergency Care and Intermediate Care Services (ICS).
- Rolling out the national Appropriate Hospital Access Protocols to standardise patient transfer to EDs/other areas.
- Evaluating the national pilot Emergency Aeromedical Service (EAS).
- Supporting the continuing professional competence of paramedics and advanced paramedics.

Key Facts

330,000 — **Total calls received**

281,003 — **Emergency calls received, increase of 14,000 calls on 2012**

453 — **Missions completed by the Emergency Aeromedical Service since its establishment**

47 — **Paramedics/Advanced paramedics trained during the year**

523 — **Emergency vehicles on the road**

54 — **Intermediate Care Vehicles**

Progressing Our Strategic Priorities

There has been significant investment in the National Ambulance Service over the past number of years as part of transformation.

Single National Control Centre

- The move to a single national control centre over two sites (Ballyshannon and Tallaght) was progressed through a total planned investment of €26.2m. This included revenue (€4.44m) and capital (€7m) in 2013. An additional 55 WTEs were allocated of which 44 (80%) were in post by end 2013.
- Nine control centres will move into one National Control Centre over two sites; the migration of Cork, Tralee and Navan Control Centres to Townsend Street Control Centre was completed in 2013.
- The implementation of Tetra Digital Radio continued across the country, which has greatly improved voice communication, vehicle location and data management.

Intermediate Care Services

- €2.95m was invested in the development of the Intermediate Care Services (ICS) and enhancement of Emergency Care Services. This is a more appropriate model of patient transfer service for people who need to move between hospitals or other care facilities. ICS frees up emergency ambulance personnel to focus on the core function of the delivery of pre-hospital emergency care.
- A positive effect on availability of emergency ambulances is evident when ICVs cover patient transfers. By December 2013, over 70% of the total patient transfer calls were handled by ICVs compared to August when all patient transfers were carried out in emergency ambulances.
- 25 intermediate care vehicles were procured and 73.4 WTEs were appointed to Intermediate Care Operative (ICO) positions across the country in 2013. This brings the total available to 54 vehicles and 120 WTEs.

Vehicle and equipment replacement programme

A major vehicle and equipment replacement and upgrade programme was carried out in 2013:

- €9.3m has been invested to facilitate the purchase of:
  - 27 Emergency Ambulances
  - 27 additional Rapid Response Vehicles
  - 25 additional Intermediate Care Vehicles.

Key Targets

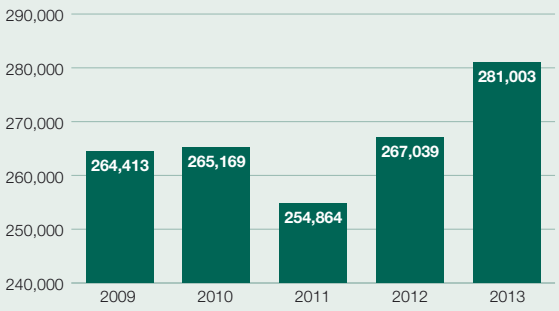
	Target 2013	Achieved 2013
% of **Clinical Status 1 ECHO** incidents responded to by a patient-carrying vehicle in **18 minutes and 59 seconds** or less (HIQA target 85%)	> 70%	69.3%
% of **Clinical Status 1 DELTA** incidents responded to by a patient-carrying vehicle in **18 minutes and 59 seconds** or less (HIQA target 85%)	> 68%	63.8%

Data source: HSE Performance Reports

Note:

- ECHO calls are calls to patients who are in cardiac or respiratory arrest.
- DELTA calls are calls to patients who are in life-threatening conditions other than cardiac or respiratory distress.

Figure 11: Total no. of emergency ambulance calls



Data source: National Ambulance Service

In addition

- The Ambulance Quality Improvement Group (AQuiP) developed a suite of clinical outcome indicators which underwent external peer review and evaluation. Collection and reporting of these will be phased in during 2014.
- Following additional budget funding of €0.8m, 2.3 WTEs were recruited to the EAS and training commenced. The review of the service was finalised and submitted to the Minister in July.
- A 30% reduction was achieved in staff overtime costs versus 2012. Pay costs were €1.8m less. On call cover in the South was completely eliminated, with progress made in the West with a project plan in place. The North Leinster service reduced their overtime by 58% with a saving of nearly €2m.
- The national absenteeism rate for NAS has continued to fall and was 4.68% in December (reduced from almost 7% at the start of 2013).
- Continuous quality improvement, focused improvement in response times, reconfiguring services and delivering service plan initiatives on intermediate care, aero-medical services, control services and robust budget management were key priorities for management and staff. While response times are showing some improvement, issues such as geographical location, delays in hospital turnaround times and poor road infrastructure are impeding responses within the requisite timeframes – good progress has been made in meeting the HSE target of > 70% response for clinical status 1 calls, however, there is still improvement needed in terms of meeting all the targets identified by HIQA. An intense focus on these will continue into 2014 when improvements in data quality and the implementation of the performance framework will assist in making the necessary improvements to reach targets.
- In 2013 a total of 281,003 emergency calls were received. This is an increase of 13,964 calls when compared to 2012, which equates to an average monthly increase of more than 1,000 calls.

A Focus On… RTÉ Ireland's Search and Rescue Series

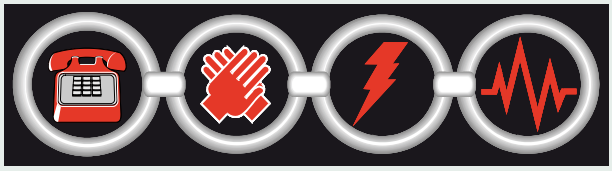
The life-saving work of HSE South's emergency medical response team doctors and paramedics bringing emergency medicine to the roadside was featured in a television documentary series during 2013, which drew over one million viewers.

The doctors based at Cork University Hospital are the only team in Ireland formally dispatched by the National Ambulance Service to travel out to treat critically ill patients at the scene. The team is led by a professor in emergency medicine ensuring strict adherence to patient safety protocols.

Dr. Jason van der Velde, one of HSE South's emergency medical response team doctors, who featured in the series

A Focus On… First Responders

Five new **Community First Responders** Schemes went live in 2013, bringing the total number of schemes nationally to 93. For example, in October, Croílíne Chois Fharraige was launched in Spiddal, Co. Galway to provide the local community with resources to respond quickly and effectively to cardiac arrest. Officially registered with the HSE West Ambulance Service, the group will be activated by the ambulance service to respond to appropriate calls in the area.



Primary Care Division

SUPPORTING PEOPLE IN PRIMARY CARE SETTINGS

The development of primary care is a key element of the overall health reform programme. The main objective is to achieve a more balanced health service by ensuring that the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings.

Future Health provides the framework for health reform and for the introduction of universal health insurance with equal access to care for all. A central tenet of Future Health is the strengthened role of primary care with primary care teams (PCTs) being the central point of service delivery in the community. Evidence shows that the cost effectiveness of any national health care system is strongly correlated with the strength and position of primary care within that system.

Priorities in 2013 included:

Primary Care

- Strengthening primary care teams and community intervention teams.
- Introducing chronic disease management programmes including:
  - Implementation of the national diabetes integrated care package and the appointment of 17 integrated care diabetes nurse specialists as well as the diabetic retinopathy screening programme.
  - Continued implementation of the audiology programme.
- Providing appropriate accommodation to enable the successful functioning of PCTs through the development of primary care centres.

Social Inclusion

- Delivery of specific targeted services for people who may experience social exclusion, supporting enhanced responsiveness of mainstream services and facilitating partnership and inter-sectoral working.

PCRS

- Provision of a wide range of community schemes nationally to 3.4m people by 7,007 primary care contractors, including general practitioners, pharmacists, dentists and optometrists or ophthalmologists.

Enhancing Primary Care

Key Facts

978,071 — **Contacts with GP out of hours services**

175,926 — **Physiotherapy referrals received**

145,000 — **Physiotherapy patients seen for a first time assessment**

75,800 — **Primary care occupational therapy referrals received**

12,216 — **Patients on average received a direct occupational therapy service each month**

93% — **Patients on orthodontic assessment waiting list waited < 12 months**

Progressing our Strategic Priorities

- €20m additional funding was provided to support the recruitment of prioritised front line PCT posts, including €1.475m to further develop community intervention teams.
- 138.5 of these 264.5 new primary care posts took up duty with the recruitment of the remainder in progress.
- 467 PCTs were established with 419 having regular multi-disciplinary clinical meetings.
- Over 1,317 primary care staff have been assigned to Health and Social Care Networks.
- A review of orthodontic services was completed which outlined the need for clear governance arrangements for orthodontic services.

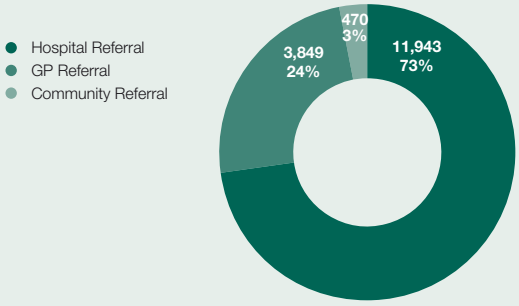
- Four dental inspectors commenced assessment of all new contract holders entering the Dental Services Scheme, regarding acceptable standards of practitioners and premises. A number of probity investigations were undertaken in Dental Treatment Services Scheme (DTSS) practices.
- Full self-assessment assurance of dental council standards in relation to infection control was carried out across all salaried dental services, including new contract entrants who were separately inspected.
- All regions had at least one trained dental team providing intravenous sedation as an alternative to patients awaiting general anaesthetic services in hospitals.
- 196 health centres implemented the Tobacco Free Campus Policy and all new primary care centres opened are tobacco free.

Pictured at the official opening of Tramore Primary Care Centre were (L-R): Cllr. Paddy O' Callaghan; Cllr. Dee Jacques; Pat McDonald, Developer, Summerhill Centre; Ciara Conway TD; Alex White TD, Minister of State for Primary Care; Anna Marie Lanigan, Area Manager, South East Community Services and St. Luke's General Hospital; Richard Dooley, General Manager, Waterford Regional Hospital/South East Acute Services; TJ Dunford, General Manager, Waterford Community Services; and Susan Murphy, Primary Care Lead, Waterford Community Services

Enhancing primary care services

- €1.475m was allocated to fund or expand CITs in the following areas:
  - Expansion of existing CIT in Dublin South to cover Wicklow (Dublin Mid-Leinster).
  - Expansion to Dublin North and Dublin North City (Dublin North East).
  - New CIT in Galway (West).
  - Expansion to existing CIT in Carlow/Kilkenny (South).
- Overall, CITs received 16,262 referrals, an increase of 24% on the previous year.
- National Electronic GP Referral Pilot: Phase 1 continued with pilot projects in the South (160 GPs) and Tallaght (36 GPs). The HIQA general referral form was integrated into the four accredited GP software packages. This enables electronic referral to and from the hospital from a GP perspective.

Figure 12: CIT referrals 2013



Data source: HSE Performance Reports

Chronic Disease Management

Clinical Programmes including diabetes, heart failure, stroke and COPD all progressed during the year.

Additional funding of €1.8m was targeted towards implementing the **National Integrated Care Package for Diabetes**. 17 integrated care diabetes nurse specialists were approved and by year end, ten were in post with the others in process.

The **Heart Failure** and **Diabetes** Programmes commenced a screening project for left ventricular dysfunction among diabetic patients to focus cardiovascular prevention strategies on high risk patients, defined by BNP testing. This will reduce hospitalisations and enhance new diagnosis of heart failure in the community. It is based on community outreach, mobile diagnostics and virtual consultation in the Midlands.

Early supported discharge programmes for **Stroke** were implemented in the Mater, AMNCH Tallaght and Galway University Hospitals. The integrated hospital and primary care Atrial Fibrillation Screening in General Practice Study was progressed. The two implementation sites are Galway University Hospitals and Sligo Regional Hospital. An expression of interest was issued to GPs in Galway and Sligo/Leitrim and 100 GPs have signed up to participate. An education programme was delivered and document packs and on-line resources made available to GPs.

Pulmonary Rehabilitation is accessible for **COPD** in 14 Integrated Services Areas or 66% of ISAs.

The **National Radiology Programme** undertook a survey of 47 radiology departments within the largest public hospitals. This involved an assessment of current levels of GP access to radiology diagnostics within hospitals providing radiology services. Recommendations included agreeing acceptable waiting times for investigations, developing protocols and referral pathways for a range of radiological investigations and the establishment of a steering committee to progress recommendations. Work on this is underway.

Strengthening cancer care in the community

- Prostate e-learning was completed and rolled out for GPs.
- Follow-up guidelines for breast cancer patients, who are five years post treatment, were circulated to GPs and specialist breast centres. This primary care-based service is for women who successfully completed their hospital treatment for breast cancer and are discharged to their GP.
- University accreditation for the community nurse training programme for cancer care was received from the National University of Ireland, Galway and the Community Oncology Nurse Education Programme.
- A training programme for primary care nurses was delivered across all regions and areas. Topics included cancer epidemiology, prevention and healthy lifestyles, cancer screening, referral and management of cancers. Training was attended by approximately 600 nurses.

Audiology

- Newborn hearing screening has been rolled out across all regions.
- €1.9m additional funding was allocated to progress implementation of the recommendations from the *National Audiology Review*.
- A National Clinical Lead and Assistant National Clinical Lead for Dublin North East were appointed. Other Assistant Lead posts are being progressed.
- A business case is progressing for the implementation of an Audiology IT Patient Management System.
- The national bone anchored hearing aid programme was rolled out to the designated six hospital sites.
- A waiting list initiative commenced across the country resulting in reduced waiting lists and times for appointments.

Developing primary care infrastructure

A modern, well-equipped primary care infrastructure is central to the effective functioning of PCTs.

- Considerable progress has been made in the delivery of primary care centres (PCCs) and 34 centres have opened since 2011. A total of seven new PCCs were completed or opened in 2013.
- The National Development Finance Agency (NDFA), on behalf of the Health Service, gave notice of its intention to procure a Public Private Partnership within the PCC Programme to design, build, finance and provide services to between 10 and 14 PCCs.

The new Blanchardstown Primary Care Centre which opened its doors to the public in November 2013

TACKLING SOCIAL EXCLUSION

Key Facts

2,000 — **People admitted to emergency accommodation hostels/facilities each quarter**

64% — **Of those admitted had a medical card on admission**

9,655 — **Clients in receipt of methadone at year end, 539 clients within prisons**

3,812 — **Clients treated by GPs in the community with methadone dispensed by 600 pharmacies**

95 — **Pharmacies providing needle exchange services**

Social Inclusion has a remit for a range of issues and vulnerable groups, including addiction, alcohol, homelessness, intercultural health (including asylum seekers, refugees and migrants), Irish Travellers and Roma, Lesbian, Gay, Bisexual and Transgender (LGBT) and HIV/AIDS.

Census 2011 figures reflect the continuing growth in ethnic and cultural diversity of the population (for example 12% of the population in Ireland is born in other countries).

Priorities in 2013 included:

- Delivery of specific targeted services for people who may experience social exclusion, supporting enhanced access to mainstream services and facilitating partnership and inter-sectoral working wherever possible.

Progressing our Strategic Priorities

Homeless Services

- 76% of service users admitted to homeless emergency accommodation hostels/facilities had their needs formally assessed within one week and 66% had a written care plan in place within two weeks.
- 64% of service users admitted to emergency accommodation hostels/facilities had a medical card on admission.

Intercultural Health

- The *Intercultural Guide* was converted into an app for use on mobile devices facilitating immediate information and support for service providers working with service users from diverse cultures and faiths.

Traveller Health

- An asthma education programme was developed as a partnership project between the Health Service, Pavee Point and the Asthma Society of Ireland.

Roma Health

- Since the establishment of the Roma GP Mobile Clinic in 2012, demand has led to increasing the service to two sessions each week. This is a multi-agency primary care initiative between the Health Service, Tallaght Roma Integration Project, Safetynet, Pavee Point and Tallaght Hospital. Attendance at the clinic should result in:
  - A reduction in the use of ED at Tallaght Hospital by the Roma community, thus reducing cost of health care provision.
  - Alleviating health inequalities experienced by the Roma population in Ireland.

Substance Misuse

- Of the 9,655 clients in methadone treatment, 9,116 or 94% were receiving treatment outside prisons with 539 clients or 6% in methadone treatment in prisons.
- 73 Health Service clinics provided methadone treatment, with an additional ten clinics provided in the prison service.
- 3,812 were treated by GPs in the community, and methadone was dispensed by 600 pharmacies.
- 754 clients attended at pharmacy exchange clinics, 88% above target.
- The National Drugs Rehabilitation Framework (NDRF), which was developed in 2010, was piloted in 10 sites during 2013, and an evaluation has recently been completed by Trinity College Dublin. The research found that there was almost universal agreement on the Framework, and that a considerable shift in focus on how services are delivered is required.

Needle Exchange Programme

- 95 pharmacies are currently providing needle exchange, 27% below the target of 130. Training is continuing to enable pharmacies sign service agreements.
- 2,742 pharmacy needle exchange packs were provided, 52% above target.
- 719 clients on average each month availed of pharmacy needle exchange, 80% above target.
- On average 81 needle/syringe packs were provided per person each month with a return rate of 32%.
- Reports were produced on opioid substitution therapy and a national waiting list analysis was conducted. 22 of the 48 clinics had no waiting times, and 33 of the 48 had waiting times of less than one month.
- One day seminars on Screening and Brief Intervention for Problem Substance Misuse were held across the country as well as Training for Trainers.
- A Hidden Harm National Project Steering Group identified two pilot sites for the development of a practice change initiative.

PROVIDING COMMUNITY SCHEMES

Key Facts

1.8m — **People or 40.3% of the population covered by a medical card, of which 50,294 or 2.7% were granted on discretionary grounds**

125,426 — **People covered by GP visit cards, of which 25,793 or 20.6% were granted on discretionary grounds**

98% — **Completed applications processed within 15 days**

20.1m — **GMS prescriptions claimed with almost 62.1m related claim items**

Community Schemes services are provided nationally to 3.4m people by 7,007 primary care contractors, including general practitioners, pharmacists, dentists and optometrists or ophthalmologists.

Community Schemes

The Community Schemes include:

- General Medical Services (GMS) – Medical Card Scheme including GP Visit Cards
- Drug Payment Scheme
- Long Term Illness Scheme
- Dental Treatment Services Scheme
- High Tech Drug Arrangements
- Primary Childhood Immunisation Scheme
- Community Ophthalmic Scheme
- Health (Amendment) Act 1996
- Methadone Treatment Services
- Immunisation for certain GMS eligible persons
- European Health Insurance Card

Progressing our Strategic Priorities

- Eligibility for medical cards has increased by 61% since January 2005.
- 927,505 long term illness claims were processed.
- Over 2.45m drug payment scheme claims were processed.
- 829,867 treatments were provided under the Community Ophthalmic Scheme, of which 756,106 were adult treatments and almost 73,761 were child treatments, a 3% and 5% increase on 2012 respectively.
- 1,322,119 treatments were provided under the Dental Treatment Services Scheme (DTSS).
- There was a 4% reduction in GMS expenditure in 2013 from the previous year, attributed to the continued impact of drug price reductions, the introduction of the *Financial Emergency Measures in the Public Interest (FEMPI) Act 2013*, a reduction in the overall number of eligible persons and the number of GMS items dispensed.

Medical Cards/GP Visit Cards

Medical cards or GP visit cards are provided to persons who are unable, without undue hardship, to arrange GP services for themselves and their dependants. Under the *Health Act, 1970*, the Health Service must have regard to the overall financial means of the applicant.

Medical card processing is now carried out with single national governance in a central office location compared with the 100 different locations in the past. Customer service processes, assessment of applications and reviews, correspondence and the application of discretion, are now operated in a consistent and equitable manner across the country.

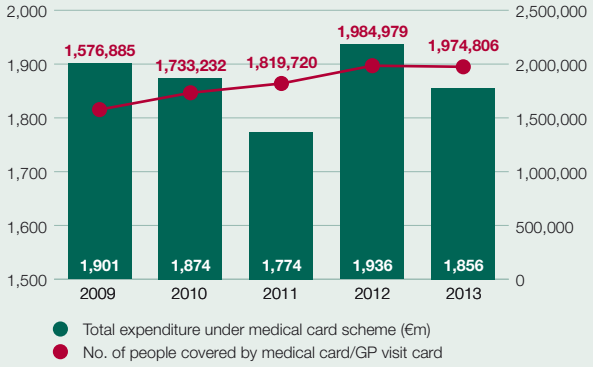
Turnaround performance in processing of medical cards is reported online each week. The target of 90% processed within 15 days has well been surpassed with over 98% of complete applications processed. The 2% not processed within target relates to applications where the income is in excess of the qualifying limits and/or a medical assessment is required.

While the number of cards is a cost driver in schemes, the primary drivers relate to prescribing practices and the number of items contained within each prescription.

Given the number of cards in circulation and the cost to the State, it is a priority of the Health Service to ensure the highest level of probity is applied to the issuing of cards and to making of payments to service providers on behalf of card holders. Many types of review are undertaken including audits of service providers, reviews of eligibility on expiration of cards, and risk based reviews based on criteria such as cards being inactive for specified periods. In 2013, 705,023 medical cards were assessed of which 74,092 were initially assessed online.

New legislation was passed which created the legal basis for sharing of records with the Office of the Revenue Commissioners and the Department of Social Protection. This will allow for further improvements in the management of the medical card system and offers additional assurance that eligibility continues to be provided to people appropriately, in line with national assessment guidelines for eligibility. The availability to the Health Service of data indicating changes in a medical card holder's circumstances, such as change in employment status, income levels etc will inform the Health Service in focusing reviews on subsets of the register, to identify clients who may no longer be eligible.

Figure 13: 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

Figure 14: High Tech – Payments to wholesalers (€m) and patient care fees to pharmacy (€m)

Data source: PCRS Management Accounts and PCRS Statistical Analysis

Reference Pricing/Generic Substitution

The *Health (Pricing and Supply of Medical Goods) Act* was enacted in 2013, and provides for the introduction of a system of generic substitution and reference pricing. This involves setting a common reimbursement price for selected groups of medicines and it is only this reference price which is reimbursed by the State. Payments commenced in the latter part of the year based on new reference pricing. Any patients affected by the changes through the pricing system will be informed by their GP, their pharmacist or through information online.

Health and Wellbeing Division

Health and Wellbeing services support people to live healthier and more fulfilled lives, protect the public from threats to health and wellbeing and create an environment that supports health and wellbeing for all. This work is underpinned by *Healthy Ireland, a Framework for Improved Health and Wellbeing 2013-2025*.

Health and Wellbeing services include public health, health protection, child health, screening programmes, health promotion and improvement, environmental health, emergency management and health intelligence. Our services are delivered by a range of experienced, highly trained and professional staff across communities, hospitals and other settings.

Priorities in 2013 included:

- Programmatic review of health promotion.
- Child health, including immunisation and targeted screening programmes.
- Preventing and controlling infectious diseases.
- Enforcing legislation and promoting activities to assess and prevent factors in the environment which adversely affect the population.
- Ensuring a co-ordinated response to major emergencies in the health services.
- Implementing recommendations of Tobacco Control Frameworks, legislation and policies.

Key Facts

95% **Uptake in 6 in 1 childhood immunisation at 24 months in most regions**

86% **Uptake for MenC3 vaccine**

92.4% **Uptake for MMR vaccine at 24 months in most regions**

84% **Newborn babies visited by a public health nurse within 48 hours of discharge**

88% **Or 66,000 children reaching 10 months had developmental screening before reaching 10 months**

Progressing our Strategic Priorities

Child Health

- The first full MMR catch up programme was implemented in all second level schools.
- Tetanus, diphtheria and pertussis booster vaccination programme implemented for all first year students.

Health Protection

- Directly Observed Therapy Guidance developed and distributed throughout the system for the care of TB.
- Leaflets produced for people with TB and contacts.
- Verocytotoxigenic Escherichia coli (VTEC) cases continued to rise to over 700 from 530 in 2012.
- Over 650 infectious disease outbreaks were dealt with, some involving more than a hundred people.
- The Health Service was a partner to the launch of the Environmental Protection Agency's (EPA) Air Quality Index.

Environmental Health

- 33,507 planned and planned surveillance inspections were carried out of food businesses, which exceeded the target of 33,000.
- There were 37,247 inspection outcomes of food businesses in relation to all inspection types. The outcomes were as follows:

Satisfactory	29%
Minor non-compliance	47%
Unsatisfactory	18%
Unsatisfactory significant	5%
Unsatisfactory serious	1%

- 465 formal food safety enforcement actions: from improvement notices (311) to prosecutions (11).
- 4,693 food samples analysed and investigated as part of the food product sampling plan, and 2,356 drinking water samples assessed for compliance with fluoridation.
- 121 consultations in relation to Environmental Impact Assessments.
- 1,100 inspections of early years services.
- All eight designated ports and airports received an audit in relation to International Health Regulation requirements.

Key Targets

	Target 2013	Achieved 2013
Uptake in 6-in-1 **childhood immunisation** at 24 months	95%	95%
Uptake for 1st dose **MMR** vaccine at 24 month	95%	92%
% newborn babies **visited by PHN** within 48 hours of hospital discharge	95%	84%
% of children reaching 10 months who have had their **child development health screening** before reaching 10 months of age	95%	88%

Data source: HSE Performance Reports

Emergency Management

- The new Crowd Events Guide was approved and issued across the Health Service. It is currently being used in planning for events with both event organisers and other principal response agencies.
- The Severe Weather Working group was convened and relevant issues were progressed.
- The Hospital Standard Plan template was piloted in a number of hospitals.

Health Promotion and Improvement

- A number of documents were published including: Wellbeing in Post-Primary Schools: Guidelines for Mental Health and Suicide Prevention; Schools for Health in Ireland; Guidance Document for Hospitals on Health and Wellbeing Standards.
- 18 GAA clubs enrolled in the Healthy Club Programme.
- Cork, Galway, Waterford were designated World Health Organisation Healthy Cities.
- 40% of maternity units/hospitals were designated Baby Friendly Hospitals.
- 1,395 healthcare workers were trained in Brief Interventions for Smoking Cessation.
- 1,035 GPs completed the Physical Activity e-learning module with accompanying mobile app.
- 20 trainers completed ENGAGE Men's Health Train the Trainers programme.
- 215 community based breastfeeding support groups were provided.

Mothers and babies at an event to mark HSE National Breastfeeding Week at Lusk Community Centre, Dublin

- 13,000 orders were processed for health information materials, and approximately 4,000,000 resources distributed to schools, health service providers, community groups and the general public.
- Implementation of national Healthy Schools model in primary and post-primary schools.

Health Intelligence

- The roll out of the National Quality Assurance Information System continued in partnership with the Royal College of Physicians in Ireland and Royal College of Surgeons in Ireland.
- The use of the Health Atlas Ireland information system supported decision-making regarding the location of hospital and community services.
- Implementation of specialised modules of the Health Atlas Ireland information system supported major emergency management including the work of the helicopters of the National Aeromedical Service.

Human Papillomavirus (HPV) Vaccination Campaign

- The free vaccination programme involved the administration of three doses of HPV vaccine over a 6-12 month period to give full protection.
- The vaccine protects against seven out of ten cervical cancers, so it is still important for girls to have regular smear tests when they are adults.
- Most of the vaccinations were administered in schools by Health Service Immunisation Teams, with some girls invited to Health Service clinics.
- Uptake rates have exceeded targets with an uptake of 86% for the three vaccine doses, up from 82% from 2010/2011 and above the target set of 80%.
- 97% of first year girls and 95% of sixth year girls, who received a 1st dose of HPV vaccine, completed the 3 dose schedule.
- A catch up programme was introduced for all sixth year girls with a 72% rate for completed vaccination courses for sixth year students well beyond the target of 60%.

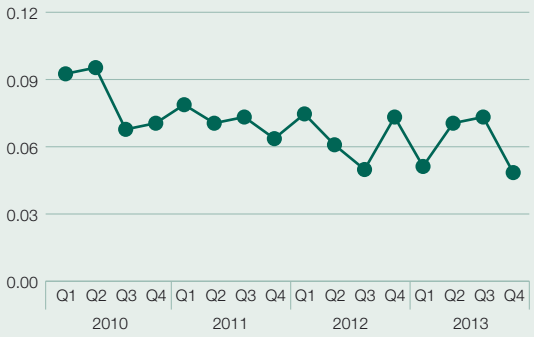
Other highlights:

The aim of our work on Healthcare associated infection (HCAI) is to ensure that HCAI and antimicrobial resistance (AMR) are not inevitable consequences of healthcare and that every healthcare worker recognises that infection prevention is a key element of clinical and non-clinical governance. The national clinical programme aims are:

- Improving hand hygiene
- Using antimicrobials appropriately
- Preventing medical device-related infections.

- The 6th **National Hand Hygiene Audit** took place in 48 acute hospitals (42 of which were public). Compliance had improved from previous audits to 86.2% but is still below the 90% target.
- The rate of Methicillin-Resistant *S. aureus* (MRSA) bloodstream infection for public hospitals is continuing to decrease as is the rate of new cases of *C. difficile* infection in acute hospitals.

Figure 15: Rate of MRSA bloodstream infection reported by acute public hospitals per 1,000 bed days used 2010-2013



Data source: Health Protection Surveillance Centre

- **Antibiotic use** in the community in Ireland decreased in 2008 and 2009 but increased again in 2012. New updated guidelines on prudent antibiotic prescribing have been developed to help promote the safe and effective use of antibiotics by GPs and dentists.
- Gonorrhoea is a common **sexually transmitted infection**. Between 2011 and 2012 there was a 33% increase in cases, and young men and women aged 17 to 29 years have been identified as a particular at risk group. Over 1,000 people were diagnosed in 2013. A new social media campaign was launched warning of the steady increase in levels of gonorrhoea infection, particularly in the Dublin area.

- 'Think Contraception' is an initiative of the **Crisis Pregnancy Programme**. A new television, cinema and online campaign aimed at 18-24 year olds was launched. The campaign promotes consistent use of contraception, particularly condoms, to address issues of unplanned pregnancy and to combat the high numbers of sexually transmitted infections among the 20-29 age group.
- Towards tackling **childhood obesity**, the Health Service, Safefood, Department of Health and Department of Children and Youth Affairs have delivered an all-island three-year childhood obesity campaign. A range of supports for parents have been developed and are available on *www.healthpromotion.ie*, *www.hse.ie/weightmanagement* and on *www.getirelandactive.ie*

At the launch of the Safefood and HSE Childhood Obesity Campaign were (L-R): Cate Hartigan, Head of Health Promotion and Improvement, HSE; Frances Fitzgerald TD, Minister for Children and Youth Affairs; Dr. James Reilly TD, Minister for Health; and Martin Higgins, Chief Executive, Safefood

- The 3rd World Health Organisation Childhood Obesity Surveillance Initiative (COSI 2013) shows stabilisation in relation to the proportion of children age seven who are overweight or obese, compared to data from 2009 and 2007.
- A Health Service – ICGP weight management treatment algorithm for children was developed which provides a clear clinical pathway for health professionals in addressing overweight and obesity. This will assist in identifying overweight and obese children in junior infants who require support to halt their tendency towards weight gain through family, community-based multi-disciplinary lifestyle interventions. This is being rolled out next year.

A Focus On… Community Games

The HSE Community Games provide an ideal catalyst for young people to be active and develop healthy habits which, if continued in later life, can reduce the risk of illness such as obesity, heart disease and diabetes. It is also an opportunity to have fun.

620 communities in Ireland, North and South, participate in the HSE Community Games with a total of over 200,000 participants, 10,000 volunteers and 1.3 million supporters.

Sonia O'Sullivan at the launch of the 2013 Community Games

In addition the inaugural Health Events Awards took place in 2013. The awards are designed to encourage Community Games organisers, volunteers, parents and participants to think about the way events are fun in their communities and to try to make them more health promoting in the areas of sun safety, physical activity, nutrition, substance misuse and mental health.

Former Republic of Ireland goalkeeper Packie Bonner with (L-R) Aoibhinn Harte, Niamh Holohan and Brendan Finnan at the 2013 Healthy Events Awards

A Focus On… Tobacco Control

Tobacco use is a significant cause of ill health and mortality in the population. It affects one million people in Ireland, and their families, and over 5,000 Irish people die every year from smoking-related diseases.

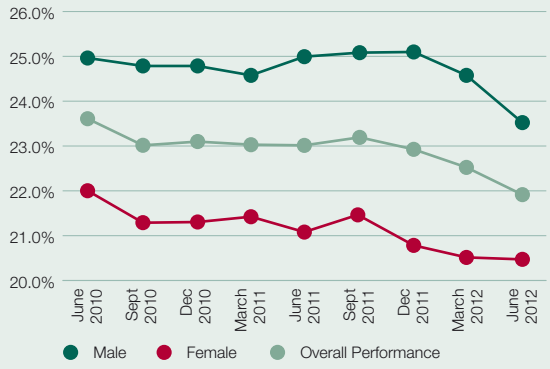
International evidence supports the importance of consistent, sustained investment in mass media campaigns as part of a broad programme of promotional activity.

QUIT is a HSE health education campaign aimed at encouraging smokers to quit and is based on the stark fact that 1 in every 2 smokers will die of a tobacco related disease. Overall smoking prevalence continues to decline. The latest data from the Tobacco Control Office shows a decrease in the 12 month rolling average 1.8% from June 2010 – December 2012 (22%) with a flattening of rates among women.

The late Gerry Collins and his family. Gerry led a powerful new phase of the QUIT campaign in 2013, where he made a series of ads talking about his tobacco-related terminal lung cancer. Gerry passed away on March 2, 2014

Nicole McDermott (7) and Sarah Louise Greene (9) at Coombe University Hospital on its first day as a tobacco-free campus

Figure 16: Cigarette Smoking Prevalence



Data source: National Office of Tobacco Control

In 2013 as part of the National Tobacco Control Framework, the Health Service set a target that all hospitals, newly opened primary care sites and 35% of existing sites, together with all administration sites, would have a tobacco free policy and that by 2015 all workplaces and campuses would be smoke free.

The national tobacco control inspection programme of the Environmental Health Service assesses compliance over a wide range of tobacco control provisions on an ongoing basis. 13,745 inspections were carried out in 2013 by Environmental Health Officers in relation to all aspects of tobacco control legislation.

Social Care Division

In late 2013, a Social Care Division was established to support the ongoing requirements of older people and people with disabilities, as part of the Health Reform Programme. This was a fundamental step in moving forward with the design and implementation of models of care across these care groups to support and maintain people to live at home or in their own community and to promote their independence and lifestyle choices in as far as possible.

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 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 compliance with the *National Quality Standards for Residential Care Settings for Older People in Ireland*. We also continued to administer the Nursing Homes Support Scheme (NHSS) – A Fair Deal during the year.

Priorities in 2013 included:

- Providing quality long stay residential care for older persons who can no longer be maintained at home.
- Providing comprehensive home and community supports such as home help, home care packages, Community Intervention Teams, day/respite care for older persons to live independently, in their own homes, for as long as possible.
- Encouraging and supporting older people to keep healthy, remain at home and stay out of hospital.
- Progressing the Single Assessment Tool (SAT) to ensure a robust equitable national standardised care needs assessment.

A Focus On… Kenmare Community Hospital

A new 40 bed hospital, built at a cost of €8m, was opened in **Kenmare, Co. Kerry** to provide residential care for people in the region as well as a wide range of community supports, including convalescent, respite and hospice care. In addition the facility also provides a mental health day care centre and a new ambulance base.

Resident John McCarthy is welcomed into the new Kenmare Community Hospital by Margaret O'Sullivan, Assistant Director of Nursing, with the assistance of the National Ambulance Service staff

Key Facts

7,193 **Public beds provided**

26% **Residential care beds were public**

11,873 **People in receipt of a home care package**

9.74m **Home help hours delivered**

41,000 **People living with dementia in Ireland today**

Progressing Our Strategic Priorities

- A total of 9.74m home help hours were delivered, with 46,454 persons in receipt of home help services at December 2013 – an increase of 749 on 2012.
- A total of 11,873 persons received home care packages (HCPs), an increase of 850 on 2012.
- At the end of the year, 23,007 long term public and private residential places were funded under the NHSS.
- A number of capital projects were progressed. A new 40 bed hospital was opened in Kenmare, Co. Kerry. Major refurbishment projects also commenced in Baltinglass, Trim, Dundalk, Lusk and Navan Road, Dublin.
- A number of initiatives commenced to support older people to keep healthy, remain at home and stay out of hospital. Examples included:
  - A new Community Falls Service in St. Mary's Hospital, Phoenix Park, providing a one stop shop for assessing and treating older people who have fallen or are at risk of falling.
  - *National Positive Ageing Strategy* was launched by Kathleen Lynch TD, Minister of State for Disability, Equality, Mental Health and Older People.
  - Working with DoH on the finalisation of the Dementia Strategy, for publication in 2014.

- Working in partnership with Genio to develop individualised supports to people who present with more complex needs related to the more advanced stage of their dementia and which result in positive outcomes. Individualised supports will target inappropriate delays in discharges from acute hospitals and also responses that support complex cases in the community so that admission to acute settings can be reduced or avoided. Initiatives are underway in settings in Blackrock/Stillorgan, Louth, Leitrim, Roscommon, Mayo, Kilkenny, South Tipperary, and Cork.

- There were 2,331 elder abuse referrals, an almost 2% decrease compared to 2012, with psychological abuse the most common category (27.3%).
- Following a comprehensive selection and pilot process the InterRAI™ suite of tools was selected as the single assessment tool (SAT). This tool will be implemented over 2014 and 2015 and will underpin the future development of services for older people, providing a standardised base for the allocation and development of services to older people based on their assessed needs. Implementation of a SAT is needed to:
  - Support current national policy on enabling older people to remain at home in independence for as long as possible.
  - Ensure care is provided in the most appropriate setting e.g. preventing inappropriate admission into long term care or acute service admissions by early identification of needs and appropriate crisis prevention/planning, where possible.
  - Provide demonstrable fairness of access to resources for NHSS, HCP, and home help schemes.
  - Maximise value to older persons through prioritisation within the available budget resource.
  - Facilitate an efficient application of case-mix in long term care (replacing current cost of care model).

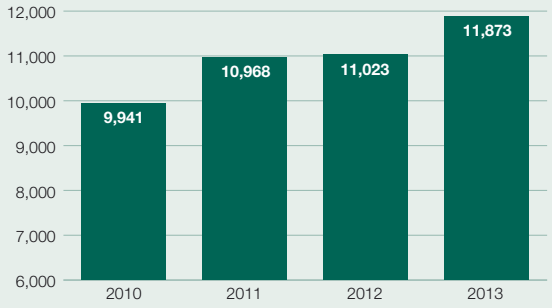
On a visit to St. Camillus' Hospital, Mr. Tony O'Brien, Director General, with clients Andrew O'Brien and John McSweeney playing badminton organised by Margaret Divilly, Activities Co-ordinator. Also pictured is Majella Cussen, Director of Nursing at the hospital

Key Targets

	Target 2013	Achieved 2013
% of complete **NHSS applications** processed within four weeks.	100%	100%
% of **elder abuse referrals** receiving a response from senior case worker within four weeks.	100%	96.7%

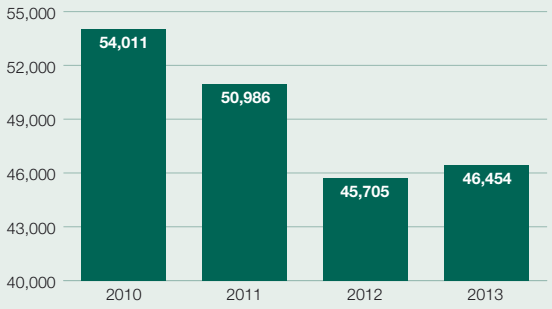
Data source: HSE Performance Reports

Figure 17: No. of persons in receipt of a home care package (HCP)



Data source: HSE Performance Reports

Figure 18: No. of persons in receipt of home help hours (excluding provision from HCPs)



Data source: HSE Performance Reports

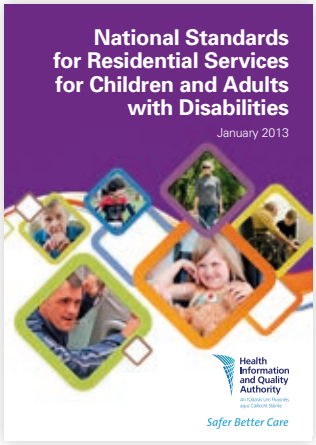
SUPPORTING PEOPLE WITH DISABILITIES

Working in partnership with other stakeholders, our aim is to ensure 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. Services are delivered by both the Health Service and our non-statutory partners. Approximately 80% of all disability services are delivered by the non-statutory sector, funded through section 38 and 39 of the Health Act 2004. The funding allocated to the non-statutory sector is covered by either Service Arrangements or Grant Aid Agreements.

Priorities in 2013 included:

- Implementing the *Value for Money and Policy Review of Disability Services in Ireland*.
- Improving the quality of disability services, including implementing the HIQA standards for residential services for children and adults.
- Improving information systems, data collection and developing outcome focused performance indicators.

Progressing Our Strategic Priorities



- The *National Implementation Framework of the Value for Money and Policy Review of Disability Services* was approved. The framework described the project management and monitoring processes needed to ensure reform is achieved in a planned, timely and cost effective manner.
- Kathleen Lynch TD, Minister of State for Disability, Equality, Mental Health and Older People launched the *National Standards for Residential Services for Children and Adults with Disabilities*. From 1st November, HIQA embarked on the registration and inspection process.
- An eight bedded regional specialised therapeutic service for Cork and Kerry, to support adults with intellectual disability who present with challenging behaviour, became operational during the year with an outreach team operating from the unit.
- 4,261 applications were received for assessments under the *Disability Act 2005* (a 22% increase on 2012), with nearly 40% of applications coming from children of school age. 2,883 assessments were completed with 24.8% completed within the timelines as provided for in the regulations.
- In respect of the reconfiguration of children's services, 25 Local Implementation Groups are now in operation, covering the whole country. West Cork became the first area to successfully reconfigure the services.
- A protocol for joint national working was developed between disability, children and families, mental health and primary care services to enhance the quality and experience of services for children and young people.

Key Facts

2,898 **People with disabilities benefiting from Rehabilitative Training (RT)**

8,880 **People with disabilities benefiting from residential services**

242,699 **Bed nights used in residential-centre based respite**

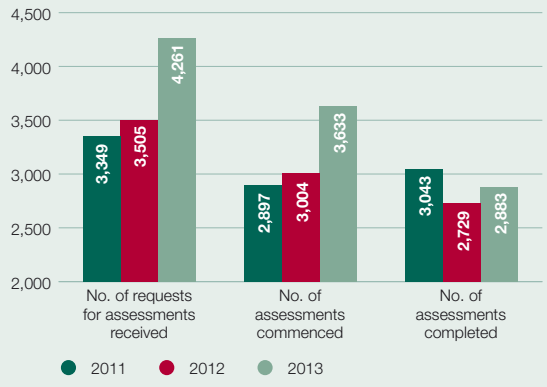
1.27m **Personal Assistant (PA) hours delivered to adults with a physical and/or sensory disability**

173 **People completed their transition to community living**

3,200 **People remaining in congregated settings**

- In order to assist agencies in the development of their child protection policies, *Children First in Disability Services – A Guide to Policy Formation and Implementation* was published and information was made available on *www.hse.ie*
- A draft Quality Standards Framework for Day Services was finalised and a consultation process agreed.

Figure 19: Disability Act compliance 2011-2013



Data source: Disability Information Unit

Key Targets

	Target 2013	Achieved 2013
% of **assessments commenced** within the timelines as provided for in the regulations (Disability Act, 2005)	100%	77.2%
% of **service statements** completed within the timelines as provided for in the regulations	100%	57.1%

Data source: HSE Performance Reports

A Focus On…Enable Ireland – Cork and West Cork STEP Programme

Enable Ireland works in partnership with the HSE to provide services to children and adults with disabilities and their families from 40 locations in 14 counties. A programme has been pioneered in Cork and West Cork which is set to become a template for the development of services nationally.

Enable Ireland
Programmes for children with complex physical disability
Surveillance Treatment Education Prevention

Children with a complex physical and/or neurological disability require a range of orthopaedic services to meet their needs. The right services must be delivered at the right time to prevent functional limitations developing.

Our non-statutory partners, Enable Ireland – Cork and West Cork, have implemented the Surveillance, Treatment, Education and Prevention (STEP) Programme to support the Network Disability Teams being formed in line with the Progressing Disability Services for Children and Young People Programme (0-18s Programme). This includes the recently re-configured services for children with disabilities in West Cork.

The STEP service, which has been described as "World Class", serves to focus the specialist services necessary and is an excellent example of building relationships between professionals from multiple agencies in order to allow children and families to access services in a co-ordinated and integrated manner.

A Focus On… St. Joseph's Intellectual Disability Service

Thirty-eight clients from St. Joseph's Intellectual Disability Service, Portrane completed the **Awards Scheme Development and Accreditation Network (ASDAN) – Towards Independence Programme** during the year. The programme presents a framework of activities through which personal, social, communication and independent living skills are developed and accredited. This was the third cohort of participants from St. Joseph's since it registered for the programme in 2007.

Pictured (L-R) are: Caroline Coakley, Service Manager, North Dublin Mental Health Services; client Louis Carrick with his ASDAN award; and Eileen Kelly, Director of Nursing, St. Joseph's Intellectual Disability Service

..... Altering people's lives for the better

Kilcornan – Moving to the Community

"Joe loves his daily jobs of feeding the hens, collecting the eggs and then feeding Birdie his dog. He loves going to his art and his computer classes and particularly likes his regular treats in the G Hotel in Galway. These are now ordinary things in an ordinary life for Joe. A few years ago they may have been considered extraordinary for Joe who used to live in Kilcornan Centre, a campus setting for individuals with an Intellectual Disability. Joe now shares a house with four other friends in a rural area near Ballindereen in County Galway. Joe is described as being non-verbal and is on the Autism Spectrum. In the past Joe would be described as having challenging behaviour. His major challenge now for the staff is keeping up with his busy schedule!

Kilcornan Centre was opened by the Brothers of Charity in 1952 and initially services were provided in 'the Big House' for over 100 men. In 1972, the first campus based service in Ireland was developed in Kilcornan with the building of thirteen bungalows. At the time, this was hailed as a bold new step in the development of services. In the 1970s and 1980s there was a shift in policy to develop community based services and individuals moved out from Kilcornan to local towns in the region. People with more complex needs then filled these vacated places. In 2005, there were 80 people living in Kilcornan with varied complex needs with 73% described as having a severe or profound intellectual disability, 75% had challenging behaviour, 35% were on the autistic spectrum and 25% had an additional physical and sensory disability.

In 2003, the Brothers of Charity Services announced that Kilcornan was going to close. The HSE comprehensively reviewed the Kilcornan Transformation Plan. Today there are just five individuals still living in Kilcornan. It is hoped that this group can move out in 2014 with options to make this happen currently being explored. This will be one of the first closures of a congregated setting in line with the HSE policy *Time to move on from Congregated Settings*, 2011.

The first group of the present phase of the reconfiguration of services moved out to a house in Claregalway in 2006, and each year a new group has moved out. Each group who have moved out have been delighted with the additional space and better facilities that are available to them in their new house. Each move has enhanced opportunities for the individuals to partake in ongoing events in their local community.

There are many ingredients that led to the success of this project. One principal focus has been a partnership approach and careful planning with the various stakeholders, including the individuals themselves, their families, the staff who worked with them and the Unions who represented the staff. Another key partnership was with local and national HSE management who supported the project. A key focus was on planning and supporting each individual work out what was right for them. Finding the right mix of accommodation, staffing levels, transport, activities and supports was critical.

It is true that many of the individuals have complex needs and careful planning and co-ordination is required to achieve the optimal solution for each individual. However the key ingredients of success are simple and for Joe and the other individuals who have moved on, it is listening to them and facilitating the ordinary things in life to happen."

Mental Health Division

Guiding the development of services is *A Vision for Change (2006)* – a progressive, evidence based and pragmatic policy document, which proposes a model of service delivery designed around the service user, one that is recovery-orientated and community-based. A Vision for Change is strong on values: prioritising and promoting positive mental health, service user focused service delivery, recovery-orientated services, social inclusion and sets out a comprehensive change programme for our mental health services.

Priorities in 2013 included:

- Enhancing the community mental health team (CMHT) capacity in general adult and child and adolescent mental health services (CAMHS) through the realisation of the 2012 and 2013 investment programmes.
- Investing in the development of services for older people with a mental illness, those with an intellectual disability and mental illness, and forensic services.
- Implementing the recommendations of the suicide prevention strategy *Reach Out*.
- Developing the service user and carer partnership.
- Developing and rolling out of the Counselling in Primary Care (CIPC) service to provide access to quality psychotherapy and counselling for adults with a medical card.

Progressing Our Strategic Priorities

- An investment of €35m was made available to mental health services with up to 477 posts for a range of initiatives including to enhance general adult and CAMH team provision, to develop the mental health services for older people and for those with an intellectual disability, suicide prevention initiatives and forensic services. At the end of December 2013, the recruitment process was complete for 205 or 43% of these posts.
- The continued implementation of the 2012 investment of €35m ensured that the recruitment process was complete for 391.5 WTEs or 94% of the posts allocated in 2012.
- A clinical pathway for mental health in intellectual disability (MHID) community teams was devised and included a Standard Operating Procedure for the new service being recruited for the four counties in Dublin North East. This has been provided nationally to assist in developing the MHID services.
- Kathleen Lynch, TD and Minister of State for Disability, Equality and Mental Health and Alex White TD and Minister of State for Primary Care jointly launched the CIPC service for adults with a medical card meeting a *Programme for Government* commitment funded from the investments in mental health in 2012 and 2013.
- The Enhancing Teamworking Project worked with CMHTs nationally to develop their multi-disciplinary teamworking and support the integration of new staff onto the teams.

Key Facts

21% **Decline in admissions 2003-2012**

14% **Decrease in admissions to older traditional psychiatric hospitals 2010-2013**

30% **Diagnoses were for depressive disorders**

15,319 **Referrals received by the child and adolescent mental health services, 17% more than planned**

65 **CAMH Teams (59 community based, 3 liaison and three day) in place**

200 **GPs accessed the e-learning suicide prevention programme**

At the leadership event (focus on ARI), June 2013 were (L-R): Michael Ryan, Project Manager ARI; Rory Doody, Recovery Advocate; Martin Rogan, MHS, Quality and Patient Safety; Elaine Brown, Peer Support Worker; and Ray Noble, Peer Advocate

- The Advancing Recovery in Ireland (ARI) Project represents the first systematic approach to delivering a core part of *A Vision for Change* using a comprehensive organisational change methodology – 'Implementing Recovery through Organisational Change' (ImROC). It was developed across seven sites in 2013.
- A number of new resources were developed including an e-learning module developed in collaboration with service users to assist staff meet the needs of people with an intellectual disability and mental health challenge (available on *www.hseland.ie*).

- 7,000 counselling sessions were delivered by the CIPC to 1,916 individuals, from its launch in July 2013 to the end of December.
- There is an increase in the numbers on the CAMHS waiting list, largely relating to the 17% increased referrals beyond expected activity. Access to CAMHS is based on a clinical assessment of need and 70% of children were offered first appointment and seen within three months.

  There is an ongoing focus, including continued investment, on service improvement targeting reduced waiting times, improved access and delivering the most appropriate service response.

Key Targets

	Target 2013	Achieved 2013
% of new/re-referred children **offered first appointment** and seen < three months	70%	70%
% of referrals to Psychiatry of Old Age Teams offered an appointment and seen within 12 weeks	New PI	96%
% of **referrals to General Adult Community Teams** offered an appointment and seen within 12 weeks	New PI	73%
No. of **admissions to acute inpatient units**	14,044	13,377
Total number on **CAMHS waiting list**	1,696	2,602

Data source: HSE Performance Reports

National Office for Suicide Prevention

- The National Office for Suicide Prevention (NOSP) established a Community Resilience Fund, coordinated with the local suicide prevention officers/local ISA managers. This funding supported 23 additional community projects throughout the country.
- Applied Suicide Intervention Skill Training (ASIST) and SafeTalk programmes continued throughout 2013. Approximately 30,000 people received ASIST by year end and approximately 22,000 people received SafeTalk. It is estimated that one in every 100 Irish adults has received suicide prevention training through ASIST and SafeTalk.
- The NOSP in partnership with the Irish College of General Practitioners developed an online training programme for GPs and primary care staff. Over 200 GPs have accessed the programme.
- Eight new Suicide Crisis Assessment Nurses were approved for appointment. This service provides active liaison between primary care and mental health services.
- The NOSP in partnership with the Health and Wellbeing Division published the National Guidelines for Post Primary Schools on Mental Health and Suicide Prevention.

Gerry Raleigh, Director of the National Office for Suicide Prevention, with (L-R) David Shaughnessy, Nadine Connors, Julieanne Murphy, and Mihai Cadere

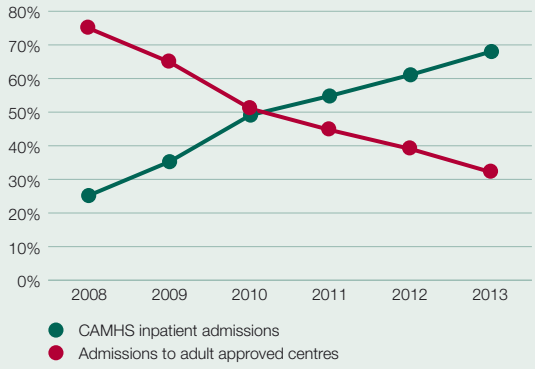
A Focus On… Reduction in Number of Children Admitted to Adult Inpatient Units

The **reduction in the numbers of children admitted to adult acute inpatient facilities** has been a focus for the Mental Health Services for the last number of years and progress in this area has been extensive.

In 2008, 25% of admissions of children to HSE acute inpatient units were to age appropriate Child and Adolescent acute inpatient units. By 2013, this had increased to 68% of admissions.

However, the 90 admissions of children to adult units in 2013 is still unacceptable and there is a prioritised service improvement plan being developed to ensure the admission of children to the most appropriate settings.

Figure 20: Child and adolescent mental health admissions (excluding private units)



Data source: HSE Performance Reports

A Focus On… Modern Mental Health Facilities

Phoenix Care Centre

Phoenix Care Centre, Grangegorman

The Minister for Health, Dr. James Reilly TD, and Minister of State, Kathleen Lynch TD, officially opened the new Mental Health facility the 'Phoenix Care Centre' at Grangegorman. The purpose built 54 bedded mental health facility provides a highly specialised tertiary psychiatric intensive care service for the entire Dublin North East Region, South Dublin and Wicklow.

Purpose Built Accommodation in Clonmel

The development of Haywood Lodge Community Nursing Unit and Garryshane House, a high support hostel, facilitated the closure of the old St Luke's Hospital in Clonmel providing modern residences for service users.

..... Altering people's lives for the better

Service User Peer Led Initiative – Cork Mental Health Services

When a group of mental health peers came together to discuss what might benefit themselves and other peers in their recovery, it was the driver for the commencement of a service user initiative in Cork Mental Health Services. This is their story.

"We wanted to create a project that would educate, train and empower peers in a recovery environment, but in an informal manner that would encourage participation for those of us who have forgotten how self-confidence, self-esteem and self-worth can feel. Isolation is a big concern in this part of Cork Mental Health Services and it played a major part in the discussion of what kind of a peer support project we wanted.

The drivers that influenced us in developing the **Peer Support Phone Service project** included:

- Aiming to break the cycle of loneliness, isolation and low self-worth to mention a few negative factors.
- Developing a project that will nurture, encourage and create personal responsibility, self-belief, courage, HOPE, trust, self-respect, boundaries, dreams, limits, dreams, commitment, belonging, confidence and community.

Mental Health Peers as a group meet in a supported environment to "make calls and support others" through the **Peer Support Phone Service**.

This is how it works...

- Mental Health Peers meet for 30 minutes 'Checking-in and engaging with 'Group Process' and 'Mutual Support'.
- The group then spends an hour making phone calls.
- These calls are about 'Social Realities'.....that's all!
- It is a one-way phone line, "we call you".
- It is NOT a helpline, it is non-clinical and non-judgemental.
- We have a 'Recovery Environment', relaxed, welcoming with recovery information available.
- The Group making the call are facilitated, supported and moderated by the Facilitator (a Peer).
- There is time allotted for de-briefing.
- We provide a safe, peer-led, facilitated, confidential environment to support recovery.

Co-production is what makes this project work – we have the mentorship of our Health Service Community Worker, we are being trained by another community project similar in nature, we have partners in the community providing a location and governance, the facilitator is supervised by the local psychology team and we have the unanimous backing of the local mental health services management team.

This is a start; it is seen as a sound foundation from which peers can move to more formal areas of education and training."

Children and Families Services

We are committed to putting the interests of children first, and supporting the role of parents, carers and families in the development of their children and young people. There are 1,148,687 children (0-18 years) living in Ireland (CSO, 2011), a small minority of whom require additional support or protection at periods in their young lives. The focus in 2013 was to progress the disaggregation of HSE Children and Families Programme from the HSE to a single dedicated State agency – the Child and Family Agency, overseen by a single dedicated government department, all focused on providing a continuum of services committed to children's wellbeing and protection.

Priorities in 2013 included:

- Preparing for final transition of responsibilities to the Child and Family Agency on 1st January 2014.
- Delivering statutory services for the care and protection of children in keeping with the *HIQA Standards for the Protection and Welfare of Children*.
- Working to ensure full implementation of *Children First: National Guidance for the Protection and Welfare of Children, 2011*.
- Promoting quality and safe services underpinned by sound knowledge and information management.
- Implementing reform to provide a comprehensive range of service for children in care.
- Promoting effective multi-disciplinary shared practice and efficient community engagement.
- Developing a Workforce Development Strategy.

Progressing Our Strategic Priorities

- The national organisational structures for the Child and Family Agency, TUSLA, were finalised and implemented.
- The first Chair of the Board of TUSLA was appointed in April, with membership of the full Board announced in September.
- The *Child and Family Agency Act, 2013* was signed into law in December.

Key Targets

	Target 2013	Achieved 2013
% of children in care who had a **written care plan**	100%	87.4%
% of children in care who had a **social worker**	100%	91.8%
% of children in care who were cared for by **foster carers**	–	92.8%

Data source: HSE Performance Reports

Key Facts

6,462 **Children in care at the end of the year**

4,699 **Notified early years services**

359 **Complaints received and investigated in respect of early years services**

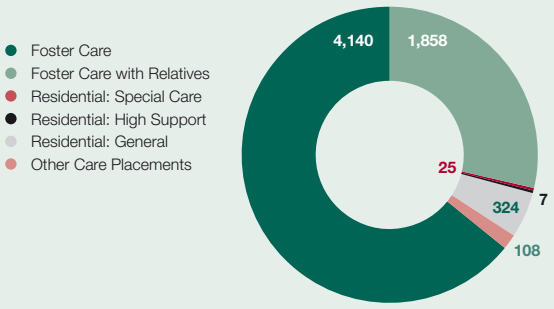
1,547 **Children on the Child Protection Notification system**

4,315 **Foster Carers caring for children**

- *Adoption (Amendment) Act, 2013* was enacted in December.
- Progress on 24/7 access to a national register of children with a Child Protection Plan extended to GPs, hospitals and Garda Síochána was made in 2013 under a dedicated project manager. This was completed to design stage by year end with implementation planned for 2014.
- National and Regional Editorial Boards established to manage publication of Early Years (Pre-school) Inspection Reports now available on www.pobal.ie
- The recruitment process in respect of five additional early years inspectors was advanced and these will be coming on stream in Q2 of 2014.
- A number of seminars took place on a nationwide basis on Neglect Audit and Serious Incident Review, which challenged staff to examine their practice in responding to child welfare and protection.
- A number of reports by the National Review Panel for Serious Incidents and Child Deaths were published. The panel's function is to determine the quality of service provision to the child/young person prior to their death or experience of a serious incident.
- A number of mergers/boundary changes took place including Dublin 15 Child and Family Services merging with Dublin North.
- The design of the Service Delivery Framework was completed, with each area team moving to implementation phase from Q4 2013.

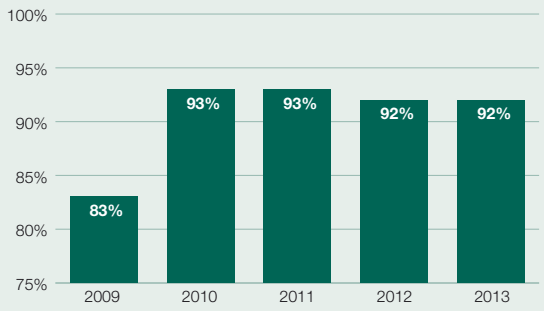
- Major project undertaken to centralise payroll services within Health Service Shared Services for all staff transferring to the Child and Family Agency, TUSLA (approximately 4,000).
- A group was convened to develop the National Charter for Children and a working draft was completed by year end. This work will be concluded in 2014, ensuring it reflects the interdependencies with other relevant policy documents including the *National Healthcare Charter for Children's Services*.
- The 116000 Missing Children Hotline came into effect 24/7, following a successful pilot initiative initiated by the Department of Children and Youth Affairs (DCYA) in partnership with a number of cross sectoral agencies, including the Health Service. The hotline is run by Irish Society for Prevention of Cruelty to Children (ISPCC).
- Enhancement of the provision of specialist therapeutic services for children in residential special care units with the Assessment, Consultation and Therapy Service (ACTS) becoming fully operational in mid-2013.
- National Review of Residential Care, including reconfiguration of High Support and Special Care Units. This has doubled the special care capacity from 17 to 34 beds.
- Launch of a new awareness campaign for foster carers 'Change a Life, Become a Foster Carer' with associated information available on an updated website *www.fostering.ie*
- A Children and Families DNE Internet Hub was launched. The hub is designed to be user friendly and provide staff with relevant, up to date information with easy access to all new policy and procedure documentation, while supporting effective communication.

Figure 21: No. of children in care by care type 2013



Data source: HSE Performance Reports

Figure 22: % of children in care who have an allocated social worker



Data source: HSE Performance Reports

A Focus On… Foster Caring

Change a Life, become a foster carer… Foster carer Kathleen O'Farrell from Baldoyle was recently crowned 'Woman's Way and Lidl Dublin Mum of the Year' after being nominated by her daughter. Kathleen and her husband have been fostering and working with the Health Service social work department in North Dublin for over 25 years. Kathleen's daughter said "while my mother had six kids of her own, there are more than 60 foster children out there who have called her "Mam" at some stage – kids of all ages, from all backgrounds, cultures and nationalities. One is now 19 and has been long-term fostered by Mam and Dad having first come into their care at just 10 months old."

Maurice Murphy, Fostering Team Leader, Social Work Dept. Dublin North, confirmed that "Kathleen is such a deserving winner. Becoming a foster carer is a hugely rewarding experience, when foster carers open their hearts and homes like Kathleen and her husband they literally change children's lives for the better."

Dublin Mum of the Year 2013, Kathleen O'Farrell

Corporate Support Services

Support services play a vital role in the efficient running of the Health Service. Under the health reform programme, the role of the corporate support services has been identified as an essential enabler to support the reform and delivery of direct patient/client service provision. To achieve this, the support services functions also require changing and adapting to new thinking and new models of working. In 2013, a new division was created to focus on a range of support services which can be delivered on a 'shared basis'.

In addition to developing the shared service model, priorities in 2013 to support the reform agenda included:

- Developing financial management systems.
- Supporting the implementation of all ICT enabled health service and e-health initiatives.
- Improving acute hospital and community health infrastructures.
- Supporting succession requirements at senior management level.
- Agreeing action plan for integrated workforce planning strategy.

Progressing Our Strategic Priorities

Corporate Finance

The Finance Reform Programme is an important element in the overall health reform programme. Phase 1 was completed in September 2013 and resulted in an agreed Finance Operating Model for the Irish health system. Implementing a new model provides a unique opportunity to completely transform the financial management of the health system and will support the delivery of key elements of *Future Health* including introducing Hospital Groups and Money Follows the Patient. Central to the implementation of the new model is the development of a service delivery model that comprises three distinct components: Operations Excellence, Finance Specialists and Business Partners, which will be progressed and implemented in 2014.

This programme is the start of a journey that will ultimately affect all staff within the health system as it will fundamentally transform the way we manage finance, facilitated by a change in culture, systems and processes. Other progress during the year included:

- Considerable development work to progress the 'money follows the patient' programme:
  - A shadow-funding exercise was undertaken to assess the impact of the new process on individual hospitals. The learning from this exercise is being built into the 2014 programme.
  - Significant IT work was carried out to develop business intelligence capability for hospitals.
  - Approval was obtained for a national patient-level costing system.
  - A 'state of readiness' review was conducted.
- The speed of Health Service claims submissions improved by 9% year on year (€85m in December 2013 against €94m in December 2012).
- Claims relating to the 2012 advanced payment (more than €20m in May 2013) were cleared by year end, and claims at risk of loss which stood at €8m in June were also cleared by year end.
- National electronic claims management system now live in 24 hospitals and handling over 77% of value of Permanent Health Insurance (PHI) claims. A further 23 hospitals to go live in 2014.
- National Income reporting refined and being further developed to include hospital group reporting.
- A review of the national capital payments system completed.
- The extraction of the Child Care budget in preparation for the new Child and Family Agency.
- An audit of tax compliance was commenced.

Corporate Human Resources

The focus in 2013 was to support the delivery of key structural reform objectives of the Health Reform Programme, working collaboratively and effectively with all relevant stakeholders to achieve this. Supporting delivery of this agenda required the appropriate HR structure at all levels. A new HR model was implemented in 2013 to best meet the needs of the organisation as it transitions. In addition:

- A succession management programme was introduced in the West North West Hospital Group for 22 senior managers.
- A number of external executive coaches were selected to support the ongoing development of internal coaches to support senior management development.
- A five week blended learning Financial Programme was developed and tested with participants.
- *www.HSELand.ie* scooped a prestigious gold award in the international Brandon Hall, Excellence in Learning Awards (Best in Learning Technology Implementation).
- A Leadership Development Programme for health and social care professionals was developed, for delivery in 2014. A Leadership Development Programme for 75 Directors and Assistant Directors of Nursing and Midwifery commenced.
- Work commenced on the development of a tiered Workforce Planning Framework and workforce planning processes. This will succeed the current *Workforce Planning Strategy, 2009*. Developed in consultation with the DoH, it will ensure the effective management of human resources and development of organisational capability, being cognisant of the overall policy on staff numbers and payroll targets.
- Irish Health Repository LENUS was included into the national Open Access portal RIAN which collates the research output from ten higher education repositories in Ireland.
- 120 staff attended the first Heath and Social Care Professionals research conference.

- A Memorandum of Understanding was signed between the Medical Council and the Health Service to focus on enhancing cooperation between the two bodies in the area of medical education and training.
- A Performance Management System was formally introduced to the Health Services for senior managers under the *Public Service Agreement 2010-2014*. Work continued during 2013 to extend this process to other staff categories, as agreed under the *Haddington Road Agreement*.

Shared Services

In 2013 as part of the ongoing health reform programme, a number of support functions were brought together as part of the development of a shared service health business function. The introduction of a shared business services model in the health sector is as a result of a government led initiative to organise and supply internal support services more efficiently and effectively whilst freeing up organisational capacity to concentrate on core health and social care functions, i.e. the delivery of safe health services. It is also a direct response to the need to support the emerging entities in the Health Service as they are put in place and avoid duplication of administrative costs. The functions involved are:

- Finance Shared Services
- HR Shared Services
- ICT
- Estates
- Procurement
- Enterprise and Resource Planning.

Finance Shared Services

Finance Shared Services supports many of the finance transactional activities such as paying staff, paying bills and collecting income. Some key improvements in 2013 included:

- Extension of the online payslip service for staff and retirees. Over 23,000 have now registered for the service.
- The electronic Health Private Insurance Management System (Claimsure) was implemented across 23 hospitals (75% of private income base).
- Payroll and financial processing arrangements were put in place to support the new Child and Family Agency.

Human Resources Shared Services

HR Shared Services provides a number of key support functions including pension management, recruitment and the administration of personal records. Recent years have been particularly turbulent for pensions operations in the Health Service due to the implementation of various exit schemes, “grace period” initiatives and budgetary changes introduced. In 2013:

- The National Pensions Management Service continued to administer the Health Service pension commitments. The Health Service pensions bill for lump sums averaged €113m per annum in the last four years with the national pension payroll amounting to €176m in 2013.
- The National Recruitment Service (NRS)
  - Received over 25,000 applications for jobs
  - Received on average 334 requests to recruit each month
  - Made 2,634 appointments to jobs.
- Prepared for the provision of personnel administration services for the new Child and Family Agency.

Key Facts

606 **Procurement contracts awarded in 2013**

4m **Visits to www.hse.ie internet site**

23,000 **Staff and retirees registered for online payslips**

83,365 **Staff were paid and 27,863 pensioners paid**

2m **Invoices were paid**

997 **Capital projects supported (406 ICT projects and 591 Estates projects)**

25,000 **Job applications received by the National Recruitment Service**

A Focus On… Intertrade Ireland Seminars

Supporting the development of strategic relationships, a number of cross public sector collaborative events took place in 2013. Over 1,400 small and medium sized enterprises (SMEs) took part in the **Intertrade Ireland seminars**, giving the health sector unique opportunity to engage with the supply base in face-to-face meetings, to continue to ensure that all supply chain activities are managed in line with our business principles, values and requirements. The feedback was very positive from those in attendance – “excellent event gave a great insight into how to approach the relevant bodies correctly”.

Health Business Services (Shared Services)

The overarching public service reform programme includes the implementation of **shared service models** within each public sector as one of fourteen reform initiatives. The adoption of shared service models for support function delivery has a strong Government mandate and remains a key aspect of reform policy across the public service, including health.

The creation of a shared service entity is also a key support and enabler to the wider health reform programme as set out in ***Future Health***, which will ensure that the creation of new administrative structures in the health sector will not result in duplication of administrative functions or increases in administrative costs. The new health structures will require use of shared business services, particularly in relation to estates, procurement, payroll, ICT, financial processing, recruitment, pensions and personnel records. In a time of significant change for the health sector in Ireland, the achievement of the Future Health vision will require delivery of support services at a high quality and in a cost efficient manner.

During 2013, the structure and governance for a shared service model was established and a ***Health Business Strategy 2014-2016*** was developed, for publication in early 2014. The shared services entity will serve all elements of the health system including the voluntary sector and will be driven by a strong awareness of client needs and the challenges facing the wider health environment. The successful implementation of a shared services model will also avoid the risk of investment in duplicated support services across the country in the emergent Hospital and Community Trusts.

What is shared services? A shared service is the consolidation of business operations that are used by multiple parts of the same organisation and is an approach used by companies around the globe to organise and supply internal support services more efficiently and effectively. This is delivered by the streamlining of processes, elimination of duplication, improving the quality and consistency of services provided and delivery of economies of scale whilst freeing up the remaining organisation to concentrate on their own core business. Services are typically back office functions but can also be applied to some middle or front office functions too.

Information and Communication Technology (ICT) Shared Services

This function has responsibility for the development and implementation of ICT strategy and for the delivery of value adding ICT services, projects and support across the entire health system.

- Dr. James Reilly, TD, Minister for Health published an eHealth Strategy for Ireland, the Health Identifiers Bill 2013 and announced the recruitment of a Chief Information Officer for the Health Services. This heralds the establishment of 'eHealth Ireland' in 2014 to progress areas such as ePrescribing, online referrals and appointment scheduling, Telehealth and summary patient records.
- A number of systems were introduced or rolled out during the year including:
  - The national Patient Administration System (PAS) throughout the former South East, Dublin Maternity Hospitals combined, Mercy University Hospital and South Infirmary University Hospital, Kerry/Cork amalgamation.
  - The National Medical Laboratory Information System.
  - Phase 1 of the National Electronic Blood Tracking System (EBTS).
  - National Newborn Screening Laboratory System in the Children's University Hospital, Temple Street.
  - Outpatients self service check-in at Tallaght Hospital for patients.
  - Claimsure.
  - HR Document Management System.
- A new health service and health information site was launched on *www.hse.ie*, which now has a Health A-Z database with easy to follow information on over 600 health conditions.
- ICT supports over 99,000 staff, 45,000 devices and over 1,750 systems.

Estates Shared Services

The Health Service estate comprises 1,640 owned and 954 rented properties. A number of significant projects were progressed which included:

- Seven new Primary Care Centres completed or became operational.
- Seven mental health projects completed and construction commenced on a further eight projects.
- The design of the new National Forensic Hospital and associated services has progressed to planning stage.
- The location of the new National Children's Hospital on the St James's Hospital campus was announced. The Minister for Health established the Children's Hospital Group Board and re-established the National Paediatric Hospital Development Board (NPHD). The NPHD progressed its work to complete the design brief, prepare the site at St James's campus and to appoint a Design Team for the project.
- The construction of a major new extension to the Mater Misericordiae University Hospital was completed, with over €200m in capital funding provided by the Health Service.
- Works were progressed in Cork and Galway to support the next phase of the National Radiation Oncology programme. In both instances these works also supported the development of new acute Mental Health Units.
- Tenders were received for the construction of the Mercer's Institute for Successful Ageing at St. James's Hospital, a €50m capital project co-funded with Atlantic Philanthropies.
- The roll out of NIMIS (a National Integrated Imagining System) continued. At year end, 27 acute hospitals were connected to the system and a further 12 will connect in 2014.
- Over €30m was made available for the replacement of radiology or diagnostic medical equipment in acute hospitals.
- Funding for HIQA compliance works in many older people long term care facilities was made available including Baltinglass, Kenmare (new unit), Lusk, Cuan Ross, Schull, Fermoy, Dalton Home, St Joseph's Trim, Virginia, Ennistymon and others.
- Essential developments in acute hospitals to support service need. For example emergency departments in Wexford, Waterford, Kilkenny and Limerick
- Construction of the National Ambulance Service Control and Command Centre commenced.

- A Health Service Health Energy Office was established to oversee energy management in the Health Service. An energy and water usage database is being developed. (See Appendix 6).
- The new mental health services Phoenix Care Centre in Grangegorman, built at a cost of €21m, won the category 'Best Health Building' at the 2013 Irish Architecture Awards.

Additional information in relation to all capital projects can be found throughout this annual report and summarised in Appendix 5.

A Focus On… Critical Care Block at University Hospital Limerick

The five storey Critical Care Block in University Hospital Limerick was equipped in 2013 following completion of the build in 2012 at a cost of €35m. In the foreground is the two storey ED and Renal Dialysis Block which commenced construction in 2013 and will be operational in early 2015.

Procurement Shared Services

Procurement is the strategic sourcing, purchasing, storage and distribution of Health Service products and services to optimise efficiencies and support the achievement of best value for money, cost reductions and security of supply in the delivery of patient care.

- A reporting system was developed – the Procurement Project Management System (PPMS) – a single system which will be the main management and customer reporting tool for procurement.
- It will also support the savings plan tracking which in 2013 achieved the following savings:
  - €11.5m – equipment and laboratory diagnostics
  - €5.6m – hotel services
  - €2m – professional services
  - €6.2m – logistics and inventory
  - €7.8m – medical and surgical portfolio

A Focus On… National Procurement Awards

The Health Service Procurement Team has scooped three top awards at the **National Procurement Awards 2013** organised by Event Strategies in association with the Irish Institute of Purchasing and Materials Management. The National Procurement Awards aim to encourage teams and individuals to constantly raise the bar, to innovate and maintain their commitment to achieving excellence in procurement in their day-to-day endeavours. The awards attracted over 60 entries, with judges commenting on the overall high standards which made choosing the eventual winners all the more difficult. A distinguished panel of judges was drawn from State, semi-state and private sectors.

The team at the National Procurement Awards 2013 were Peter McGowan, Category Specialist; John Swords, Head of Procurement; Donal Mitchell, Category Specialist;Joe Redmond, Category Management; Fra Mollen, Logistics; Brian Long, Logistics; and Brendan White, Category Management.

Some team members, and supporters, receiving the award

- The initial phase of a National Distribution Centre (NDC) has been established in Tullamore. The centre will be responsible for the purchase, storage and distribution of items, replacing fragmented stand alone stores and departments around the country. Eventually, nine regional hubs will support the new infrastructure for receipt and transportation of stock to customers. Implementation has commenced on a phased basis with complete roll out to be achieved by 2015.
- The Procurement Business Management Unit developed an e-learning training programme to support portfolio and category management teams in completing category analysis. This project was rolled out in conjunction with HSEland and will ensure a standardised approach to category analysis across procurement and will also facilitate the development of category workbooks to support future projects.

Appendix 1: *Membership of Directorate*

As at 31st December 2013

Mr. Tony O'Brien
Director General

Mr. Pat Healy
National Director, Social Care

Ms. Laverne McGuinness
Chief Operating Officer/
Deputy Director General

Mr. John Hennessy
National Director, Primary Care

Mr. Thomas Byrne
Chief Financial Officer

Mr. Stephen Mulvany
National Director, Mental Health

Mr. Ian Carter
National Director, Acute Hospitals

Dr. Stephanie O'Keeffe
National Director,
Health and Wellbeing

Secretary to the Directorate – **Mr. Dara Purcell**

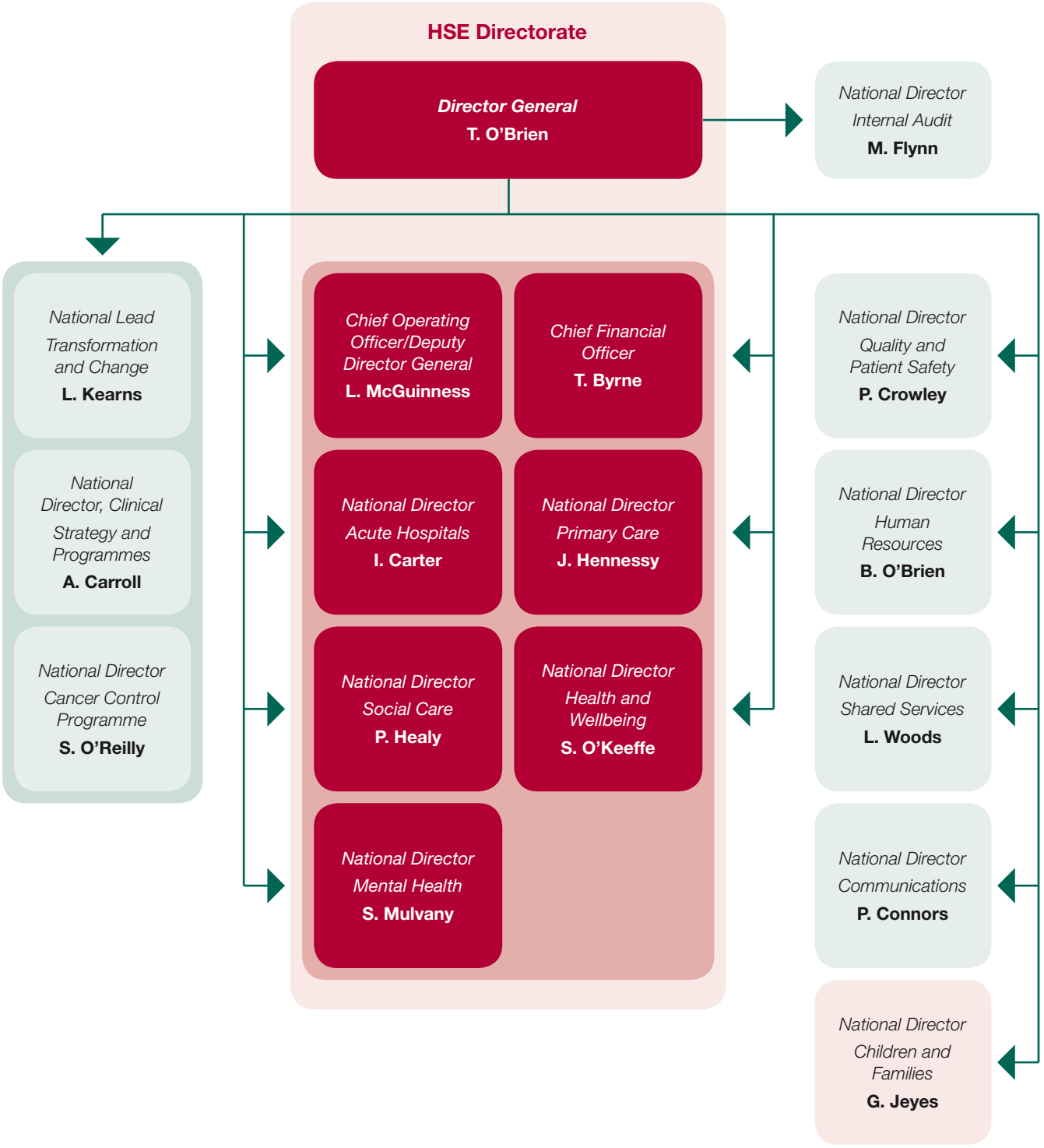
Appendix 2: *Membership of Leadership Team*

As at 31st December 2013

- **Mr. Tony O'Brien** (Director General)
- **Mr. Thomas Byrne** (Chief Financial Officer)
- **Dr. Áine Carroll** (National Director, Clinical Strategy and Programmes)
- **Mr. Ian Carter** (National Director, Acute Hospitals)
- **Mr. Paul Connors** (National Director, Communications)
- **Dr. Philip Crowley** (National Director, Quality and Patient Safety)
- **Mr. Michael Flynn** (National Director, Internal Audit)
- **Mr. Pat Healy** (National Director, Social Care)
- **Mr. John Hennessy** (National Director, Primary Care)
- **Mr. Gordon Jeyes** (National Director, Children and Families Service)
- **Mr. Leo Kearns** (National Lead, Transformation and Change)
- **Ms. Laverne McGuinness** (Chief Operating Officer/Deputy Director General)
- **Mr. Stephen Mulvany** (National Director, Mental Health)
- **Mr. Barry O'Brien** (National Director, Human Resources)
- **Dr. Stephanie O'Keeffe** (National Director, Health and Wellbeing)
- **Dr. Susan O'Reilly** (National Director, National Cancer Control Programme)
- **Mr. Liam Woods** (National Director, Shared Services)
- **Mr. Dara Purcell** (Secretary to the Leadership Team)

Appendix 3: *Organisational Structure*

HSE Directorate and Leadership team



The above reflects the organisational structure as at 31st December 2013. Children and Families Services were disaggregated from the HSE as and from 1st January 2014.

Appendix 4: *Performance against Key National Service Plan Targets 2013*

	Key Performance Indicator	Actual 2012	Target 2013	Actual 2013	% Variance from Target 2013
Acute Services	**Emergency Care**				
	% of all attendees at ED who are discharged or admitted within six hours of registration	67.5%	95%	66.3%	-30.2%
	% of all attendees at ED who are discharged or admitted within nine hours of registration	81.5%	100%	80.8%	-19.2%
	Elective Waiting Time				
	No. of adults waiting more than eight months for an elective procedure	New PI 2013	0	4	
	No. of children waiting more than 20 weeks for an elective procedure	89	0	193	
	Colonoscopy/Gastrointestinal Service				
	No. of people waiting more than four weeks for an urgent colonoscopy	0	0	0	
	No. of people waiting more than 13 weeks following a referral for routine colonoscopy or OGD	36	0	96	
	Outpatients				
	No. of people waiting longer than 52 weeks for OPD appointment	New PI 2013	0	4,937	
	Day of Procedure Admission				
	% of elective inpatients who had principal procedure conducted on day of admission	56%	75%	62%	-17.3%
	% of elective surgical inpatients who had principal procedure conducted on day of admission	New PI 2013	85%	67%	-21.2%
	Re-admission Rates				
	% of surgical re-admissions to the same hospital within 30 days of discharge	New PI 2013	< 3%	2%	31.8%
	% of emergency re-admissions for acute medical conditions to the same hospital within 28 days of discharge	11.1%	9.6%	10.7%	-11.5%
	Surgery				
	% of emergency hip fracture surgery carried out within 48 hours (pre-op LOS: 0, 1 or 2)	84%	95%	83.2%	-12.4%
	Stroke Care				
	% of hospital stay for acute stroke patients in stroke unit who are admitted to an acute/combined stroke unit	Data under review	50%	59%	18.0%
	Acute Coronary Syndrome				
	% STEMI patients (without contraindication to reperfusion therapy) who get PPCI	73%	70%	88.3%	26.1%
	Average Length of Stay				
	Medical patient ALOS	7.2	5.8	6.7	-15.5%
	Surgical patient ALOS	New PI 2013	5.26	4.5	14.4%

	Key Performance Indicator	Actual 2012	Target 2013	Actual 2013	% Variance from Target 2013
Acute Services	**Healthcare Associated Infections**				
	Rate of MRSA bloodstream infections in acute hospitals per 1,000 bed days used	0.058	< 0.06	0.064	-6.7%
	Rate of new cases of Clostridium Difficile associated diarrhoea in acute hospitals per 10,000 bed days used	2.3	< 2.5	2.3	8.0%
	Cancer Services				
	% of breast cancer service attendances whose referrals were triaged as urgent by the cancer centre and adhered to the HIQA standard of two weeks for urgent referrals *(% offered an appointment that falls within two weeks)*	98%	95%	97.9%	3.1%
	% of patients attending lung cancer rapid access clinic who attended or were offered an appointment within ten working days of receipt of referral	89%	95%	91.2%	-4.0%
	% of patients attending prostate cancer rapid access clinic who attended or were offered an appointment within 20 working days of receipt of referral	47%	90%	55.4%	-38.4%
	Palliative Care				
	% of specialist inpatient beds provided within seven days	93%	92%	94.9%	3.2%
	% of home, non-acute hospital, long term residential care delivered by community teams within seven days	83%	82%	87%	6.1%
Ambulance Service	**Emergency Response Times**				
	% of Clinical Status 1 ECHO incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less *(HIQA target 85%)*	69.49%	> 70%	69.3%	-1.0%
	% of Clinical Status 1 DELTA incidents responded to by a patient-carrying vehicle in 18 minutes and 59 seconds or less *(HIQA target 85%)*	67.06%	> 68%	63.8%	-6.2%
Primary Care	**Primary Care**				
	No. of PCTs implementing the national Integrated Care Package for Diabetes	New PI 2013	51	0	-100%
	No. of primary care physiotherapy patients seen for a first time assessment	New PI 2013	139,102	145,213	4.4%
	Social Inclusion				
	% of individual service users admitted to residential homeless services who have medical cards	64%	> 75% (1,847)	64% (1,219)	-14.7%

	Key Performance Indicator	Actual 2012	Target 2013	Actual 2013	% Variance from Target 2013
Health and Wellbeing	**Health Protection**				
	% of children 24 months of age who have received three doses of 6-in-1 vaccine	95.1%	95%	95.3%	0.3%
	% of children 24 months of age who have received the MMR vaccine	92.4%	95%	92.4%	-2.7%
	% of first year girls who have received the third dose of HPV vaccine by August 2013	91.2%	80%	Data under validation	
	Child Health				
	% of newborn babies visited by a PHN within 48 hours of hospital discharge	84%	95%	84.2%	-11.4%
	% of children reaching ten months in the reporting period who have had their child development health screening on time before reaching ten months of age	85.7%	95%	88.1%	-7.3%
Social Care	**Older People Services**				
	No. of people being funded under the NHSS in long term residential care at the end of the reporting period*	22,065	22,761	23,007	1.1%
	No. of people in receipt of a Home Care Package	11,023	10,870	11,873	9.2%
	No. of Home Help Hours provided for all care groups (excluding provision of hours from HCPs)	9.89m	10.30m	9.74m	-5.5%
	% of elder abuse referrals receiving first response from senior case workers within four weeks	99%	100%	96.7%	-3.3%
	Disability Services				
	Total no. of home support hours (incl. PA) delivered to adults and children with physical and/or sensory disability	2.14m	1.68m	2.87m	70.9%**
	No. of people with ID and/or autism benefiting from residential services	8,188	8,172	8,051	-1.5%
Mental Health	**Child and Adolescent Mental Health**				
	% on waiting list for first appointment waiting more than 12 months	15%	0%	17%	> 100% (444)
	Adult Acute Mental Health Services Inpatient Units				
	No. of admissions to adult acute inpatient units	13,584	14,044	13,377	-4.7%
Children and Families	**Child Protection and Welfare Services**				
	% of children in care who have an allocated social worker at the end of the reporting period	91.9%	100%	91.8%	-8.2%
	% of children in care who currently have a written care plan, as defined by the Child Care Regulations 1995, at the end of the reporting period	87.6%	100%	87.4%	-12.6%

* Figures include those funded under NHSS and exclude those with approvals issued but not yet in payment

** Technical adjustment made to NSP target during 2013

Appendix 5: *Capital Projects*

ACUTE HOSPITALS INCLUDING CANCER SERVICES AND PALLIATIVE CARE

Project Stage – Planning

Dublin North East

- **Beaumont Hospital, Dublin –** 44 additional dialysis stations; Upgrade and refurbishment of St. Damian's Ward; Expansion of the histocompatability and immunogenetics laboratories and equipping of theatre 12 to accommodate expansion of the National Renal Transplant Programme; Refurbishment of existing accommodation for the National Cochlear Implant Programme;
- **Connolly Hospital, Blanchardstown, Dublin –** Phased upgrade of the existing radiology department;
- **Rotunda Hospital, Dublin –** Emergency theatre and delivery suite upgrade;
- **Our Lady of Lourdes Hospital, Drogheda –** Phase 2: Construction of a ward block to accommodate 50 replacement beds (single rooms) and the provision of a new theatre department (x4 theatres).

Dublin Mid-Lands

- **Naas General Hospital, Co. Kildare –** Replacement endoscopy suite;
- **Portlaoise Midland Regional Hospital, Co. Laois –** Replacement maternity unit, theatre department, hospital sterile services department, medical assessment unit (MAU), main concourse; Refurbish vacated units to expand day services etc.

Dublin East

- **Mullingar Midland Regional Hospital, Co. Westmeath –** Phase 2: Replacement ward accommodation, theatre department and ED;
- **National Maternity Hospital (NMH), Holles Street, Dublin –** Relocation of NMH, Holles Street to the St. Vincent's University Hospital campus.

South/South West

- **St. Mary's Orthopaedic Hospital (SMOH), Cork –** Upgrade existing ward to facilitate the relocation of Mercy University Hospital's (MUH)Outpatient Department (OPD) to SMOH;
- **South Infirmary/Victoria University Hospital, (SIVUH) Cork –** Refurbishment/upgrade of accommodation to facilitate relocation of ophthalmic surgery from Cork University Hospital (CUH);
- **CUH, Cork –** Haematology/oncology ward upgrade and provision of isolation facilities; Rolling programme of ward refurbishment and upgrade – Phase 1: 50 bed decant ward to enable refurbishment works to commence;
- **MUH, Cork –** Regional Gastroenterology Centre; Replacement/upgrade of boiler and heating controls;
- **Waterford Regional Hospital –** Replacement mortuary and post mortem facilities; new block to include replacement inpatient beds and a palliative care unit.

West/North West

- **Letterkenny General Hospital, Co. Donegal –** Relocate oncology day unit and refurbish/upgrade area to accommodate a new endoscopy suite;
- **Roscommon General Hospital –** Endoscopy suite for medical day procedures and upgrade of HSSD;
- **Merlin Park University Hospital, Galway –** Reconfigure acute rehabilitation beds;
- **Sligo General Hospital –** Neuroscience facility on grounds of hospital; Ward block replacement;
- **Portiuncula Hospital, Ballinasloe –** Replacement ward block;
- **University College Hospital, Galway –** Upgrade and extension of existing ED.

University of Limerick

- **Nenagh Mid-Western Regional Hospital –** Ward block upgrade programme.

National Cancer Control Programme

- **CUH, Cork –** Radiation oncology unit;
- **University College Hospital Galway –** Radiation oncology unit; New clinical block.

ACUTE HOSPITALS INCLUDING CANCER SERVICES AND PALLIATIVE CARE

Project Stage – Planning

Palliative Care

- **Castlebar, Co. Mayo –** 24 bed hospice;
- **Sligo, Co. Sligo –** North West hospice extension;
- **Newbridge, Co. Kildare –** Redevelopment of the existing Drogheda Memorial Hospital to provide hospice care;
- **Wicklow, Co. Wicklow –** New hospice to serve Co. Wicklow;
- **Waterford Regional Hospital –** New block to include replacement inpatient beds and a palliative care unit.

Other

- **National Children's Hospital, Dublin –** Development of National Paediatric Hospital;
- **Our Lady's Hospital for Sick Children, Crumlin –** Catherisation laboratory unit;
- **Clinical Strategy and Programmes –** Pre-assessment units, acute surgical assessment units, minor operations and day service units in acute hospital settings.

ACUTE HOSPITALS INCLUDING CANCER SERVICES AND PALLIATIVE CARE

Project Stage – Continuation of construction in 2013

Dublin North East

- **Connolly Hospital, Blanchardstown –** Provision of an acute MAU; Expansion of urology unit;
- **Rotunda Hospital, Dublin – Mortuary upgrade –** retaining wall stabilisation (boundary wall) and electrical distribution system upgrade;

Dublin Mid-Lands

- **Temple Street Hospital, Dublin –** Interim works including an ECG room, admissions unit, cochlear implant/audiology facility, rapid access clinic in ED, endoscopy and radiology upgrade;
- **Tallaght Hospital, Dublin –** Reconfiguration/upgrade of the adult and paediatric ED to provide additional cubicle space, additional resuscitation accommodation, rapid access and additional triage and upgrade to endoscopy unit; Upgrade/ replacement of the existing renal unit and reverse osmosis water system;
- **St. James Hospital, Dublin –** Upgrade of the main campus wide electrical distribution to facilitate current developments; Mercer Institute for Successful Ageing (co-funded by Atlantic Philanthropy).

Dublin East

- **NMH, Holles Street, Dublin –** Relocation of neo-natal intensive care unit;
- **Mater Misericordiae University Hospital, Dublin –** Refurbishment of a shell and core area in new block to facilitate upgrade of oncology day unit to include a drug compounding unit;
- **St. Luke's Hospital, Kilkenny –** Phase 1: New ED, MAU and day services unit (including endoscopy) and relocation of the education centre; Phase 2: Redevelop hepatology and oncology departments, and the provision of an MRI.

South/South West

- **Wexford General Hospital –** Upgrade and replacement of fire detection and alarm systems, emergency lighting and passive fire protection works;
- **Waterford Regional Hospital –** Upgrade of hospital infrastructure (roads, utilities, power supply etc.) to facilitate the future development of the hospital in line with the hospital's Development Control Plan;
- **CUH, Cork –** Provision of an MRI and CT fit out area above existing PET scanner for MRI; Refurbish/upgrade of existing ward for an acute respiratory care unit (5 bed) and an adult cystic fibrosis inpatient unit (10 bed); Reconfigure existing paediatric care OPD to provide additional isolation facilities in adjacent ward and provision of new paediatric OPD over acute MAU; Provision of a new Helipad; Final phase of acute MAU;
- **MUH/SIVUH, Cork –** Upgrade (phased) of existing inpatient accommodation;
- **MUH, Cork –** Upgrade of the electrical supply and distribution system to comply with current standards;
- **Bantry General Hospital –** Provision of a MAU.

West/North West

- **Letterkenny General Hospital, Co. Donegal –** Emergency and reinstatement (including betterment) works following flooding (radiology, catering, CCU, OPD, Pharmacy, etc.);
- **University College Hospital, Galway –** Clinical research centre; New ward block (75 bed);
- **Sligo General Hospital –** Ward block replacement, enabling works; CSSD Upgrade;
- **Mayo General Hospital –** Renal unit refurbishment and upgrade.

ACUTE HOSPITALS INCLUDING CANCER SERVICES AND PALLIATIVE CARE

Project Stage – Continuation of construction in 2013

University of Limerick

- **Limerick Mid-Western Regional Hospital –** Construction of ED shell and core adjacent to the critical care block; Fit-out of ED; Symptomatic breast, dermatology, acute stroke and cystic fibrosis inpatient and outpatient block; Construction and fit-out of a renal dialysis unit over ED.

Palliative Care

- **Design and Dignity Scheme –** Minor works in acute and non-acute hospital environments to enhance end of life care.
- **Ballina District Hospital, Co. Mayo –** Two-bed end of life care facility.

Other

- **Fire Detection and Alarm Systems –** Hospital wide fire detection, alarm systems and emergency lighting systems to Irish Standard (IS) 3218 and IS3217;
- **Equipment Replacement Programme –** Medical and diagnostic equipment replacement programme;
- **Fire Safety Risk Works –** following 2013 assessment;
- **National Paediatric ED Initiative –** Provision to separate paediatric and adult treatment services in EDs;
- **Special Delivery Units (SDUs) –** Capital allocation to enable SDU initiatives to be implemented.
- **Our Lady of Lourdes Hospital, Drogheda –** Refurbishment of the former nurses home to provide a medic al education centre.

ACUTE HOSPITALS INCLUDING CANCER SERVICES AND PALLIATIVE CARE

Project Stage – Construction completed in 2013

Dublin North East

- **Connolly Hospital, Blanchardstown, Dublin –** MRI installation;
- **Beaumont Hospital, Dublin –** Epilepsy monitoring beds;
- **St. Columcille's Hospital, Loughlinstown, Co. Dublin –** Upgrade and refurbishment of endoscopy suite.

Dublin Mid-Lands

- **Temple Street Hospital, Dublin –** Upgrade 'top flat' ward and neurology unit to comply with infection control and building standards.

Dublin East

- **Mater Misericordiae University Hospital, Dublin – Redevelopment of Mater Adult Hospital –** Phase 3: completion of final works (2 operating theatres and part of North Circular Road entrance);
- **Wexford General Hospital –** New delivery suite and obstetrics theatre, ED and main concourse.

South/South West

- **Mallow General Hospital, Co. Cork –** Day procedures unit/endoscopy suite;
- **CUH, Cork –** Upgrade and refurbishment of existing cardiac theatres (vacated in 2011) to create one trauma and one emergency theatre; Provision of new cardiac and renal facilities in new block on hospital site (including the provision of cath labs and an additional 27 CCU and HDU Beds);
- **Wexford General Hospital –** New delivery suite and obstetrics theatre, ED and main concourse.

West/North West

- **University College Hospital, Galway –** Upgrade of campus wide utility infrastructure to facilitate other major developments.

University of Limerick

- **Mid-Western Regional Hospital, Limerick –** Additional and upgrading of existing infrastructure to meet requirements of the hospital's Development Control Plan – Phase 1: upgrade of electrical distribution system;
- **Mid-Western Regional Hospital, Nenagh –** Provision of two new theatres adjacent to existing theatre department and upgrade of adjacent accommodation capacity (phased completion).

NATIONAL AMBULANCE SERVICE

Project Stage – Planning

National Ambulance Service

- **National Ambulance Control Centre –** Cork Compute Centre: Provision of an integrated National Command and Control Centre on the site of St. Finbarr's Hospital, Cork (combined Garda Síochána/Local Government/HSE facility);
- **Cherry Orchard, Dublin –** Intermediate care ambulance base and motorcycle response base;
- **Loughlinn, Co. Roscommon –** Fit-out of an existing garda station as ambulance station;
- **Cork City –** Ambulance base and headquarters to serve Cork City and County;
- **Ballybofey, Co. Donegal –** Ambulance restroom, St. Joseph's Hospital, Stranolar;
- **Middleton, Co. Cork –** Replacement ambulance station;
- **Tipperary Town –** Ambulance station, St. Vincent's Hospital;
- **Enniscorthy, Co. Wexford –** Ambulance station, St. John's Hospital;
- **Gorey, Co. Wexford –** Ambulance station, Gorey District Hospital.

NATIONAL AMBULANCE SERVICE

Project Stage – Continuation of construction in 2013

National Ambulance Service

- **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;
- **Upgrade Ballyshannon ambulance headquarters** to provide backup and support to the Tallaght Centre;
- **Replacement Ambulance Programme –** Replacement ambulance programme including ambulances, rapid response vehicles, LEAD/ECT02 defibrillators and maintenance of existing fleet.

PRIMARY CARE

Project Stage – Planning

Primary Care

- **Primary Care Centres –** Hacketstown/Tullow/Rathvilley, Co. Carlow; Ballyshannon, Co. Donegal; Corduff, Dublin; On Grangegorman site, Dublin; Monaghan Town (including accommodation for mental health services); On SMOH site, Cork City; Newtowncunningham, Co. Donegal; Finglas, Dublin; Baltinglass, Co. Wicklow; Rowlagh/North Clondalkin, Dublin;
- **Primary Care Centres (Lease agreement):** Kilnamanagh/Tymon; Shankill, Dublin; Swinford, Co. Mayo; Limerick (Market/ Garryowen/Pennywell).

Social Inclusion

- **Ennis, Co. Clare –** Fit for purpose residential addiction treatment service to replace the existing facilities in Bushy Park.

PRIMARY CARE

Project Stage – Continuation of construction in 2013

Primary Care

- **Loughrea, Co. Galway –** Refurbishment of a section of the recently vacated St. Brendan's Community Hospital to provide accommodation for the primary care team;
- **Ballinamore, Co. Galway –** 20 Bed CNU and a primary care centre;
- **Nazareth House, Sligo – Refurbishment –** relocating child development services, mental health day centre, primary care team and other community services; Delivery of a centre for child and adolescent mental health services (CAMHS) in Nazareth Primary Care Centre;
- **Primary Care Centres:** Manorhamilton, Co. Leitrim; Laytown/Bettystown, Co. Meath; Clane, Co. Kildare; Carrigtwohill, Co. Cork.

PRIMARY CARE

Project Stage – Continuation of construction in 2013

Community Health

- **Ballybofey-Stranolar, Co. Donegal –** Phase 1: Refurbishment of ground floor St. Joseph's Community Hospital, Stranolar as local area headquarters to facilitate exiting from a number of existing leases;
- **St. Conal's Hospital, Letterkenny, Co. Donegal –** Phase 2: Refurbishment – fabric upgrade.
- **Meath Hospital, Dublin –** Demolition of a number of derelict buildings in the Meath Hospital Campus and the refurbishment of a number of buildings (City Lodge and doctor's residence) to accommodate services currently in rented accommodation in the South City area;
- **Tullamore, Co. Offaly –** Refurbishment of vacated hospital (Scott's) buildings to replace rented accommodation in the Tullamore area.

PRIMARY CARE

Project Stage – Construction completed in 2013

Primary Care

- **Primary Care Centres by lease agreement –** Newbridge, Co. Kildare; Athlone, Co. Westmeath; Blanchardstown, Co. Dublin; Schull, Co. Cork; Athenry, Co. Galway.

Community Health

- **Kells, Co. Meath –** Purchase and refurbishment of a building to accommodate all the community services in Kells;
- **Chamber House, Dublin –** Fit-out of top floor to accommodate the Environmental Health Service from (other) rented accommodation.

SOCIAL CARE

Project Stage – Planning

Services for Older People

- **Bandon, Co. Cork –** Bandon Community Hospital extension and refurbishment – Phase 1: Upgrade of existing beds;
- **Sacred Heart Hospital, Castlebar, Co. Mayo –** Refurbishment and extension to three long stay wards (85 beds) and a rehabilitation ward (36 beds);
- **Galway –** Dedicated alzheimers residential unit on site adjacent to Merlin Park Hospital.

Disability Services

- **Letterkenny, Co. Donegal –** Refurbishment and upgrade of existing early learning day and outreach facility to accommodate second team;
- **Ballinasloe, Co. Galway –** High support hostel accommodation for residents with intellectual disabilities in St. Brigid's;
- **National Rehabilitation Hospital, Dun Laoghaire, Co. Dublin –** Phase 1: Redevelopment/replacement of existing facility in a phased development.

SOCIAL CARE

Project Stage – Continuation of construction in 2013

Services for Older People

- **Upgrade of non-acute residential facilities to meet HIQA standards –** including Cúan Ros, Seanchara Community Units and St. Oliver Plunkett Hospital, Dundalk;
- **Ballinamore, Co. Leitrim –** CNU on HSE campus (20 bed);
- **Schull, Co. Cork –** Upgrade and refurbishment of Schull Community Hospital;
- **Keel, Co. Mayo –** Purpose built day care centre, St. Coleman's to accommodate comprehensive day care and support to older and disabled people.

Disability Services

- **National Rehabilitation Hospital, Dun Laoghaire, Co. Dublin –** Fire safety works;
- **Fethard, Co. Tipperary –** 2x6 bed high support residential accommodation to replace accommodation in St. Luke's (in association with the Brothers of Charity);
- **Deansgate, Kilkenny –** Purchase and refurbishment of day facility in Deansgate, Kilkenny.

SOCIAL CARE

Project Stage – Construction completed in 2013

Services for Older People

- **Kenmare, Co. Kerry –** Community hospital replacement;
- **Borrisokane, Co. Tipperary –** Day hospital/day centre for the elderly on existing (convent) site;
- **Baltinglass Community Hospital, Co. Wicklow –** Upgrade and refurbishment to fully comply with HIQA guidelines;
- **St. Ita's, Newcastle West, Limerick –** Extension and upgrade of the day and inpatient rehabilitation unit;
- **St. Vincent's Hospital, Athy, Co. Kildare –** Upgrade and refurbishment of Our Lady's, the Holy Family and St. Mary's Units to comply with HIQA standards; Fire safety works; Creation of two 20 bed unit (dementia specific) in St. Anne's Unit;
- **Incorporated Orthopaedic Hospital, Clontarf –** Refurbishment and upgrade of fire alarm and emergency lighting systems, heating distribution system and the installation of a disabled access lift;
- **Lusk Community Unit, Co. Dublin –** Upgrade of non-acute residential facilities to meet HIQA standards;
- **St. Joseph's CNU, Trim, Co. Meath –** Refurbishment (Phase 1 and 2).

Disability Services

- **Sligo (Cregg House Campus) –** Purchase and refurbish existing community group homes on Cregg House Campus;
- **Angle Day Care Centre, Dungloe, Donegal –** Refurbishment/upgrade;
- **Coralstown, Billistown and Crookedwood, Co. Westmeath –** Refurbishment of houses to provide appropriate accommodation for people with intellectual disabilities currently in St. Loman's Hospital;
- **St. Peter's Intellectual Disability Services, Castlepollard, Co. Westmeath –** Upgrade of residential units.

MENTAL HEALTH

Project Stage – Planning

Mental Health Services

- **National Forensic Mental Health Services –** 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*;
- **Clonskeagh, Dublin –** Upgrade of unit 1 to facilitate the primary care service currently accommodated in St. Broc's on campus; Refurbishment of unit 2 to accommodate the Reimse Mental Health Outreach Service;
- **Inchicore, Dublin –** Refurbish and extend Woodlands, Goldenbridge, to accommodate 10 additional residents currently accommodated in two other locations;
- **Portlaoise, Co. Laois –** 50 bed MHU to replace accommodation in St. Fintan's;
- **Sligo General Hospital –** Replace 25 bed Acute Mental Health Unit (MHU);
- **Loughrea, Co. Galway –** Refurbish section of St. Brendan's Community Hospital to provide accommodation for the community mental health team;
- **Tuam, Co. Galway –** Community mental health team base and day hospital;
- **Clonmel, Co. Tipperary –** 10 bed crisis housing unit to replace accommodation in St. Luke's;
- **St. Josephs, Limerick –** Community child and adolescent mental health facility to accommodate services currently in inappropriate and mostly rented accommodation;
- **St. Johns, Enniscorthy, Co. Wexford –** 10 bed crisis housing to replace accommodation in St. Senan's;
- **Waterford City –** 50 bed replacement CNU

MENTAL HEALTH

Project Stage – Continuation of construction in 2013

Mental Health Services

- **Cherry Orchard, Dublin –** 22 bed child and adolescent residential unit (Linn Dara) to serve Dublin Mid-Leinster including school; Refurbish existing office accommodation to provide accommodation for a community mental health facility and other accommodation;
- **St. Ita's, Portrane, Dublin –** Mental health residential accommodation in Carraige House, Maryfield, Dun Na Ri and Glebe House for existing residents of St. Ita's, Portrane; Stabilisation work to listed building including repairs to roofs, windows, parapet walls and heating systems;
- **Crumlin, Dublin –** 17 bed hostel

MENTAL HEALTH

Project Stage – Continuation of construction in 2013

Mental Health Services

- **Donegal Town –** Refurbish Rowanfield House for provision of a community MHU; Community mental health team base in Donegal Town;
- **Our Lady of Lourdes Hospital, Drogheda –** New acute MHU;
- **Grove House, Celbridge, Co. Kildare –** Refurbishment/upgrade;
- **Nazareth House, Sligo –** Delivery of a centre for child and adolescent mental health services (CAMHS) in Nazareth Primary Care Centre.
- **Gort Glas Day Centre, Ennis, Co. Clare –** Refurbishment to provide a mental health day centre;
- **University College Hospital Galway –** Provision of a replacement acute MHU to facilitate the development of a radiation oncology facility on campus;
- **CUH, Cork –** Replacement 50 bed acute MHU;
- **Kerry General Hospital –** Acute MHU;
- **Limerick Mid-Western Regional Hospital –** Phase 2: Refurbishment of and extension to the acute MHU on grounds of the hospital
- **Mullingar, Co. Westmeath –** 12 bed high support hostel, Dublin Road, Mullingar to replace accommodation in St. Loman's;
- **Carrick on Shannon, Co. Leitrim –** Accommodation for community based mental health services;
- **Kerry General Hospital –** Refurbishment and upgrade of acute MHU;
- **Killarney, Co. Kerry –** Combined challenging behaviour and mental health residential unit to accommodate the remaining residents of St. Finan's.

MENTAL HEALTH

Project Stage – Construction completed in 2013

Mental Health Services

- **Beaumont Hospital, Dublin –** 44 bed psychiatric unit to allow the relocation of acute psychiatric services from St. Ita's Hospital, Portrane;
- **Waterford Regional Hospital –** Upgrade of acute MHU;
- **Grangegorman, Dublin –** Replacement accommodation for all services on existing site including accommodation for residents and a day hospital;
- **Crumlin, Dublin –** Interim Primary Care Centre, Mental Health Day Hospital;
- **Ballinasloe, Co. Galway –** Community mental health residential and day facilities to facilitate transfers from St. Brigid's;
- **Mullingar, Co. Westmeath –** 44 high and complex support beds to replace accommodation in St. Loman's;
- **Limerick Mid-Western Regional Hospital –** Phase 1: Refurbishment of and extension to the acute MHU on grounds of the hospital.

CHILDREN AND FAMILIES

Project Stage – Planning

Children and Families

- **Glasnevin, Dublin –** Refurbishment and fit-out of building on Enterprise Ireland Site (now DCU) to accommodate Children and Family Social Workers currently in various leased buildings in the North City area;
- **Childcare Special Care Residential Units –** Special care and high support residential facilities for children and adolescents in Crannog Nua, Portrane and Gleann Alainn, Cork.

CHILDREN AND FAMILIES

Project Stage – Continuation of construction in 2013

Children and Families

- **Drogheda, Co. Louth –** New accommodation for childcare social workers providing services to the North East;
- **Farrybank, Waterford –** Fit-out of building in Farrybank to provide accommodation for childcare staff.

Appendix 6: *Annual Energy Efficiency Report*

Introduction

The Health Service is one of the largest public sector organisations in the country with an estate ranging from domestic houses to major acute hospitals. In response to legislation (SI 542 of 2009) which requires public sector organisations to report annually, this appendix outlines the Health Service's position on its energy use and actions taken to reduce consumption.

In early 2013 the National Health Sustainability Office (NHSO) was established within the Estates function of Health Business Services (formerly Shared Services). It operates at a strategic and operational level within the overall health organisation and acts as the central focal point for all health sustainability issues.

Overview of Energy Usage in 2013

Based on the information issued to Sustainable Energy Authority of Ireland (SEAI) in compliance with the legislation SI 542 of 2009, the table below summarises the energy consumed in 2013:

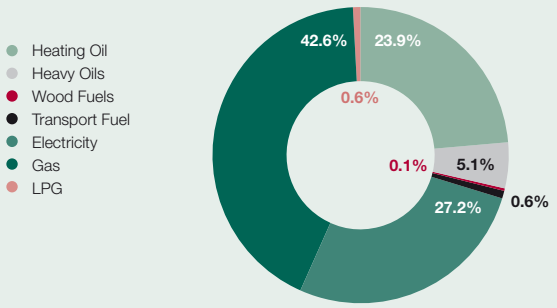
Table 10: Energy Consumption

Energy	Total Energy Use kWh/Yr	%
Electricity	241,613,600	27.2
Gas	378,762,800	42.6
LPG	4,976,760	0.6
Heating Oil	212,620,862	23.9
Heavy Oils	45,376,476	5.1
Wood Fuels	1,221,093	0.1
Transport Fuel	5,179,527	0.6
Total	**889,751,118**	**100.0**

Data source: National Health Sustainability Office

With 1,938 MPRNs and 575 GPRNs reported and verified on the SEAI database, the Health Service is now fully compliant with this Statutory Obligation of SI 542.

Figure 23: Health Service Energy % Breakdown



Data source: National Health Sustainability Office

Actions Undertaken in 2013

The Health Service recognises that as one of the largest energy users in the state, it must be at the forefront in introducing energy reducing initiatives.

A number of significant projects were undertaken including:

- Energy Usage Database
  - A major geographical survey involving 2,443 site surveys was carried out and the key deliverables included photos of the site and relevant buildings, approximate size of the location, photos of all meters on-site and meter numbers, GPS co-ordinates of the site, relevant plant and equipment and vehicle fuel tanks on-site.
  - The prime purpose of establishing this database was to obtain key information necessary for national sustainability programmes, particularly the Corporate Energy and Financial Management Services programme and the National Sustainability Concession Contract programme. The information obtained will also feed into the Estates property database and Health Atlas and it can also act as a snapshot property database verification.
- NHSO and HSE Procurement
  - The NHSO represents the Health Service technically at the Office of Government Procurement (OGP) on the Utilities and Facilities Management Category Councils.
  - Invitation to Tender issued for the provision and supply of refined petroleum products (the approximate value of tender is €20m per annum). The tender also includes an option for developing a pilot metering and monitoring system using Cavan General Hospital as the pilot location.

- National ESCO Action Group (NEAG), Exemplar Projects
  - The Health Service is at the pre-qualification questionnaire (PQQ) stage with three Energy Services Company (ESCO) proposals, namely the installation of wood fuelled boilers in Roscommon General Hospital, Sacred Heart Hospital, Roscommon and Áras Attracta, Swinford, Co. Mayo which also includes some deep retrofit.
- Energy MAP Training
  - The national training programme on energy management and capacity building was run in conjunction with SEAI. The attendance over the three-day programme equated to approximately 400 person days and included representation from the voluntary hospitals.
- Energy Efficient Design Reviews
  - One project is complete under this process and five more projects are included in the programme.
- National Monitoring and Reporting Programme
  - Three sites have been piloted, Oak House (Naas), Dr Steeven's Hospital and Sir Patrick Dun's (Dublin) in the Office of Public Works (OPW) energy management programme; Tallaght Hospital and Galway University Hospital are also under consideration.
- District Heating Proposal
  - Two systems are under review – Letterkenny and Kerry General Hospitals.

Actions Planned for 2014

The NHSO is now established as a separate entity within Health Business Services (Estates) and has built up strong working relationships with other key players including the Environmental Protection Agency, Department of Communications, Energy and Natural Resources (DCENR), SEAI, OGP and OPW. A number of projects are planned including the development of a National Health Sustainability Strategy which will include finalising and launching the Health Energy Strategy and developing national strategies for clinical and hazardous waste, domestic waste, water and wastewater.

Financial Governance

Operating and Financial Review

This operating and financial review outlines the key financial results for 2013, along with the principal drivers of the HSE's performance, both past and future.

Financial Overview

Following the provision of additional funding by way of Supplementary Estimate, the HSE delivered a balanced Vote in 2013. It is a statutory requirement of the Accounting Officer that no overspending of the Vote takes place. In practice, it is almost impossible to achieve an exact breakeven position on a net Vote expenditure of €12.500 billion and it is inevitable that, in accordance with prudent management, a small surplus will be returned to the Exchequer. The surplus to be surrendered in respect of 2013 was €31.074m, (2012: €22.834m), or 0.22% (2012: 0.1%) of the total Vote of the HSE.

Table 11: Key Financial Information 2013 – Vote Accounting

	2013 Estimate	2013 Vote Outturn	Under/ (Over)	Under/ (Over)
	€'000	€'000	€'000	%
Gross Revenue Expenditure	13,562,623	13,537,828	24,795	0.18%
Gross Capital Expenditure	331,000	335,002	-4,002	-1.21%
Total Gross Vote Expenditure	**13,893,623**	**13,872,830**	**20,793**	**0.15%**
Receipts collected by the HSE	969,547	963,814	5,733	0.59%
Other Receipts (Revenue)	384,605	402,353	-17,748	-4.61%
Other Receipts (Capital)	8,000	6,266	1,734	21.68%
Total – Appropriations-in-Aid	**1,362,152**	**1,372,433**	**-10,281**	**-0.75%**
Total Net Expenditure	**12,531,471**	**12,500,397**	**31,074**	**0.25%**

This is a considerable achievement for the health services in view of the very challenging environment in which it has operated this year given the increasing demand due to demographic pressures, the need to ensure patient safety is a priority at all times and considering the very challenging targets for service delivery in areas such as waiting times. However, as a result of prudent financial management and rigorous cost containment, these risks have been mitigated and offset by savings in other areas. In addition, whilst there has been a shortfall in the savings targets, it is important to note that significant savings were achieved, notably in the PCRS with considerable reductions achieved in the cost of drugs and medicines.

The 2013 gross current voted Estimate for the HSE before supplementary reflected a net increase of €71.5m (0.54%). This net increase included new spending and unavoidable pressures of €748m and savings of €721m respectively. The reduction required of the HSE in 2013 was €721m which meant that the total reduction to the HSE budgets since 2008 was €3.3bn (22%). Staff levels have also reduced by over 12,812 WTEs since the peak employment levels in September 2007. To date, cost reductions have been achieved by reducing pay and staff numbers as well as savings in the cost of community drug schemes and procurement. This year required further savings in each of these headings.

Within the confines of the 2013 Estimate the HSE was required to impose expenditure reduction targets which were particularly significant in the acute sector. In addition to acute hospitals each division also had its budget reduced by the estimates measures relevant to it, including those associated with the Employment Control Framework (ECF), other pay related savings and procurement savings as well as significant budgetary targets set under the Haddington Road Agreement (HRA). If the HSE had simply implemented the estimate, then the hospital sector would have faced an impossible financial challenge given its carried forward deficit in addition to the cost challenges in 2013. Arising from this, the HSE undertook to address this carried forward deficit and provide budgets for hospitals through a 'system wide rebalancing' to support the 2012 activity level and the cost increases due to demographic, technology and clinical advancements.

Key Financial and Operational Messages

Services Financial

- The HSE delivered a balanced Vote in 2013 with a small surplus to be returned to the Exchequer.
- The results for 2013 show total gross expenditure of €13.642bn (2012: €13.784bn) for the delivery and contracting of health and personal social services. A Supplementary Estimate of €219m was voted by Government to the HSE at the end of the year to address expenditure difficulties in the acute hospital sector, non-achievement in respect of HRA budgetary targets, non-achievement of income targets due to a delay in the introduction of relevant legislation and timing delays relating to the introduction of primary care schemes savings targets.
- At the end of December 2013, the health sector employed 99,959 whole-time equivalent (WTE) staff, 1,021 WTEs (1%) above the end of year approved employment ceiling. The majority of this variance is in the voluntary hospital sector. This was a reduction of 1,574 WTEs (1.5%) compared to the end of 2012. In total, since employment levels peaked in 2007, the health sector has reduced its numbers by just over 11% (12,812 WTEs).

In the Statutory Sector:

- Pay costs have continued to reduce (€152m or 3% in the year) at a time of increased service activity. There have been reductions in all staff categories. There were reductions in all pay categories, except the Health and Social Care Professional pay category, which increased marginally by 0.85%. The pay reductions in the other pay categories range from 2.79% in Other Patient and Client Care to 0.26% in Management/Administration.
- Non-pay costs increased marginally by 0.12%. Clinical costs increased by 2.42%. This is related to growth in expenditure in medical and surgical supplies, x-ray imaging and other medical equipment. Patient transport costs increased by 2%. This is related to an increase in vehicle running costs of 12%. Expenditure on primary care and medical care schemes reduced by 4.3%. This is attributable to a reduction in pharmaceutical services of 7%. However, there was increased expenditure in the Dental Treatment Services Scheme of 9.4% due to increased eligibility relating to medical cards.

Service Messages

Waiting Times and Access

- The number of people waiting over eight months for an elective procedure was reduced to four people, in one hospital, at the end of December.
- 99% of people on the GI endoscopy waiting list were waiting less than 13 weeks with 96 patients waiting greater than 13 weeks by the end of December.
- 98% of people whose breast cancer referrals were triaged as urgent by the cancer centre were seen within two weeks in 2013, against a target of 95%.
- Day Case: % of Discharges which are Public was 85.3% against a target of 80%.

Hospital activity

- 393,846 people were admitted as emergencies in our acute hospitals that provide an Emergency Care service during 2013. This is 9,009 or 2.34% greater than in 2012.
- 80% of inpatients have been treated in publicly funded acute and specialist hospitals during 2013. This was 78% in 2012.

Older persons

- Home support services: 11,873 people received home care packages in 2013. 46,454 people received home help which amounted to 9.7 million hours over the year.
- Nursing Homes Support Scheme: In December 2013, 23,007 long term public and private residential places were funded under the Nursing Homes Support Scheme as opposed to 22,065 in 2012, an increase of 942.

Mental Health

- Demand on the Child and Adolescent Mental Health Service increased, with 15,319 new (including re-referred) child and adolescent referrals received during the year, 17% above target.
- The latest figures on admission rates to adult inpatient acute mental health units show an increase compared to the same period in 2012. Overall rate of admission increased from 74% to 75% per 100,000 of the population.

Disability

- 2,057 adults with a physical and/or sensory disability benefited from personal assistant hours at December 2013. This is an increase from 1,905 in March 2013. A total of 1.27 million hours were provided.

Primary care services and schemes

- 1,974,806 people had Medical Cards or GP Visit Cards at the end of 2013, down from 1,984,979 at the end of 2012, a 0.5% decrease.
- Number of patients for whom a primary care physiotherapy referral was received was up from 168,719 in 2012 to 175,926 in 2013.

Financial Performance in 2013

One of the key risks that faced the HSE in 2013 was that much of the additional spend, including the funding of the carried forward deficits was dependent on the achievement of savings. There was an inherent risk if the savings were not achieved and new costs were incurred that there would be a growing deficit. Savings measures outlined in the Estimate related predominantly to reductions in pay (including HRA) and primary care schemes expenditure and required considerable management focus to ensure their delivery in 2013. In addition, all discretionary spending had to be minimised. In this respect the health sector faced a very significant financial challenge in 2013. The budget targets set for the HSE were extremely demanding and in support of the HSE's financial management, cost containment plans had to be implemented across the health sector to deal with the continued escalation of expenditure and pressure on the Primary Care Reimbursement Service (PCRS) and acute system. The HSE projected a year end deficit early in the year, having regard to the challenging budgetary targets and the incoming deficit issues.

From the outset in 2013, the HSE identified certain risks to the achievement of the very demanding savings targets in the 2013 National Service Plan. Some of these risks did in fact materialise, such as:

- Delay in negotiating, finalising and implementing the Haddington Road Agreement
- Decision by Government to defer the introduction of charging for private patients occupying public hospital beds, and
- Delay in the introduction of regulations under the FEMPI Act to reduce fees paid to doctors and pharmacists, which could not be introduced until the HRA was finalised.

A Supplementary Estimate of €219m was voted by Government to the HSE at the end of 2013. The deficit for HSE prior to the application of supplementary funding of **€219m** was **€187.9m**, a €31.074m Vote surplus after supplementary. This compares to a Vote deficit of €337m for 2012 (prior to the application of supplementary funding of €360m). This deficit was also inclusive of any once-off savings mainly in pensions available in 2013 which will **not be available to the HSE in 2014.**

Every effort was made to minimise the impact on direct service provision by seeking efficiencies in non-service impacting areas and the service targets that were set reflected this. From a financial performance standpoint when account is taken of the deficits under the key risk areas referred to above, and these deficits are deducted from the gross deficit as they represent risks outside the direct control of the HSE, then the HSE delivered a breakeven position on its **direct services** i.e. *Hospital and Community Services.* This is after the application of once off surpluses which primarily related to fewer than expected retirements in 2013.

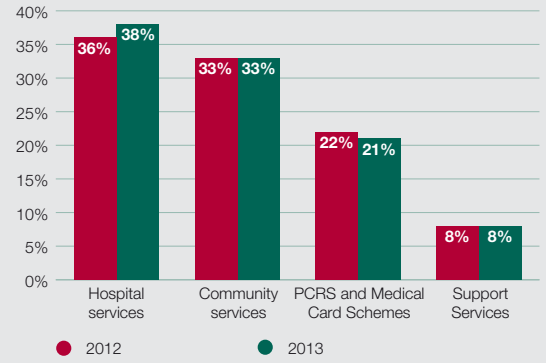
Table 12: Key Financial Information 2013 vs 2012 (Accruals Basis of Accounting)

	2013	2012	Change	Change
	€'000	€'000	€'000	%
Income	13,635,283	13,649,270	-13,987	-0.10%
Net Operating (Deficit)/Surplus: Revenue Income and Expenditure Account	(7,148)	(135,130)	127,982	-94.71%
Revenue Expenditure				
Pay and Pensions	4,871,379	5,023,780	-152,401	-3.03%
Non-Pay (HSE only)	5,293,904	5,296,408	-2,504	-0.05%
Grants to outside agencies	3,477,148	3,464,212	12,936	0.37%
Capital Expenditure	342,227	307,446	34,781	11.31%
Capital Commitments	932,462	774,614	157,848	20.38%
Net Surplus to be Surrendered to the Exchequer	**31,074**	**22,834**	**8,240**	**36.09%**

After the additional supplementary funding the HSE reported a deficit in the Revenue Income and Expenditure Account of €7.148m for 2013 (2012: deficit of €135.130m). A substantial element of this deficit is technical in nature and is attributable to the differences between the differing bases of accounting under accruals and cash accounting rules. Income and Expenditure in the Annual Financial Statements is accounted for on the accruals basis, whereas the Vote is accounted for on a 'cash' accounting basis as required by Government Accounting rules. Net annual funding from the Exchequer as reported in both the Annual Financial Statements and Appropriation Accounts represents the HSE's net recourse to the Exchequer to fund payments made, as distinct from expenditure incurred in the reporting period. As a result, the balances on the Income and Expenditure Accounts do not represent normal surpluses or deficits, as they are largely attributable to the difference between accruals expenditure and cash-based funding. Funding for capital projects in 2013 amounted to €335.708m (2012: €342.305m),of which €273.352m was expended on HSE capital projects and €68.875m on capital grants to service providers. Accordingly, a deficit of €6.519m for 2013 (2012: surplus €34.859m) 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.

The main areas of gross expenditure in 2013 are set out in Figure 24. As can be seen, €5,137m (38%) (2012: €5,002m) was spent on hospital services, €4,526m (33%) on community services (2012: €4,600m), €2,857m (21%) on primary care and medical card schemes (2012: €3,062m) and the remainder (8%) on central and support services. A further €342m was spent on maintaining and developing the capital infrastructure of the health system.

Figure 24: Gross expenditure by service 2013 vs 2012



Data source: HSE Corporate Finance

The Reform Programme

During 2012/2013 a number of reforms were initiated to strengthen the financial management system in the HSE. Following on from 'A Review of Financial Management Systems in the Irish Health Service (Ogden review)', PA Consulting were engaged to draw up measures to be put in place to strengthen the HSE's financial management capacity and processes, having regard to the findings and recommendations of the Ogden review. The review made a number of recommendations to strengthen the financial management process in the HSE with particular reference to managing the transition phase that the health sector is currently undergoing. The HSE is now working on a system-wide financial improvement programme for the HSE through the Financial Reform Programme.

Central to the establishment of the Finance Reform Programme is the recognition that successful implementation of the Government's *Future Health* reform agenda will require fundamental changes in the way financial management is delivered across the health system in Ireland. A key element of Phase 1 of the Financial Reform Programme was the development of a new finance operating model.

This model is contained in a report entitled *Defining Financial Management: A Finance Operating Model for Health in Ireland* which was endorsed by the Finance Reform Board September 2013. The report encompasses a roadmap for the finance function to facilitate delivery of an efficient and effective financial service to meet the emerging requirements of the changing organisational face of the Health System. A critical enabler for the transformation of financial management is the introduction of a single Integrated Financial Management System (IFMS). The appointment of the newly created post of Chief Financial Officer to the HSE was also central to driving forward the changes needed to develop the finance function in the context of the wider health reform programme.

Governance structures were put in place in 2013 for Phase 1 of the Finance Reform Programme which will continue for Phase 2 which commenced in early 2014. The Finance Reform Board will continue to play a key governance role in providing strategic direction for the programme and will be central to the oversight and assurance process from the perspective of the key stakeholders. One of the initial key elements of the programme will be to finalise a detailed business case for a new operating model to meet the requirements of the Office of the Government in relation to securing the necessary approval to procure a new IFMS for the health service. It will define the case for change and scope and estimate the resources required to deliver the operating model and supporting technology.

It is recognised that, while the implementation of an IFMS is key, there is also a requirement for significant organisational change within the finance function. Accordingly, another critical work stream within Phase 1 relates to the design of organisational structures to support the new operating model and to deliver the organisational changes required to successfully transform financial management in health.

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 2014 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. These plans will be monitored through a range of scorecard metrics. Service managers will be held to account and under-performance will be addressed. The National Service Plan 2014 sets out health and personal social services to be delivered by division. Each chapter contains a list of priorities, key actions and measures which will provide information about progress throughout the year. These will link through Divisional Operational Plans, where explicit local targets are named. Performance reports will track delivery against plan and a performance framework will support performance management at local service delivery unit level as it continues to be embedded in the operational system, for hospitals and community services. All reporting formats will be amended to support the new organisational structure and roles. Funded agencies will be managed through improved Service Agreements which will include greater linkages to national priorities and increased transparency in relation to corporate overheads and senior salaries.

Strengthening Governance Arrangements with the Non-Statutory Sector

Since 2009, significant progress has been made in improving the governance and management framework between the HSE and voluntary service providers. National standard governance documentation is mandatory since 2009 and, at the end of December 2013, signed service arrangements and grant aid agreements were in place for 97% of the volume of funding for voluntary/community agencies recorded on the national register.

The Controls Assurance involved in the negotiation and completion of a Service Arrangement now reflects the complexity of the services and includes corporate and clinical governance requirements, quality standards and codes of practice for services and financial controls.

While the Grant Aid Agreement is simpler from a governance control standpoint it still requires adherence to minimum standards. These include a written constitutional document, separate bank account, financial management and tax compliance compulsory for all, and further complaints and human resource requirements where appropriate.

A new Compliance Statement for the boards of voluntary agencies sets out their requirements in relation to key controls assurances and will be a requirement in 2014 for all Section 38 Agencies.

Main Trends likely to affect future Performance and Position

Given the significant financial challenges facing the Health Service, set out below are some of the key risks in 2014. 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 2014.
- In the absence of significant capital investment to bring public long stay residential care facilities in line with HIQA standards, there may be a reduction in residential care capacity, with a resulting increase in hospital and community waiting times. Meeting new HIQA standards within the Disability sector will also pose a significant challenge given the current budgetary constraints.
- Unspecified pay savings of €108m remain to be allocated and will be the subject of a separate process. Until a plan is in place setting out how these savings might be achieved, they pose a risk to the overall approach to financial management in 2014.
- In the event that the budget for pension lump sums is not sufficient to pay the numbers of staff retiring there will be an unfunded liability for the Health Service. Given the risk involved, implementation of this approach will be closely monitored throughout the year as part of the Financial Reporting process.
- Continued implementation of the Reform Programme requires a clear road map for the changes to be implemented in 2014 and beyond. Building the organisational capacity to deliver this change, effective planning will be essential to ensuring the overall governance and stability of services across the country in the midst of these changes.

Conclusion

Looking forward to the 2014 financial year it is evident that it will be one of the most financially challenging years that the Health Service has faced and it will be particularly challenged to fully meet all of the growing demands being placed on services. Implementation of the Health Services Reform Programme as well as a continuation of the Finance Reform Programme will be key priorities for 2014. This important work will be supported by the continued implementation of the Haddington Road Agreement, which will afford us the opportunity to achieve greater efficiencies across all of our services. The health system will undergo further structural change in 2014 and the year ahead will be very challenging on many fronts. It will be with the commitment and dedication of all our staff that the Health Service will be able to meet these challenges to deliver high quality services.

Directorate Members' Report

Introduction – Directorate

The HSE Directorate was established on 25 July 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 is replaced by a Directorate headed by the Director General as Chairperson. The other members of the Directorate are appointed by the Minister from persons employed as HSE National Directors or no less senior grade.

The 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. This creates a new direct line of accountability for the Directorate to the Minister.

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 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.

Organisational structures

In accordance with the organisational structure, governance and management arrangements set out in the Reform Programme *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* the Directorate has mandated that services are now arranged into Divisions covering Primary Care, Social Care, Mental Health, Health and Wellbeing and Acute Services.

In this new structure and as a precursor to the Healthcare Commissioning Agency, the five new National Directors are beginning the process of moving towards a commissioning environment in each of their respective areas of responsibility. The Chief Operating Officer now has primary responsibility for overall performance management across the entire service, service planning, and for ensuring that services are delivered in an integrated and co-ordinated way across all areas. A new role of Chief Financial Officer was established in May 2013 to deliver stability through the implementation of consistent systems and controls and transform the HSE's financial system through the development of a new operating model for finance. The role will also define and implement a long term financial strategy for the HSE.

Meetings of the Directorate (July – December)

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. Between July and December 2013 the Directorate met on 13 occasions, holding six monthly Directorate meetings and seven additional meetings. The attendance at Directorate meetings is recorded in Table 13.

Table 13: Attendance at Directorate meetings (July-Dec 2013)

	HSE Directorate monthly meetings		HSE Directorate additional meetings	
Member	**Total number of meetings**	**Attendance**	**Total number of meetings**	**Attendance**
T. O'Brien	6	6	7	7
L. McGuinness	6	6	7	6
T. Byrne	6	6	7	7
I. Carter	6	5	7	5
P. Healy	6	6	7	6
J. Hennessy	6	6	7	7
S. Mulvany	6	6	7	7
S. O'Keeffe	6	6	7	7

Committees

The *Health Service Executive (Governance) Act 2013* provides for the establishment by the Directorate of the Committees it considers necessary for the purposes of providing assistance and advice to it in relation to the performance of its functions. For the first time provisions are made in the 2013 Act for a statutory audit committee to advise both the Director General and the Directorate on financial matters.

Membership of the new Audit Committee with an independent chair, comprising one Director and five external members in accordance with the provisions of the Health Service Executive (Governance) Act, 2013 was finalised in January 2014.

The Directorate also established the Risk Committee in September 2013 as a standing Committee.

Audit Committee

The role of the Health Service Executive Audit Committee is to advise both the Director General and the HSE Directorate on financial matters relating to their functions. The Committee's duties include, as set out in Section 40(l) (3) of the *Health Service Executive (Governance) Act*, 2013, advising 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 has mandated that non-financial risk management comes within the role of the Risk Committee.*

The duties of the Audit Committee include reviewing and questioning, where necessary, financial reporting, internal financial control and financial risk management.

The Audit Committee also has a role in promoting good accounting practice and reporting, improved and more informed financial decision-making and continued focus on regularity, propriety and value for money throughout the Health Service Executive.

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 Audit Committee membership since January 2014 comprises Mr. Peter Cross (Chairman), Dr. Gerardine Doyle, Mr. Joe Mooney, Mr. John Hynes, Mr. David Smith and Ms. Laverne McGuinness.

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 (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 (both the interim and final audits) of the HSE's annual financial statements and appropriation accounts. The Committee receives regular reports from the National Director of Internal Audit and reports from management on other aspects of financial control, financial risk management and value for money from time to time.

Risk Committee

The Committee's focus is on all non-financial risks and controls, especially:

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

In particular the Committee:

- Advises the Directorate on the HSE's overall risk tolerance and strategy, taking account of the current and prospective macroeconomic and healthcare environment drawing on authoritative sources relevant to the HSE's risk policies;
- Reviews arrangements in place by which employees may, in confidence, raise concerns and receive reports, on a timely basis, of concerns raised under the Policy on Good Faith Reporting, or Procedures on Protected Disclosures of Information and advise on appropriate action to maintain the highest standards of probity and honesty throughout the health services;
- Reviews, at least annually, and if necessary proposes changes to, the HSE's Governance Framework relating to risk management;

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 Risk Committee membership comprises Mr. Tom Beegan (Chairman), Mr. Ger Crowley, Mr. Simon Kelly, Ms. Margaret Murphy, Mr. Pat Kirwan and Dr. Stephanie O'Keeffe.

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 will meet separately with the National Director of Quality and Patient Safety at least once a year.

Support to the Committees

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

HSE Board

From the start of 2013 until its dissolution in [July 2013], a Board was in place, consisting of 11 members, the Chairman and 10 ordinary members, all appointed by the Minister for Health and the Deputy CEO of the HSE as ex-officio member in accordance with Section 11 of the *Health Act 2004*. The Board consisted of senior figures from the DoH and the HSE. The Board members, as of the 25th July 2013, are listed in Table 13 below.

Meetings of the Board (January – July)

Between January and July 2013, the Board met on eight occasions, holding seven monthly Board meetings and one additional meeting. The attendance at Board meetings is recorded in Table 14.

Table 14: Attendance at Board meetings (Jan-July 2013)

	HSE Board meetings		HSE Board additional meetings	
Member	**Total number of meetings:**	**Attendance**	**Total number of meetings:**	**Attendance**
A. McLoughlin	7	6	1	1
T. O'Brien	7	7	1	0
P. Barron	7	6	1	1
J. Breslin	7	5	1	1
Á. Carroll	7	6	1	0
P. Crowley	7	6	1	0
G. Fitzpatrick	7	5	1	1
T. Holohan	7	4	1	1
L. McGuinness	7	7	1	1
B. Nic Aongusa	7	7	1	1
F. Spillane	7	7	1	0

Committees of the Board

The Board had two standing committees in place: the Audit Committee and the Risk Committee.

Audit Committee

The Audit Committee with an independent chair, comprising three Board members and one independent member was in place until the dissolution of the Board in July 2013. The Audit Committee met on four occasions in 2013, and the external auditors attended two meetings of the Committee. The attendance at Committee meetings is recorded in Table 15.

Table 15: Attendance at Board Committee meetings – Audit Committee (Jan-July 2013)

Member	Total number of meetings	Attendance
P. Barron	4	4
G. Fitzpatrick	4	2
L. McGuinness	4	3
T. O'Higgins (Chair)*	1	1
G. Doyle (Chair)	4	4

** Mr. Tom O'Higgins notified the Board after the first meeting that due to ill health he would not be able to continue to Chair the Committee. Dr. Gerardine Doyle agreed to serve as Acting Chair of the Committee for a period of time.*

Risk Committee

The Risk Committee established by the Board also met on four occasions in 2013. The attendance at Committee meetings is recorded in Table 16.

Table 16: Attendance at Board Committee meetings – Risk Committee (Jan-July 2013)

Member	Total number of meetings	Attendance
Á. Carroll	4	3
P. Crowley	4	3
T. Holohan	4	2
B. Nic Aongusa	4	2
P. Kilbane	4	4
M. Murphy	4	1
P. Harrison	4	3
D. Monaghan	4	4
A. Casey	4	3
J. Lavelle	4	3

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.

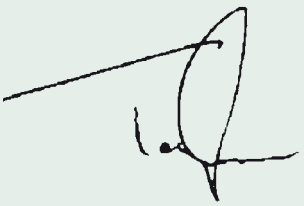
Section 36 of the *Health Act 2004* (as amended by the *Health Service Executive (Governance) Act, 2013*), requires the Health Service Executive to prepare the annual financial statements in such form as the Minister for Health may direct and in accordance with accounting standards specified by the Minister.

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

20 May 2014

Statement on Internal Financial Control

This Statement on Internal Financial Control represents the position for the year ended 31 December 2013.

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. The HSE must comply with directives issued by the Minister for Health under the Act.

The HSE Directorate was established on 25 July 2013, following the enactment of the Health Service Executive (Governance) Act 2013. The new Directorate is accountable to the Minister for Health, for the performance of the HSE. The establishment of the Directorate was a step in a much wider process of reform which envisages, as set out in the Programme for Government, the eventual dissolution of the HSE. The HSE (Governance) Act builds on existing accountability arrangements under the Health Act 2004, such as annual service plans and reports, codes of governance and the provision of information to the Minister for Health. The Act 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 (DG). 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 DG's functions include carrying on, managing and controlling generally the administration and business of the Executive. The DG is the Accounting Officer for the HSE. The DG 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. Management at all levels of the HSE is responsible to the DG 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.

Basis for Statement

I, as Chairman of the Directorate, make this statement in accordance with the requirement set out in the Department of Finance Code of Practice for the Governance of State Bodies.

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 expenditure of €14billion incurred by the HSE in 2013 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 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 the review in 2013 of current financial management arrangements reiterated the consensus amongst the finance community in the HSE that the current financial operating model is 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. The Programme is a key element of overall system reform and, following on from reports by Ogden and PA Consulting in 2012, a report recommending a new operating model for Finance, ***Defining Financial Management – A Finance Operating Model for Health in Ireland***, was completed by PA Consulting in 2013. It is expected that the new finance operating model for health, when implemented, will support far reaching and fundamental change in financial management practice and will be an important enabler in wider system reform. Underpinned by a single integrated financial management system and mandated financial management framework, these changes will ensure stability and an improved control environment within a reformed health system and will drive a culture of collective responsibility and cost consciousness. 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* including introducing Hospital Groups and Money Follows the Patient. Phase 1 of the programme is now complete and has made a significant impact in tackling specific challenges in service planning, budgeting and cost-containment. The challenge facing the HSE is how best to transform financial management during a period of unprecedented change across the healthcare system. There is a need to build on what has been achieved in recent months and to deliver an approach to financial management that secures medium term stability and cost containment while allowing sufficient flexibility to support the wider reform agenda. Phase 2 of the Finance Reform Programme commenced in December 2013 and involves the development of a business case to obtain the necessary approval to procure a new integrated financial management system for the health service. This programme is the start of a multi-year project that will ultimately affect all staff within the health system as it will fundamentally transform the way we manage finance, facilitated by a change in culture, systems and processes. The Finance Reform Programme is the single most important non-clinical priority of the Health Service for 2014.

Key Internal Financial Control Procedures

The following is a description of the key processes and procedures, designed to provide effective internal financial control, which are in place across the HSE:

- 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.
- 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.
- 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. 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. Ten National Financial Regulations were updated in 2013 to reflect new organisation structures, legislation and best practice. Six new National Financial Regulations were launched during the year, standardising policy and procedures in key HSE operations. 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.
- 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 DG within a formal performance monitoring framework (National Planning and Performance and Assurance Group process), described in further detail below.
- 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.
- A detailed **standardised appraisal process** is conducted for all capital projects 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 VFM 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 Department of Public Expenditure and Reform's VFM Code (2012). 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.
- **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 DG, 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 DG must then be submitted to the Directorate for final approval. Any disposal of property below market value requires approval of the Directorate.
- 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. While clinical risk management processes in the HSE are relatively mature, non-clinical and financial risk management processes are subject to ongoing development. The full suite of HSE risk management policies, procedures and guidelines are published on www.hse.ie.

- 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 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 2013. 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.
- The legal framework under which the HSE provides grant funding to non-statutory service providers is set out in the Health Act 2004. The HSE has a formal **national governance framework** with national standardised documentation which governs grant funding provided to non-statutory organisations. The governance framework for the non-statutory sector seeks to ensure the standard, consistent application of good governance principles which are robust and effective to ensure that both the HSE and the agency meet their respective obligations.

  All grant funding is now governed by one of four standard document types, depending on the nature of the arrangement, as follows:

  - *Section 38 Service Arrangements:* these cover all voluntary hospitals and major non-acute voluntary agencies, in total 39 agencies;
  - *Section 39 Service Arrangements:* cover all other voluntary and community agencies not included above, in receipt of funding over €250k, currently 366 agencies;
  - *Section 39 Grant Aid Agreements:* cover all agencies in receipt of funding under €250k, the vast majority of agencies fall into this category with some 1,959 agencies currently funded; and For-Profit Service Arrangements cover all agencies in the commercial for-profit sector regardless of funding level, currently some 252 Agencies.

  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. Various guides and process control forms are maintained on the HSE's intranet site together with a comprehensive operational manual supporting the recently issued HSE National Financial Regulation, *NFR-31 Grants to Outside Agencies*. 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 advances will allow the HSE to advance the strategies outlined in *Future Health*, and enable the development of a "money follows the patient" funding model.

  The Grant Aid Agreement, while a simpler governance control, sets out minimum standards, such as the requirement for a written constitutional document, separate bank account, financial management and tax compliance, which is compulsory for all. Further compliance requirements are also included where appropriate.

  The documentation has been reviewed and updated in recent years and changes have been made to ensure the documentation reflects current legislation, regulation and government department directives. In 2013 an additional information return was added to all Section 38 and Section 39 Service Arrangements, requiring agencies to separately report on all individual staff paid at Grade VIII level equivalent or above, detailing their salary including allowances and any other benefits paid. This additional information is required by 31 May 2014. A new Compliance Statement setting out additional assurances in relation to key controls assurances will be required to be signed off in 2014 by the Boards of all Section 38 Agencies.

- **A National Register of Non-Statutory Agencies' Service Arrangements and Grant Aid Agreements**, is in operation. This Register is managed by the National Business Support Unit (NBSU) and has created a unique identifier for each agency allowing the maintenance of key information on each separate funding arrangement which includes both current and historic funding, compliance with national standard governance documentation, and key contact details. This is available on the HSE intranet site as a reference guide for all HSE managers. Monthly performance monitoring statistics and reports are prepared.
- As part of the HSE's Transformation and Change Agenda, a **System Reform Group (SRG)** was established to project manage the HSE Reform Programme. The SRG is led by the National Lead for Transformation and Change. The National Lead leads the HSE Reform Programme on behalf of the DG, providing the strategic vision and driving the change management and benefits focused culture across the organisation. The SRG manages the HSE Reform Portfolio and provides expertise and change management support to the individual programmes.
- As part of the HSE's annual review of the effectiveness of the system of internal controls, all staff at Grade VIII (or equivalent) level and above are required to complete a **Controls Assurance Statement**, confirming their compliance with policies and procedures and attesting to the existence and operation of controls which are in place in their area of responsibility, or identifying where exceptions or weaknesses exist.

Planning, Performance Monitoring and Reporting

- 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, HSE (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 social care to the people who use HSE services. It includes performance and activity measures 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 required to meet estimated need and can be delivered within the resources that are available in the year. The 2013 National Service Plan was submitted to Minister for Health on 21 December 2012 and approved on 9 January 2013. 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. This was following an extension of the time-limits, as allowed in legislation, following a request to the Minister by the HSE. The plan was approved by the Minister on 17 December 2013.
- To underpin the National Service Plan, a **National Operational Plan 2013** was published to support implementation, setting out a national position for each main care group/programme in order to guide the translation of national policy into the four Regional Service Plans and three Hospital Group Plans. 2013 was a year of transition for the health service, moving from a regional governance model to a national Divisional model, with local accountability. The format and structure of all plans and reports will evolve to reflect these new arrangements in 2014.
- During 2013, as part of the overall planning and performance framework, a National Planning, Performance Assurance Group (NPPAG) was formally established by the DG and its monthly meetings are chaired by the COO/Deputy DG. The NPPAG is the principal planning and performance assurance group within the HSE and 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 (PAR) for submission to the DG and HSE Directorate after which it is submitted to the Department of Health and published.

  The core membership of the NPPAG includes the Chief Financial Officer and all those who are responsible and accountable for budgets and service delivery.
- The performance management process is managed at local, regional and national levels. Its approach seeks to ensure:
  - Performance management and responsibility resides at the most appropriate level;
  - A stronger regional role in managing performance;
  - Performance management at national level has a dual purpose of providing assurance to the DG and Minister and is an escalation process for addressing underperformance.

  To support performance assurance, a robust management process takes place in preparation of the monthly NPPAG meeting, following which the COO/Deputy DG meets with the DG to review the draft 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
- Timely and comprehensive reports about how services are performing against various targets, including financial, enable HSE staff and managers to increase service efficiency and effectiveness. These include:
  - Regional Management Data Reports: produced to assist the performance management process at regional level (Regional Directors Operations/Regional Directors Performance and Integration (RDPI)). These reports are made available to the COO/Deputy DG and service Directors;
  - 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. The forum provides for a resolution focussed approach to improving performance and sharing best practice;
  - Monthly regional Performance Exception Reports are aggregated to produce a report to inform the COO 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).
- 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 in June each year.

- The HSE Appropriation Account – prepared by the HSE and audited by the Comptroller and Auditor General and 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.

- 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.
- 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.
- 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.
- The HSE is required to submit a monthly Vote issues report and return and a monthly Vote expenditure 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.
- 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.
- 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.
- 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. The BIU comprises two units:
  - BIU Acute to manage data streams from 48 acute hospitals;
  - BIU Non-Acute to manage data streams from all non-acute Divisions: Health and Wellbeing, Primary Care, Social Care, Mental Health and the National Ambulance Services.

  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.

Directorate Oversight

- 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. 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. The work of the Internal Audit division is reviewed by the Audit Committee, which reports to the Directorate. Procedures are in place to ensure that the recommendations of Internal Audit are followed up. The National Director of Internal Audit reports to the DG of the HSE through the Chairman of the Audit Committee and has a close working relationship with the DG and is a member of the HSE leadership team. Any instances of fraud or other irregularities identified through management review or audit are addressed by management and, where appropriate, An Garda Síochána are notified. Work is ongoing to increase the resources of the Internal Audit Division.
- An **Audit Committee** with an independent chair, comprising three Board members and one independent member was in place until the dissolution of the Board in July 2013. The Chairman of the Audit Committee was not a member of the HSE Board but reported to the Board on all significant issues considered by the Committee. The Committee operated under agreed Terms of Reference and met on four occasions in 2013. The National Director of Finance and the National Director of Internal Audit attended meetings of the Committee, while the CEO and other

members of the executive management team attended when necessary. The external auditors attended as required and had direct access to the Committee Chairman at all times. In accordance with best practice, the Committee met with the National Director of Internal Audit and with the external auditors in the absence of management. A new Audit Committee with an independent chair, comprising one Director and five external members was appointed in January 2014, in accordance with the provisions of the Health Service Executive (Governance) Act, 2013.

- A **Risk Committee** with an independent chair, comprising four Board members, one independent member and three members of HSE senior management was in place until the dissolution of the Board in July 2013. This Committee met on four occasions in 2013. The Chairman of the Risk Committee was not a member of the HSE Board but reported to the Board on all significant issues considered by the Committee. Following the enactment of the Health Service Executive (Governance) Act, 2013, a Risk Committee was established, reporting to the Directorate. This Risk Committee has an independent chair and comprises a Director and four external members. The Risk Committee of the Directorate met on one occasion in 2013. Both Risk Committees operated under agreed Terms of Reference and focused principally on assisting the Board/Directorate in fulfilling its duties by providing an independent and objective review of non-financial risks. The Committees also considered internal audit reports concerning the effectiveness of non-financial internal controls and HIQA reports including the implementation of HIQA recommendations. Liaison will be facilitated by periodic joint meetings of the two committees and regular engagement between the two committee chairs. Minutes of the meetings of each committee will be shared reciprocally.
- **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 Managers in the HSE with responsibility for the development and maintenance of the management control framework. 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 Leadership Team and actions are taken to implement recommendations. Monitoring and review of their implementation is overseen by the Audit Committee.

Significant Breaches of the Control System in 2013

Governance of Section 38-Funded Agencies

In 2013, almost €3.5 billion of the HSE's total expenditure related to grants to voluntary agencies.

A condition of these grants is that the individual agencies sign either a Service Agreement or a Grant Aid Agreement which sets out the amount of the grant and the services that the agency will deliver. In addition, the agency must comply with public sector pay policy. The HSE has processes in place to monitor agencies which includes checks to ensure that agencies are complying with the terms of the Service Agreement and the review of audited accounts from the agency.

Audit work carried out by the Comptroller and Auditor General and the HSE's Internal Audit has identified weaknesses in relation to the HSE's overall monitoring of S38 agencies and in agencies' compliance with public sector pay policy. At the end of 2013, signed governance documentation was in place in relation to 97% of the value of grant funding provided.

In relation to compliance with pay policy:

The Department of Health drew up a pay policy for the health service with a particular focus on Section 38 Agencies. This was issued to the HSE on 27 September 2013. The Department of Health Circular was issued to the health sector by the National Director of Human Resources by way of HSE HR Circular 016/2013 on 30 September 2013. As part of the ongoing process to reach compliance, organisations seeking to make a business case for the continuation of an unapproved allowance were invited to submit their business cases for consideration by the HSE. Business cases were also required for the continued payment of allowances which are not encompassed by or in line with the Department of Health Consolidated Salary Scales but may have been sanctioned in the past. A total of 202 business cases were received.

143 business cases were received in respect of Senior Managers (i.e. those at salary level of Grade VIII and above) for consideration by the Internal Review Panel. In addition, 59 business cases in respect of salary level below Grade VIII have been reviewed at operational level by the Regional Directors of Performance and Integration with support from Regional HR.

An Internal Review Panel, comprising of nominated members of the HSE Leadership Team, reviewed each business case in detail and their deliberations were summarised in a report. Agencies that had submitted business cases were advised of the decision of the Internal Review Panel on 8 April 2014 and were also sent a copy of the report of the Internal Review Panel. The report provided details on the criteria the Panel used when assessing the merits of each business case; provided a narrative on the decisions made; and outlined legal considerations to assist when making arrangements to cease the payment of unapproved remuneration. Each agency was also provided with a breakdown of the business cases received in respect of their organisation and the decision made in each case.

It is now the responsibility of each Agency to implement the recommendations made by the Internal Review Panel as a matter of urgency. A period of up to three months to 1 July 2014 has been set to allow time for Agencies to make the necessary arrangements to cease the payment of all unapproved remuneration and to ensure appropriate risk mitigation measures are put in place to deal with issues as they arise. Agencies were requested to set out the course of action they intend to take to give effect to the decisions of the Internal Review Panel and to respond to the National Director of Human Resources no later than 16 May 2014.

In relation to the HSE's monitoring of agencies to ensure that funds are being applied for the purpose granted and that value for money is being achieved:

During 2013, the HSE completed a specific project aimed at strengthening the management and governance framework with specific emphasis on the appropriate management processes required to effectively manage its relationship with the non-statutory sector and meet its accountability arrangements. As a result of the project, a number of guidance documents have been developed to assist budget holders in improving their management of the relationship with funded agencies.

Where agencies did not complete a service agreement (or similar document) in 2013, the HSE has communicated with the agency involved and taken appropriate action, resulting in some cases in the cessation of contracts.

In order to ensure continued focus on compliance with service agreements, the rate of compliance with the requirement for grant-funded agencies to sign funding agreements is included as a key performance indicator for both Corporate and Regional reporting.

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.

As the Accounting Officer, I am required in the Statement on Internal Financial Control to attest to compliance with all relevant procurement procedures during the financial year. In addition, 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 to maintain a register of contracts awarded without a competitive process. Rather, it relies on individual areas to identify and report such non-compliance. As a result of this manual self-assessment process, the HSE was unable to submit the 40/02 return by the required date. In the past, returns submitted did not include all instances of non-competitive procurement that were appropriate for declaration in the return.

In 2013 and in previous years, audits have identified a significant level of non-compliance with procurement rules. In order to address the weaknesses, during 2013 the HSE assigned responsibility for collating the required information to a designated Assistant National Director of Procurement and ensured that control assurance statements signed by individual managers require a declaration that managers have complied with procurement guidelines. During 2014, the HSE plans to increase the level of communication and training to staff on the requirements of Circular 40/02 and on procurement rules generally, with a view to improving compliance in this area in 2014.

Tax compliance

The HSE is currently finalising a comprehensive review of tax compliance which was commenced in 2013. The detailed self-review was conducted across all tax heads for which the HSE needs to account and focused in particular on those risk areas identified by the formal tax risk assessment which was conducted with external specialist tax assistance in 2012. Any underpayment of tax identified in the self-review will be the subject of a voluntary disclosure to the Revenue Commissioners in 2014. The HSE has obtained specialist tax advice which indicated that any liability which might arise would not be expected to be material in the context of the HSE's overall annual tax liability. The HSE's tax control framework is immature and requires significant further development from a tax governance, risk management and compliance perspective. A number of initiatives to improve future compliance are underway, such as the establishment, in 2013, of an in-house specialist tax function for the HSE, and the development of a structured ongoing training programme for staff and a rolling programme of self-review, which will be rolled out during 2014. The HSE remains committed to exemplary compliance with taxation laws.

Recovery of income from other States

Income from services provided under EU Regulations accrues to the State where:

- People from other EU countries access health services in Ireland using a European Health Insurance Card (EHIC) in either an acute hospital, a Local Health Office, a pharmacy or from a GP.
- Where people from other states come to live in Ireland and are issued with medical cards by the HSE whilst retaining their social security link to another State.

It has been established that all the data necessary for claiming refunds from other EU Member States for these services has not been collected in some cases.

A project has commenced to improve data collection and quality to maximise the income generation potential for this recovery. Notwithstanding the constraints of a manual system, it is anticipated that the HSE will issue its first reimbursement claims in Quarter 2 2014. It is not possible to be specific on the value of such claims until such time as they are finalised.

Control 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 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 this information sharing for the purposes of control over medical card eligibility continues to develop.

Renewal Notice Reviews

At 1 January 2013, there were almost 1,854,000 full medical cards and just over 131,000 GP visit cards in issue. During 2013, 1,279,000 cards were due to expire in monthly tranches. The full cohort in 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 almost 601,000 persons. Renewal notices were not issued to the remaining 678,000 persons as it was concluded on the basis of the 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 601,000 renewals issued in 2013, 284,000 involved a full review and 317,000 requested the cardholder to self-assess.

As at 7 April 2014, the assessment of eligibility had been concluded in relation to 75% of the cardholders selected for review.

- Continuing eligibility was confirmed in relation to 429,000 cards (71%).
- 22,500 cards (3.75%) were not renewed because the eligibility criteria e.g. income thresholds were not met.
- In 8,000 cases (1.3%) the cardholder was deceased.
- Almost 18% 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 34,000 cards (5.7%).

Targeted Reviews

A review is categorised as "targeted" when it is initiated during the eligibility period rather than when the card is due for renewal. During 2013, the HSE issued 44,000 targeted reviews. As at 7 April 2014, the assessment of eligibility had been concluded in relation to 9,200 cardholders.

- Continuing eligibility was confirmed in relation to 6,900 cards (75% of the completed assessments)
- Eligibility was removed in 2,300 cases (25% of the completed assessments) because the eligibility criteria e.g. income thresholds were not met.

In a further 39% 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 17,400 cards and in 192 cases the cardholder was deceased.

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 2013, 102,000 individuals whose medical cards had been inactive for periods of more than 12 months were contacted requesting residence confirmation. As at 28 February 2014, 76,600 individuals (75%) had confirmed residence. Eligibility was removed in relation to 25,403 cards (25%).

Overall Ineligibility Rate

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

Review of the Effectiveness of the System of Internal Financial Control

The annual review of the effectiveness of the system of internal control of the HSE is directed at enabling the DG 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 2013 a formal **Review of the System of Internal Control** in the HSE was completed by the Finance Directorate with input from the Quality and Patient Safety Directorate, the results of which have informed this Statement on Internal Financial Control. The review was carried out by finance and quality and risk managers with specific expertise in the areas of finance, audit, control, quality 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 2013.

The methodology of the 2013 review involved reference to:

- Status of the recommendations of the 2007 – 2012 Reports on the Review of the Effectiveness of the System of Internal Control;
- Controls Assurance Statements completed by all senior managers, administrative and clinical, from National Director Level to Grade VIII (or equivalent relevant) level. This had regard to the 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;
- Results and findings of formal structured bilateral interviews with a representative sample of approximately 100 managers and heads of service and their responses to an internal controls questionnaire (ICQ) completed during each interview;
- Internal Audit reports, 2013 audit programme;
- Audit Committee and Risk Committee Minutes/Reports;
- Reports and management letters of the Comptroller and Auditor General;
- The 2013 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 Board/Directorate 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 ;
- Mental Health Commission 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 Programme for Government.

The scope of the review has been expanded over previous years to require the completion of Controls Assurance Statements by clinical management, and for Clinical Directors to complete a self-assessment review in the bilateral interview sessions. The content of the Controls Assurance Statement itself was enhanced to include assurances in relation to compliance with Circular 40/02 (procurement) and with the HSE's data protection policies. In addition, managers were required to confirm that they had not issued any letters of comfort in the period under review.

A new requirement in the 2013 review was for line management to co-sign each staff member's Control Assurance Statement to confirm that they had discussed the internal controls framework of the HSE, had examined evidence of non-compliance presented in the statement and risk register, and where appropriate, had agreed action plans to address weaknesses or escalate the risk to a higher level within the organisation.

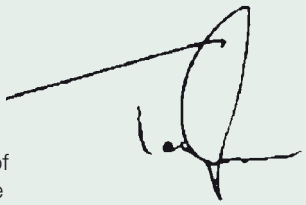
A further element of the controls assurance process, the internal controls questionnaire (ICQ), was extended in recent years to include Clinical Directors. The ICQ is completed by a sample of senior managers during a formal bilateral interview. This represents a significant integration of clinical and financial risk management to enable a comprehensive assurance process for the HSE Directorate. Full compliance by staff with the extended controls assurance process in 2013 has not been achieved. Compliance rates, within those divisions that have completed the process, range from 70% to 100%, with an average compliance rate of 92%. While the rate of overall compliance with the process has improved slightly compared with previous years, there are still particular service areas where compliance has been low. The individual National Director Registers identify the staff who have and have not signed a Controls Assurance Statement and the level of non-compliance, while improved, remains unacceptable. The absence of a signed Controls Assurance Statement attesting to the operation of controls in such a large number of cases gives rise to a concern that corporate risks may not be appropriately identified and addressed.

ICQ interviews were conducted with a sample of over 100 senior managers from across the services, including one Clinical Director. It is necessary to achieve a higher representation of Clinical Directors in this ICQ process and steps are being taken by management to obtain higher levels of participation from this cohort. It was necessary to conclude the 2013 Controls Assurance Process by the end of March 2014, however each Regional Director of Performance and Integration was instructed to conclude the 2013 process to the maximum extent possible by continuing to engage with individual managers who have not signed their statements, to ensure that they do sign.

Conclusion

The report of the Review of the System of Internal Control in the HSE was circulated to the Directorate in May 2014. Their 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 roll out and subsequent extension in scope and depth of the annual controls assurance process in recent years has had the effect of increasing awareness and understanding of the control system throughout the organisation. The monitoring of progress with the implementation of the report's recommendations has improved focus on compliance by managers.

There have been breaches of the control environment of the HSE which are referenced in this statement. These breaches point to the need for continued emphasis on and development of the control environment and a focus on the need to drive a single organisation wide culture of compliance. In summary, notwithstanding control breaches which were identified and are being addressed by management as set out above, the control environment, control and risk management processes and assurance arrangements are improving but are still not totally effective. There are a number of areas where specific action is recommended to increase effectiveness and consolidate on the improvements which have been put in place since the previous report. Structured plans for the implementation of the recommendations of the Review of the System of Internal Control in the Health Service Executive are prepared by management. The implementation of these recommendations by management will be monitored by the Audit Committee during the year and will be reassessed in the 2014 review of the system of internal controls.



Tony O'Brien
Chairman

20 May 2014

Report of the Comptroller and Auditor General

For Presentation to the Houses of the Oireachtas

I have audited the financial statements of the Health Service Executive for the year ended 31 December 2013 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 2013.

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 2013 and of its income and expenditure for 2013.

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.

Medical card ineligibility

The statement on internal financial control discloses that significant proportions of medical card holders are found, following reviews, not to be eligible to continue to hold their cards. Because cases for review are selected on the basis of risk criteria, the rate of ineligibility detected may be higher than that which exists in the cardholder population as a whole. The Health Service Executive does not currently have a reliable estimate of the underlying level of ineligibility among card holders but is examining options for developing a suitable methodology to produce such estimates.

Non-compliant procurement

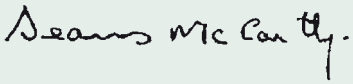
In examining a sample of procurements of goods and services by the Health Service Executive, the audit found a high incidence of failure to comply with relevant guidelines and regulations. The statement on internal financial control discloses steps being taken by the Health Service Executive to address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

Other breaches of controls

The statement on internal financial control also discloses a number of other breaches of the control systems in 2013, including

- weaknesses in the Health Service Executive's oversight and monitoring of grants to voluntary sector service providers, and instances where the service providers did not comply with public pay policy
- non-recovery of potential income from other EU States
- instances of non-compliance with the tax code.

The statement on internal financial control also outlines the steps taken by the Health Service Executive to address these lapses in control.



Seamus McCarthy
Comptroller and Auditor General

21 May 2014

Revenue Income and Expenditure Account

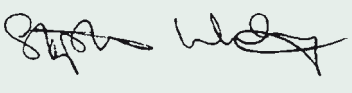
For Year Ended 31 December 2013

	Note	2013	2012
Income		**€'000**	**€'000**
Exchequer Revenue Grant	*3*	12,171,661	12,161,428
Receipts from certain excise duties on tobacco products		167,605	167,605
Income from services provided under EU regulations		220,000	220,011
Recovery of costs from Social Insurance Fund		14,748	0
Patient Income	*4*	371,124	378,716
Other Income	*5*	690,145	721,510
		13,635,283	13,649,270
Expenditure – Pay and Pensions			
Clinical	*6 & 7*	3,143,812	3,232,702
Non-Clinical	*6 & 7*	1,038,696	1,066,275
Other Client/Patient Services	*6 & 7*	688,871	724,803
		4,871,379	5,023,780
Expenditure – Non-Pay			
Clinical	*8*	856,264	836,019
Patient Transport and Ambulance Services	*8*	56,682	55,601
Primary Care and Medical Card Schemes	*8*	2,901,490	3,032,397
Other Client/Patient Services	*8*	64,866	65,729
Grants to Outside Agencies	*8*	3,477,148	3,464,212
Housekeeping	*8*	232,970	227,362
Office and Administration Expenses	*8*	408,534	386,723
Long Stay Charges Repaid to Patients	*30*	230	1,149
Hepatitis C Insurance Scheme	*31*	1,209	911
Payments to State Claims Agency	*28*	135,874	75,668
Nursing Homes Support Scheme (NHSS) – A Fair Deal: Private Nursing Home only	*32*	591,386	570,041
Other Operating Expenses	*8*	44,399	44,808
		8,771,052	8,760,620
Net Operating (Deficit) for the Year		**(7,148)**	**(135,130)**

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 85-88.

Tony O'Brien
Chairman



Stephen Mulvany
Chief Financial Officer

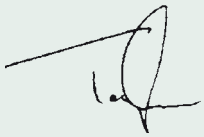
Capital Income and Expenditure Account

For Year Ended 31 December 2013

	Notes	2013	2012
Income		**€'000**	**€'000**
Exchequer Capital Funding		328,736	336,671
Revenue Funding Applied to Capital Projects		945	556
Dormant Accounts	*18(c)*	0	6
Application of Proceeds of Disposals		2,941	4,479
Government Departments and Other Sources	*18(c)*	3,086	593
		335,708	342,305
Expenditure			
Capital Grants to Outside Agencies (Appendix 2)	*18(b)*	68,875	98,357
Capital Expenditure on HSE Capital Projects	*18(b)*	273,352	209,089
		342,227	307,446
Net Capital (Deficit)/Surplus for the Year		(6,519)	34,859

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 85-88.



Tony O'Brien
Chairman

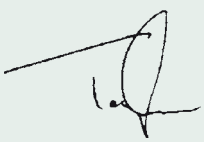
Stephen Mulvany
Chief Financial Officer

Balance Sheet

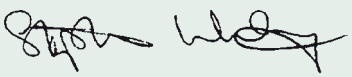
As at 31 December 2013

	Notes	2013 €'000	2012 €'000
Fixed Assets			
Tangible Fixed Assets			
Land and Buildings	*9*	4,661,118	4,672,627
Other Tangible Fixed Assets	*10*	249,120	247,139
Investments			
Financial Assets – unquoted shares		3	3
Total Fixed Assets		4,910,241	4,919,769
Current Assets			
Stocks	*11*	122,852	118,265
Debtors	*12*	262,794	220,004
Paymaster General and Exchequer Balance	*13*	77,721	80,883
Cash at Bank or in Hand		49,043	30,310
Current Liabilities			
Creditors	*14*	(1,600,020)	(1,523,789)
Net Current Liabilities		(1,087,610)	(1,074,327)
Creditors (amounts falling due after more than one year)	*15*	(49,248)	(50,807)
Deferred income	*16*	(10,440)	(9,755)
Total Assets		3,762,943	3,784,880
Capitalisation Account	*17(a)*	4,910,238	4,919,766
Capital Reserves	*17(b)*	(150,779)	(144,260)
Revenue Reserves	*17(c)*	(996,516)	(990,626)
Capital and Reserves		3,762,943	3,784,880

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 85-88.



Tony O'Brien
Chairman



Stephen Mulvany
Chief Financial Officer

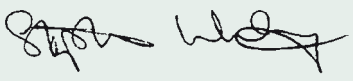
Cash Flow Statement

For Year Ended 31 December 2013

	Notes	2013	2012
		€'000	€'000
Net Cash Inflow/(Outflow) from Operating Activities	*19*	54,371	(27,896)
Net Cash Inflow/(Outflow) from Returns on Investments and Servicing of Finance			
Interest paid on loans and overdrafts		(3)	(5)
Interest paid on finance leases		(1,175)	(1,244)
Interest received		257	291
Net Cash Outflow from Returns on Investments and Servicing of Finance		(921)	(958)
Capital Expenditure			
Capital expenditure – capitalised	*18(b)*	(151,133)	(134,627)
Capital expenditure – not capitalised	*18(b)*	(191,094)	(172,820)
Payments from revenue re: acquisition of fixed assets (net of trade-ins)	*18(a)*	(29,939)	(11,043)
Revenue funding applied to Capital		945	556
Receipts from sale of fixed assets (excluding trade-ins)		2,465	5,135
Net Cash Outflow from Capital Expenditure		(368,756)	(312,799)
Net Cash Outflow before Financing		(315,306)	(341,653)
Financing			
Capital grant received		328,736	336,671
Capital receipts from other sources	*18(c)*	3,086	599
Payment of capital element of finance lease and loan repayments		(945)	(556)
Net Cash Inflow from Financing		330,877	336,714
Increase/(Decrease) in cash in hand, bank and PMG balances in the year	*20*	15,571	(4,939)

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 85-88.

Tony O'Brien
Chairman



Stephen Mulvany
Chief Financial Officer

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 Accounting Standards Board 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 2013 was €135.9m (2012: €75.7m). The actuarially estimated future liability attaching to this scheme at 31 December 2013 is €1,084m (2012: €996m) (see Note 28 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 will continue 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 Act 2013*. A net estimate of €11.5 billion has been passed by the Oireachtas for the HSE in 2014. 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.

As provided for by legislation enacted in S.I. No. 493 of 2012, *Health (Miscellaneous Provisions) Act 2009 (Commencement) Order 2012*, the assets, liabilities and reserves of the Drug Treatment Centre Board were taken into the HSE's balance sheet at net book value on 1 January 2013 and the operation of the service was transferred to the HSE from that date.

In accordance with HSE policy, formal due diligence examinations covering finance, HR, legal, insurance and governance aspects were carried out by the HSE as part of the process of subsuming the Drug Treatment Centre Board.

As mentioned above, the Child and Family Agency was officially established on New Year's Day 2014 under the *Child and Family 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 the HSE
- The Family Support Agency
- The National Educational Welfare Board

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 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 Finance's Public Financial Procedures, without Board approval and prior sanction. 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 are 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.

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 Finance'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 2013. 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 was 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 Segmental Analysis by Area of Operation

	Acute Hospital Services	Community Services	Support Services	Total	Total
	2013	2013	2013	2013	2012
	€'000	€'000	€'000	€'000	€'000
Expenditure					
Pay and Pensions					
Clinical	1,423,761	1,315,150	404,901	3,143,812	3,232,702
Non-Clinical	336,725	409,604	292,367	1,038,696	1,066,275
Other Client/Patient Services	199,465	409,688	79,718	688,871	724,803
	1,959,951	2,134,442	776,986	4,871,379	5,023,780
Non-Pay					
Clinical	568,099	245,354	42,811	856,264	836,019
Patient Transport and Ambulance Services	36,185	20,102	395	56,682	55,601
Primary Care and Medical Card Schemes	43,954	2,857,193	343	2,901,490	3,032,397
Other Client/Patient Services	2,434	62,128	304	64,866	65,729
Grants to Outside Agencies	2,290,840	1,169,038	17,270	3,477,148	3,464,212
Housekeeping	110,993	117,053	4,924	232,970	227,362
Office and Administrative Expenses	113,468	159,917	135,149	408,534	386,723
Long Stay Charges Repaid to Patients	0	0	230	230	1,149
Hepatitis C Insurance Scheme	0	0	1,209	1,209	911
Payments to State Claims Agency under the Clinical Indemnity Scheme	0	0	135,874	135,874	75,668
Nursing Homes Support Scheme – A Fair Deal	0	591,386	0	591,386	570,041
Other Operating Expenses	11,994	27,045	5,360	44,399	44,808
	3,177,967	5,249,216	343,869	8,771,052	8,760,620
Gross expenditure for the year	5,137,918	7,383,658	1,120,855	13,642,431	13,784,400

Note 2 **Net Operating (Deficit)**

	2013	2012
	€'000	€'000
Net operating (deficit)/surplus for the year is arrived at after charging:		
Audit fees	547	547
Remuneration	190	344
Remuneration comprises the following elements:		
Chief Executive Officer's (CEO) basic pay – from 1/1/2012 to 19/8/2012	#	213
CEO Superannuation scheme payments	#	51
CEO Car allowance	#	9
	#	273
Director General Designate/Deputy CEO basic pay – post existed from 20/8/2012 to 23/7/2013	109	71
Director General basic pay* – appointed 24/7/2013	81	#
	190	71

#: Post did not exist in the relevant year

* 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.

The following Board members/members of the Health Service Directorate were reimbursed for travel and subsistence, telephone and professional expenses in carrying out their duties as senior managers. No expenses were incurred in their roles as Board members/members of the Health Service Directorate.

	2013	2012
Board Members' expenses**	€	€
Cathal Magee – resigned 19/08/2012	0	612
Tony O'Brien – (2013: from 1/1/2013 to 24/7/2013; 2012: from date of appointment 20/8/2012 to 31/12/2012)	8,471	3,404
Laverne McGuinness – (2013: from 1/1/2013 to 24/7/2013, 2012: full year)	5,442	6,921
Brian Gilroy – resigned 24/2/2012	0	15
Dr. Barry White – resigned 31/12/2012	0	551
Dr. Philip Crowley – resigned 24/7/2013	5,420	1,344
	19,333	12,847

Directorate members' expenses**	€	€
Tony O'Brien	2,332	#
Laverne McGuinness	880	#
Stephen Mulvany	3,009	#
John Hennessy	919	#
Stephanie O'Keeffe	917	#
Ian Carter	1,842	#
Pat Healy	1,001	#
Tom Byrne	2,992	#
	13,892	#

#: Post did not exist in the relevant year

** Directorate members' expenses have been shown from 24/07/2013, the date of appointment as members of the Directorate. No expenses have been shown for 2012 or for 2013 up to the date of appointment as members of the Directorate.

2012 Board members' expenses have been restated to include expenses which were incurred in 2012, but reimbursed in 2013. Expenses relate from date of appointment only.

The Board comprised senior officials from the Department of Health and from the HSE. 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 were paid to Board members or Directors.

Note 3 **Exchequer Revenue Grant**

	2013	2012
	€'000	€'000
Net Estimate voted to HSE (HSE Vote 39)	12,531,471	12,520,933
Less net Surplus to be surrendered (Note 21)	(31,074)	(22,834)
Net recourse to Exchequer	12,500,397	12,498,099
Less: Capital services funding from the State (HSE Vote 39)	(328,736)	(336,671)
	12,171,661	12,161,428

Note 4 **Patient Income**

	2013	2012
	€'000	€'000
Private Charges	239,187	247,703
Inpatient Charges	36,613	34,571
Emergency Department Charges	9,260	9,574
Road Traffic Accident Charges	5,924	5,173
Long Stay Charges	80,140	81,695
	371,124	378,716

Note 5 **Other Income**

	2013	2012
(a) Other Income	€'000	€'000
Superannuation Income	181,655	195,611
Pension levy deductions from HSE own staff	234,848	241,547
Pension levy deductions from service providers	109,604	110,441
Other Payroll Deductions	8,359	8,704
Agency/Services – provided to Local Authorities and other organisations	7,282	7,928
Canteen Receipts	11,109	11,735
Income from other Agencies (See Note 5(b) analysis below)	31,701	43,664
Miscellaneous Income (See Note 5(c) analysis below)	105,587	101,880
	690,145	721,510

Note 5 **Other Income** (contd.)

	2013	2012
	€'000	€'000
(b) Income from Other Agencies		
National Council for Professional Development of Nursing and Midwifery	670	143
Department of Health (Drugs Program Unit)	21,770	22,122
Department of Arts, Heritage and The Gaeltacht (Helicopter Emergency Services)	32	50
Department of Children and Youth Affairs (Young Peoples Facilities and Services)	1,074	1,215
All Ireland Cooperative Clinical Research Group (ICORG)/Health Research Board (Academic fellowship programmes, clinical research trials)	2,083	1,029
Department of Justice (Traveller Conflict Mediation Initiative)	35	100
EU Income – CAWT (Co-operation and Working Together – EU cross border initiative)	3,130	3,910
Genio Trust (Mental Health Projects)	83	343
Limerick City Council (formerly Limerick Regeneration Agencies)	150	127
Employment Response (employment initiatives for persons with a disability)	129	203
SOLAS (formerly Fás)*	771	254
Department of Social Protection (Education and Training Boards – formerly Fás)*	437	0
Department of Social Protection (Money Advice and Budgeting Service)	19	17
National Treatment Purchase Fund**	943	14,151
Limerick City Children's Service Committee (to enhance collaboration across services for children and families in Limerick)	216	0
Elton John AIDS Foundation	159	0
	31,701	43,664

* Fás has been dissolved and SOLAS, a new further education and training authority, was formally established on 27 October 2013 by the Minister for Education and Skills. SOLAS is responsible for funding, planning and co-ordinating training and further education programmes. Education and Training Boards which were previously funded by Fás are now funded by the Department of Social Protection.

** The reduction in income from the National Treatment Purchase Fund is as a result of the operational transfer of the SDU (Special Delivery Unit) to the HSE with effect from 1 January 2013, with the associated funding included in the HSE's 2013 Vote.

	2013	2012
	€'000	€'000
(c) Miscellaneous Income**		
Rebate from Pharmaceutical Manufacturers*	38,418	36,369
Certificates and Registration Income (Births, Deaths and Marriages)	11,388	8,448
Parking	11,732	12,132
Other Miscellaneous Income (e.g. refunds, rental income, donations, training)	44,049	44,931
	105,587	101,880

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

** 2012 Miscellaneous Income has been re-stated to exclude €29.864m of Prescription Levy Income which is now offset against Pharmaceutical Services non-pay expenses. See also Note 8.

Certain prior year amounts have been re-classified on the same basis as those applying in the current year. While this has had the effect of reducing both income and expenditure by an equal amount, it has no effect on the Net Operating Deficit for 2012 as previously reported. See also Note 8 to the Financial Statements.

Note 6 **Pay and Pensions**

	2013	2012
	€'000	€'000
Clinical HSE Staff		
Medical/Dental	678,183	717,539
Nursing	1,358,040	1,389,080
Health and Social Care Professional	602,273	602,928
Superannuation	353,913	407,161
	2,992,409	3,116,708
Clinical Agency Staff		
Medical/Dental	64,217	37,041
Nursing	57,427	55,176
Health and Social Care Professional	29,759	23,777
	151,403	115,994
Non-Clinical HSE Staff		
Management/Administration	564,367	570,113
General Support Staff	313,856	322,798
Superannuation	137,628	156,243
	1,015,851	1,049,154
Non-Clinical Agency Staff		
Management/Administration	10,388	6,153
General Support Staff	12,457	10,968
	22,845	17,121
Other Client/Patient Services HSE Staff		
Other Patient and Client Care	575,514	600,152
Superannuation	74,663	92,971
	650,177	693,123
Other Client/Patient Services Agency Staff		
Other Patient and Client Care	38,694	31,680
	38,694	31,680
Total Pay Expenditure	4,871,379	5,023,780

Note 6 **Pay and Pensions** (contd.)

	Clinical	Non-Clinical	Other Client/ Patient Services	Total	Total
	2013	2013	2013	2013	2012
	€'000	€'000	€'000	€'000	€'000
Summary Analysis of Pay Costs					
Basic Pay	2,034,589	750,104	442,147	3,226,840	3,283,355
Allowances	79,532	16,963	19,051	115,546	119,371
Overtime	111,736	10,130	12,653	134,519	157,164
Night duty	50,564	6,177	10,806	67,547	70,711
Weekends	100,437	24,970	41,412	166,819	176,355
On-Call	46,236	1,462	550	48,248	55,190
Arrears	13,608	2,319	1,302	17,229	17,992
Wages and Salaries	2,436,702	812,125	527,921	3,776,748	3,880,138
Employer PRSI	201,795	66,098	47,593	315,486	322,472
Superannuation*	353,912	137,628	74,663	566,203	656,375
Total HSE Pay	2,992,409	1,015,851	650,177	4,658,437	4,858,985
Agency Pay	151,403	22,845	38,694	212,942	164,795
Total Pay	3,143,812	1,038,696	688,871	4,871,379	5,023,780

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.

	2013	2012
	€'000	€'000
***Analysis of Superannuation**		
Ongoing superannuation payments to pensioners	495,086	480,881
Once-off lump sums and gratuity payments	71,117	175,494
	566,203	656,375

Note 7 **Employment**

	2013	2012*
The number of employees at 31 December by Area of Operation was as follows (in whole time equivalents (WTEs)):		
Acute Services	26,180	26,584
Ambulance Services	1,615	1,551
Non-Acute Services	29,812	30,150
Children and Family Services	3,465	3,501
Corporate and Shared Services	2,619	2,671
Health and Wellbeing	1,232	1,230
Total HSE employees	**64,923**	**65,687**
Voluntary Sector – Acute Services	22,075	22,320
Voluntary Sector – Non-Acute Services	12,961	13,499
Total Voluntary Sector employees	**35,036**	**35,819**
Total Employees per Department of Health methodology as encompassed in the Employment Control Framework (ECF)	**99,959**	**101,506**
Other directly employed non-ECF personnel**	4,123	3,746
Total Employees	**104,082**	**105,252**

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 and exclude agency staff WTEs.

* 2012 figures have been restated to account for the move of Drug Treatment Centre Board staff from the voluntary sector to HSE on 1st January 2013 (totals not affected). The service classifications have also been revised in accordance with updated organisational structures.

** Grades included are: General Support Interns, Graduate Nursing/Midwifery, Home Helps, Other Care Interns.

Note 8 **Non-Pay Expenditure**

	2013	2012
	€'000	€'000
Clinical		
Drugs and Medicines (excl. demand led schemes)	221,592	222,953
Blood/Blood Products	27,629	31,261
Medical Gases	8,223	8,064
Medical/Surgical Supplies	235,376	225,771
Other Medical Equipment	85,369	81,660
X-Ray/Imaging	28,868	27,743
Laboratory	108,660	106,722
Professional Services (e.g. therapy costs, radiology etc.)	90,459	85,125
Education and Training	50,088	46,720
	856,264	836,019
Patient Transport and Ambulance Services		
Patient Transport	41,520	42,023
Vehicles Running Costs	15,162	13,578
	56,682	55,601

Note 8 **Non-Pay Expenditure** (contd.)

	2013	2012
	€'000	€'000
Primary Care and Medical Card Schemes		
Pharmaceutical Services	2,019,123	2,100,070
Less Prescription Levy Charges*	(85,504)	(29,864)
Net Cost Pharmaceutical Services	1,933,619	2,070,206
Doctors' Fees and Allowances	487,760	488,445
Pension payments to Former District Medical Officers/Dependents	3,927	4,226
Dental Treatment Services Scheme	70,109	64,087
Community Ophthalmic Services Scheme	31,562	30,398
Cash Allowances (Blind Welfare, Domiciliary Care, etc.)	46,550	48,127
Fostering Payments	110,522	108,981
Capitation Payments	217,441	217,927
	2,901,490	3,032,397

* Prescription levy charges were previously classified under Other Income (Note 5(c)). Prior year figures have been reclassified on the same basis for comparative purposes. Prescription levy charges have increased due to an increase in the prescription levy from €0.50 per item to €1.50 per item on 1 January 2013 and to €2.50 per item from 1 December 2013.

Other Client/Patient Services		
Professional Services (e.g. care assistants, childcare contracted services, guardian ad litem costs etc.)	58,586	59,122
Education and Training	6,280	6,607
	64,866	65,729

Grants to Outside Agencies		
Revenue Grants to Outside Agencies (Appendix 1)*	3,458,633	3,445,173
Grants funded from other Government Departments/State Agencies (Appendix 1)	18,515	19,039
	3,477,148	3,464,212

* Included in the 2012 grants is an additional €70m in once off grants to nine hospitals to cover budget overruns.

Housekeeping		
Catering	54,116	54,452
Heat, Power and Light	79,791	76,661
Cleaning and Washing	79,975	78,449
Furniture, Crockery and Hardware	6,735	5,747
Bedding and Clothing	12,353	12,053
	232,970	227,362

Note 8 **Non-Pay Expenditure** (contd.)

	2013	2012
	€'000	€'000
Office and Administration Expenses		
Maintenance	51,806	42,439
Lease Interest, Bank Interest and Charges*	2,731	2,269
Prompt Payment Interest	197	204
Insurance	4,034	3,853
Audit	547	547
Legal and Professional Fees	66,208	66,884
Bad and Doubtful Debts	28,250	12,512
Education and Training	6,915	5,712
Travel and Subsistence	52,054	53,861
Vehicle Costs	678	341
Office Expenses/Rent and Rates	153,097	156,104
Computers and Systems Maintenance	42,017	41,997
	408,534	386,723

* Lease Interest, Bank Interest and Charges includes Bank Loan and Finance Leases, Bank Interest, Lease Interest and Bank Charges previously shown separately. Prior year figures have been re-analysed into these categories for comparative purposes.

Other Operating Expenses		
Maintenance Farm and Grounds	2,053	1,606
Security	18,027	18,152
Fluoridation	2,219	2,207
Memberships	344	73
Licences	629	749
Subscriptions	601	634
Sundry Expenses	12,147	11,969
Burial Expenses	123	84
Secondment Charges	2,418	3,223
Recreation (Residential Units)	1,159	1,235
Materials for Workshops	1,707	1,889
Home Adaptations	756	757
Meals on Wheels Subsidisation	1,838	1,867
Refunds	378	363
	44,399	44,808

Certain prior year amounts have been re-classified on the same basis as those applying in the current year. While this has had the effect of reducing both income and expenditure by an equal amount, it has no effect on the Net Operating Deficit for 2012 as previously reported. See also Note 5(c) to the Financial Statements.

Note 9 Tangible Fixed Assets Land and Buildings

	Land	Buildings*	Work in Progress	Total 2013
	€'000	€'000	€'000	€'000
Cost/Valuation				
At 1 January 2013	1,714,188	3,588,142	232,847	5,535,177
Additions	9,457	17,183	67,125	93,765
Transfers from Work in Progress	48	183,700	(183,748)	0
Disposals	(2,009)	(9,701)	(3,995)	(15,705)
At 31 December 2013	1,721,684	3,779,324	112,229	5,613,237
Depreciation				
Accumulated Depreciation at 1 January 2013	0	862,550	0	862,550
Charge for the Year	0	95,465	0	95,465
Disposals	0	(5,896)	0	(5,896)
At 31 December 2013	0	952,119	0	952,119
Net Book Values				
At 1 January 2013	1,714,188	2,725,592	232,847	4,672,627
At 31 December 2013	1,721,684	2,827,205	112,229	4,661,118

* The net book value of fixed assets above includes €31.6m (2012: €33.5m) in respect of buildings held under finance leases; the depreciation charged for the year above includes €1.8m (2012: €1.8m) on those buildings.

Note 10 Tangible Fixed Assets Other than Land and Buildings

	Motor Vehicles	Equipment	Work in Progress	Total 2013
	€'000	€'000	€'000	€'000
Cost/Valuation				
At 1 January 2013	91,982	1,218,006	(7,970)	1,302,018
Additions	8,165	63,655	15,488	87,308
Transfers from Work in Progress	1,292	0	(1,292)	0
Disposals	(9,364)	(20,010)	0	(29,374)
At 31 December 2013	92,075	1,261,651	6,226	1,359,952
Depreciation				
Accumulated Depreciation at 1 January 2013	81,886	972,993	0	1,054,879
Charge for the Year	6,431	77,533	0	83,964
Disposals	(8,882)	(19,129)	0	(28,011)
At 31 December 2013	79,435	1,031,397	0	1,110,832
Net Book Values				
At 1 January 2013	10,096	245,013	(7,970)	247,139
At 31 December 2013	12,640	230,254	6,226	249,120

Note 11 **Stocks**

	2013	2012
	€'000	€'000
Medical, Dental and Surgical Supplies	31,719	33,156
Laboratory Supplies	6,449	6,260
Pharmacy Supplies	18,179	16,873
High Tech Pharmacy Stocks	33,780	32,603
Pharmacy Dispensing Stocks	1,066	1,306
Blood and Blood Products	1,250	1,421
Vaccine Stocks	19,638	15,984
Household Services	8,074	8,010
Stationery and Office Supplies	2,016	2,063
Sundries	681	589
	122,852	118,265

Note 12 **Debtors**

	2013	2012
	€'000	€'000
Patient Debtors – Private Facilities in Public Hospitals*	110,783	53,283
Patient Debtors – Public Inpatient Charges	13,840	12,530
Patient Debtors – Long Stay Charges	8,200	8,450
Prepayments and Accrued Income	18,598	20,037
Other Debtors:		
Pharmaceutical Manufacturers	15,294	27,674
Payroll Technical Adjustment	30,350	31,593
Pension Levy Deductions from Staff/Service Providers	10,549	11,314
Statutory Redundancy Claim	6,021	9,844
Local Authorities	2,292	3,241
National Treatment Purchase Fund/Special Delivery Unit	94	3,602
Payroll Advances and Overpayments**	4,275	5,008
Voluntary Hospitals re: National Medical Device Service Contracts	11,145	8,425
Sundry Debtors**	31,353	25,003
	262,794	220,004

* The increase in Patient Debtors in respect of private facilities in public hospitals relates to accelerated payments received in 2012 but not repeated in 2013. At the end of 2012 the HSE received accelerated payments totaling €49.8 million representing the insurers' estimate of amounts due to the HSE where the claim process had not been finalised. The amounts paid to the HSE during 2013 (as the relevant claims were finalised) were reduced to take account of the accelerated payments received at the end of 2012. No such accelerated payments were received from the insurance companies at the end of 2013.

** The 2012 figures for Sundry Debtors and Payroll Advances and Overpayments have been restated to reflect a reclassification between these two debtor categories in the amount of €1.4m. The overall 2012 Debtors total remains unchanged.

Note 13 **Paymaster General and Exchequer Balance**

	2013	2012
	€'000	€'000
Paymaster General Bank Account	94,946	98,242
Net Liability to the Exchequer	(17,225)	(17,359)
	77,721	80,883

Note 14 **Creditors (amounts falling due within one year)**

	2013	2012
	€'000	€'000
Finance Leases	2,014	1,945
Trade Creditors – Revenue*	133,540	142,265
Trade Creditors – Capital*	14,513	7,203
Accruals Non-Pay – Revenue*	653,765	607,744
Accruals Non-Pay – Capital*	4,199	6,812
Accruals – Grants to Voluntary Hospitals and Outside Agencies	286,072	276,400
Accruals Pay	348,980	345,718
Taxes and Social Welfare	139,126	120,796
Local Property Tax (LPT)**	147	0
Department of Public Expenditure and Reform – Single Public Service Pension Scheme***	288	0
Lottery Grants Payable****	1,708	1,232
Sundry Creditors	15,668	13,674
	1,600,020	1,523,789

* Trade Creditors and Accruals for Non-Pay have been reclassified to show both the revenue and capital element as required by the Considine Report. Prior year figures have been reclassified on the same basis for comparative purposes. The total figure remains unchanged.

** Local Property Tax (LPT) – this is a new charge with effect from 1 Jan 2013.

*** With effect from 1 Jan 2013, all superannuation contributions for new entrants under the new "Single Public Service Pension Scheme" are remitted to the Exchequer.

**** 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.

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

	2013	2012
	€'000	€'000
Finance lease obligations – buildings		
After one but within five years	5,227	4,470
After five years	30,808	32,578
Total Finance Lease obligations	**36,035**	**37,048**
Subsidised Loans – Aontacht Phobail Teoranta (Note 26)	0	70
Liability to the Exchequer in respect of Exchequer Extra Receipts*	13,213	13,689
Total Creditors (amounts falling due after more than one year)	**49,248**	**50,807**

*** 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.

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

	2013	2012
	€'000	€'000
Gross Proceeds of all disposals in year	2,554	5,180
Less: Net expenses incurred on disposals	(89)	(45)
Net proceeds of disposal	2,465	5,135
Less Application of Proceeds	(2,941)	(4,480)
At 1 January	720	65
Balance at 31 December	244	720
Liability to the Exchequer Sale Proceeds – Other Sales/Capital Grant Refunds	1,665	1,665
Liability to the Exchequer – Statutory Rebate Claim	11,304	11,304
Total Liability to the Exchequer	**13,213**	**13,689**

Note 16 **Deferred Income**

	2013	2012
	€'000	€'000
Deferred income comprises the following:		
Donations and bequests*	9,633	8,968
Income from sales of land which have not been concluded	807	787
	10,440	9,755

* 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.

Note 17 **Capital and Reserves**

	2013	2012
	€'000	€'000
(a) Capitalisation Account		
At 1 January	4,919,766	5,266,194
Additions to fixed assets in the year	181,073	145,670
Less: Net book value of fixed assets disposed in year	(11,172)	(313,245)
Less: Depreciation charge in year	(179,429)	(178,853)
Balance at 31 December	4,910,238	4,919,766
(b) Capital Reserves		
At 1 January	(144,260)	(179,119)
Net Capital (Deficit)/Surplus for the year	(6,519)	34,859
Balance at 31 December	(150,779)	(144,260)

Note 17 **Capital and Reserves** (contd.)

	2013 €'000	2012 €'000
(c) Revenue Reserves		
At 1 January	(990,626)	(856,488)
Revenue Reserves Aontacht Phobail Teoranta (see Note 26)	70	992
Revenue Reserves from the Drug Treatment Centre Board*	1,188	0
At 1 January Opening Reserves restated	(989,368)	(855,496)
Net Operating (Deficit) for the year	(7,148)	(135,130)
Balance at 31 December	(996,516)	(990,626)

* The Drug Treatment Centre Board was subsumed into the HSE on 1 January 2013.

(d) Reconciliation of Movement on Reserves		
Closing Creditors at 31 December	(1,649,268)	(1,574,596)
Less Opening Creditors at 1 January	(1,574,596)	(1,572,969)
	(74,672)	(1,627)
Less Increase/(Decrease) in Current Assets	62,948	(97,531)
(Increase)/Decrease in Deferred Income	(685)	(121)
	(12,409)	(99,279)
Net Operating (Deficit)	(7,148)	(135,130)
Revenue Reserves from subsumed agencies	1,258	992
Net Capital (Deficit)/Surplus	(6,519)	34,859
	(12,409)	(99,279)

Note 18 **Capital Expenditure**

	2013 €'000	2012 €'000
(a) Additions to Fixed Assets		
Additions to Fixed Assets (Note 9) Land and Buildings	93,765	105,044
Additions to Fixed Assets (Note 10) Other than Land and Buildings	87,308	40,626
	181,073	145,670
Funded from Capital Vote of HSE*	151,134	134,627
Funded from Revenue Vote of HSE*	29,939	11,043
	181,073	145,670

* 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.

(b) Analysis of expenditure charged to Capital Income and Expenditure Account		
Expenditure on HSE's own assets (Capitalised)	151,133	134,627
Expenditure on HSE projects not resulting in Fixed Asset additions*	122,219	74,462
Total expenditure on HSE Projects charged to capital	273,352	209,089
Capital grants to outside agencies (Appendix 2)*	68,875	98,357
Total Capital Expenditure per Capital Income and Expenditure Account	342,227	307,446

* Total capital expenditure not capitalised amounts to €191.1m (2012; €172.8m) which comprises expenditure on HSE projects not resulting in Fixed Asset additions and Capital Grants to outside agencies.

Note 18 **Capital Expenditure** (contd.)

	2013	2012
	€'000	€'000
(c) Analysis of Capital Income from Other Sources		
Income from Government Departments and Other Sources in respect of capital projects:		
Sustainable Energy Ireland (SEI) – energy savings in acute hospitals	134	317
St. Coleman's Care Centre Ltd. – Care Centre Achill	72	117
Insurance Proceeds – Letterkenny General Hospital, flood damage	2,434	0
Other Insurance Proceeds	102	0
Irish Hospice Foundation – Donation for Design and Dignity Projects	250	0
Other Miscellaneous Income	94	159
Total	3,086	593
Dormant Funds Income	0	6
Total Capital Income from Other Sources	3,086	599

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

	2013	2012
	€'000	€'000
(Deficit) for the current year	(7,148)	(135,130)
Capital element of lease payments charged to revenue	945	556
Less Interest received	(257)	(291)
Purchase of equipment charged to Revenue Income and Expenditure	29,939	11,043
All interest charged to Revenue Income and Expenditure	1,178	1,249
(Increase)/Decrease in Stock	(4,587)	3,256
(Increase)/Decrease in Debtors	(42,790)	89,336
Increase in Creditors	76,231	3,265
Revenue Reserves from Subsumed Agencies	1,258	992
(Decrease) in Creditors (falling due in more than one year) – finance lease obligation	(1,013)	(1,301)
Increase in Deferred Income	685	121
Decrease in Long Term Loan – Note 26	(70)	(992)
	54,371	(27,896)

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

	2013	2012
	€'000	€'000
Change in net funds resulting from cash flows		
Net Cash and PMG Balance at 1 January	111,193	116,132
Movement in net funds for the year from cash flow statement	15,571	(4,939)
Net Cash and PMG Balance at 31 December*	126,764	111,193
*Analysis of Net Cash and PMG Balance		
Paymaster General Bank Account (Note 13)	77,721	80,883
Cash at Bank or in Hand	49,043	30,310
	126,764	111,193

Note 21 Vote Accounting

(a) Exchequer disbursements during the year are based on annual amounts voted by Dáil Eireann. 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 2013 amounts to €31m, 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 deficit 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 2013 €'000	Outturn 2013 €'000	Estimate 2012 €'000	Outturn 2012 €'000
HSE Vote 39 Gross Expenditure	13,893,623	13,872,830	14,034,455	13,987,444
Appropriations-in-Aid	1,362,152	1,372,433	1,513,522	1,489,345
Net Vote Expenditure	12,531,471	12,500,397	12,520,933	12,498,099

	2013	2012
	€'000	€'000
Surplus to be Surrendered	31,074	22,834
Analysis of Surrender		
Surplus Appropriations-in-Aid	10,281	0
Surplus Gross Vote	20,793	22,834
Net surplus to be surrendered	31,074	22,834

Note 21 **Vote Accounting** (contd.)

	2013	2012
	€'000	€'000
(c) Extract from HSE Appropriation Account (unaudited) for the year ended 31 December 2013:		
Balance Sheet as at 31 December 2013		
Capital Assets	4,910,238	4,919,766
Financial Assets	3	3
	4,910,241	4,919,769
Current Assets		
Bank and cash and PMG	143,989	128,552
Stocks	122,852	118,265
Debtors and Prepayments	217,526	165,375
Other debit balances	45,268	54,629
Total Current Assets	529,635	466,821
Less Current Liabilities		
Creditors	148,053	149,468
Accrued expenses	1,329,183	1,259,305
Deferred Income	10,440	9,755
Other credit balances	172,032	165,823
Net Liability to the Exchequer	17,225	17,359
Total Current Liabilities	1,676,933	1,601,710
Net Current Assets	(1,147,298)	(1,134,889)
Net Assets	3,762,943	3,784,880
Represented by:		
State Funding Account	3,762,943	3,784,880

Note 21 **Vote Accounting** (contd.)

	2013	2012
	€'000	€'000
(d) Extract from HSE Appropriation Account (unaudited) for the year ended 31 December 2013:		
Net Liability to the Exchequer at 31 December		
Surplus to be surrendered	31,074	22,834
Exchequer grant undrawn	(13,849)	(5,475)
Net liability to the Exchequer	17,225	17,359
Represented by:		
Debtors		
Bank and cash and PMG	143,989	128,553
Other debit balances	45,268	54,629
	189,257	183,182
Creditors		
Due to State	(122,126)	(120,796)
Special Income and Expenditure balances	(32,393)	(27,150)
Payroll deductions and other credit balances	(17,513)	(17,877)
	(172,032)	(165,823)
	17,225	17,359

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 and 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 and Expenditure Account for 2013 was €566m (2012: €656m), which included payments in respect of once-off lump sums and gratuity payments on retirement of €71m (2012: €175m).

Note 23 **Capital Commitments**

	2013	2012
	€'000	€'000
Future tangible fixed assets purchase commitments:		
Within one year	306,472	258,397
After one but within five years	625,990	516,217
After five years	0	0
	932,462	774,614
Contracted for but not provided in the financial statements	277,694	215,708
Included in the Capital Plan but not contracted for	654,768	558,906
	932,462	774,614

The HSE has a multi-annual capital investment plan which prioritises expenditure on capital projects in line with strategic objectives in the Capital 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 2013 for which budgets have yet to be approved. This includes non-contractual commitments in respect of projects planned but yet to be approved in order to provide for healthcare infrastructural deficits including the National Children's Hospital, HIQA compliance and the new Forensic Mental Health Facility.

Note 24 **Property**

	2013	2012
	No. of Properties	No. of Properties
The HSE estate comprises 2,594 properties.		
Title to the properties can be analysed as follows:		
Freehold	1,640	1,656
Leasehold	954	970
	2,594	2,626
Primary utilisation of the properties can be analysed as follows:		
Delivery of health and personal social services	2,512	2,536
Health Business Services and Support (including medical card processing, etc)	82	90
	2,594	2,626

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 Lease Cost Reduction Initiative and the Mental Health Disposals Initiative.

Note 25 **Operating Leases**

	2013	2012
	€'000	€'000
Operating lease rentals (charged to the Revenue Income and Expenditure Account)		
Land and buildings	39,613	40,639
Motor Vehicles	73	129
Equipment	621	614
	40,307	41,382

Note 25 **Operating Leases** (contd.)

	Land and Buildings	Other	Total	Total
	2013	2013	2013	2012
	€'000	€'000	€'000	€'000
The HSE has the following annual lease commitments under operating leases which expire:				
Within one year	6,450	423	6,873	8,561
In the second to fifth years inclusive	8,568	42	8,610	7,736
In over five years	25,556	0	25,556	24,249
	40,574	465	41,039	40,546

Note 26 **Subsidiary Undertakings**

Aontacht Phobail Teoranta was partially subsumed at 31 December 2010 and the transfer of the remaining balances will be completed in 2014. The HSE has no other subsidiary undertakings.

The primary objective of Aontacht Phobail Teoranta is to promote the economic and social integration of people with disabilities. 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 loans 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. During the year the mortgages were redeemed by the HSE from the various local authorities at a cost of €56,170. There are no mortgages outstanding at 31 December 2013.

Note 27 **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.

The HSE completed a full scope Tax Risk Assessment with specialist tax assistance during 2012 in respect of all the tax heads (PAYE/PRSI, VAT, PSWT and RCT) for which it must account. A comprehensive self-review programme was progressed in 2013 of the various areas of tax risk identified, with priority being given to those areas regarded as being high risk. Any underpayment of tax identified in the self-review will be disclosed to the Revenue Commissioners and provision has been made in the financial statements. Any liability is not expected to be material in the context of the overall tax liability of the HSE. An in-house specialist tax function for the HSE was established in 2013. The HSE remains committed to exemplary compliance with taxation laws.

Note 28 **Insurance**

Prior to 1 January 2001, the HSE's 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 2013 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 Outpatient 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.

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 €4m were received in 2013

relating to revenue expenditure of €1.57m and capital expenditure of €2.43m respectively. These amounts have been reflected in the 2013 financial statements. Further claim proceeds will receivable in future accounting periods and, in accordance with HSE accounting policies, will be recognised and matched against expenditure in the year they are received.

State Claims Agency

Since 1 July 2009 the HSE is funded by the Exchequer for claims processed by the State Claims Agency on behalf of the HSE 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. In accordance with the directions of the Minister for Health, no provision has been made for this liability in the financial statements. At 31 December 2013, the estimated liability incurred to that date under the Clinical Indemnity Scheme and State indemnity was €1,084m. Of this €1,084m, approximately €1,009m relates to the Clinical Indemnity Scheme, with the balance of the estimated liability relating to non-clinical claims. In 2013, the charge to the Revenue Income and Expenditure Account was €135.9m (2012: €75.7m). Based on actuarial estimates, the charge to the Income and Expenditure Account is expected to increase significantly in future years.

Note 29 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.

Note 30 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 2013 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 31 December 2007 and nearly 14,000 claims have been received in respect of living patients and nearly 27,000 claims in respect of estates. The Scheme is now estimated to cost in the region of €489m. The Scheme received some applications relating to patients in private nursing homes which were turned down on the basis that they were not contemplated within the scope of the Scheme. Legal proceedings issued in regard to 326 cases, involving patients who spent time in private nursing home facilities. None of the cases have yet proceeded to a hearing. Consequently, it is considered inappropriate to attempt to estimate any potential future liability or to detail the uncertainties attaching thereto since to do so might prejudice the outcome of court proceedings.

Following discontinuation of appeals to the High Court brought by the HSE and the Department of Health in respect of determinations by the Appeals Officer granting eligibility to clients of certain disability services, €8m has been provided in the 2014 HSE budget to fund repayments for outstanding claims lodged under the Scheme and the associated administrative costs.

In 2013, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Repayments Scheme:

	2013	2012
	€'000	€'000
Pay	158	7
Non-Pay:		
Repayments to Patients	196	1,065
Payments to Third Party Scheme Administrator	0	64
Legal and Professional Fees	29	9
Office Expenses	5	11
Total Non-Pay	230	1,149
Total	388	1,156

Note 31 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 is estimated at €90m. The cumulative expenditure on the insurance scheme to 31 December 2013 was €6.2m.

In 2013, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Insurance Scheme:

	2013 €'000	2012 €'000
Pay	83	83
Non-Pay:		
Payments of premium loadings	522	245
Payments of benefits underwritten by HSE	676	649
Office Expenses	11	17
Total Non-Pay	1,209	911
Total	1,292	994

Note 32 Long Term Residential Care (incorporating Nursing Homes Support Scheme – A Fair Deal)

The Nursing Homes Support Scheme (NHSS) – A 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 – A Fair Deal)

	2013 €'000	2012 €'000
Private Nursing Homes	512,765	467,285
Private Nursing Homes Contract Beds and Subvention Payments	78,621	102,756
Nursing Homes Support Scheme (NHSS) – A Fair Deal: Private Nursing Home only	591,386	570,041
Public Nursing Homes*	329,312	337,572
Revenue Grants to Outside Agencies (Appendix 1)	25,625	38,915
Nursing Home Fixed and other unit costs	20,001	10,100
NHSS transitionary funding	0	16,051
Total Long Term Residential Care	966,324	972,679

* Public nursing homes costs are included under the relevant expenditure headings in the Revenue Income and Expenditure Account.

Note 32 **Long Term Residential Care (incorporating Nursing Homes Support Scheme – A Fair Deal)** (contd.)

Patient contributions

NHSS patient contributions for those patients in public homes amounted to €53.038m (2012: €48.7m) and are included in the Revenue Income and Expenditure Account under Patient Income.

NHSS patient contributions for those patients in voluntary homes (Section 38 organisations) amounted to €6.097m (2012: €5.3m) and are retained by those homes, and do not constitute income for the HSE.

Contract beds, Subvention beds

In 2013, payments of €78.6m (2012: €102.7m) 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 2013 there was an additional €20.0m (2012: €10.1m) 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 33 **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 2013 for recoupment from the commencement of the Nursing Homes Support Scheme was €21.324m representing 1,451 client loans and the Revenue Commissioners have confirmed to the HSE that they had received €11.826m of loan repayments representing 917 client loans.

Note 34 **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 35 **Related Party Transaction**

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 Board/Health Service Directorate members. These procedures have been adhered to by the Board/Health Service Directorate members and the HSE during the year. During 2013 two voluntary agencies in which HSE Board members declared an interest were approved grants; €957,476 in respect of Peter McVerry Trust and €795,736 in respect of Tribli Limited t/a Exchange House National Traveller Service. The HSE Directorate members concerned did not receive any documentation on the transactions nor did the members participate in or attend any Health Service Directorate discussion relating to these matters.

Note 36 **Approval of Financial Statements**

The financial statements were approved by the Directorate on 20 May 2014.

Appendix 1

Revenue Grants and Grants Funded by Other Government Departments/State Agencies

(Analysis of Grants to Outside Agencies in Note 8)

	Revenue Grants	Other Grants*	Total Grants**
	2013	2013	2013
Name of Agency	**€000's**	**€000's**	**€000's**
Total Grants under €100,000 (2,236 Grants)	**41,241**	**611**	**41,852**
Grants €100,000 or more each			
Ability West Ltd.	22,769		22,769
Abode Hostel and Day Centre	1,004		1,004
Acquired Brain Injury Ireland (Formerly Peter Bradley Foundation)	9,185		9,185
Active Retirement Ireland	258		258
Adapt Community Drugs Team	296	81	377
Adapt House Women's Refuge Centre, Limerick	598		598
Adapt Kerry Ltd.	165		165
Addiction	185		185
Addiction Response Crumlin (ARC)	275	670	945
Adoption Authority of Ireland	123		123
Aftercare Recovery Group	105		105
Age Action Ireland	507		507
Age and Opportunity	549		549
AIDS Fund Housing Project (Centenary House)	364		364
AIDS Help West	228		228
Aiseanna Tacaiochta	758		758
Aislinn Centre, Kilkenny	517		517
Alcohol Action Ireland	112		112
All Communicarers Ltd.	530		530
All In Care	7,282		7,282
Alliance	230		230
Alpha One Foundation	125		125
Alzheimer Society of Ireland	10,049		10,049
Amber Kilkenny Women's Outreach	399		399
AMEN	152		152
An Cosan	581		581
Ana Liffey Children's Project	165		165
Ana Liffey Drug Project	966	675	1,641
Anchor Treatment Centre	281		281
Aoibhneas Foundation Ltd.	893		893

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Aosóg	200		200
Arabella Counselling, t/a Here2Help	203		203
Aras Mhuire Day Care Centre (North Tipperary Community Services)	308		308
Arc Adoption Ltd.	190		190
ARC Cancer Support Centre	187		187
Ard Aoibhinn Centre	3,088		3,088
Ardee Day Care Centre	289		289
Arlington Novas Ireland	1,956	84	2,040
Arthritis Ireland	191		191
Asperger Syndrome Association of Ireland (ASPIRE)	259		259
Associated Charities Trust	191		191
Association for the Healing of Institutional Abuse (AHIA). (Previously known as the Aislinn Centre, Dublin).	233		233
Athlone Community Services Council Ltd.	254		254
Autism Initiatives Group	4,105		4,105
Autism West Ltd.	548		548
Aware	167		167
Baile Mhuire Recuperative Unit for the Elderly	256		256
Balcurris Boys Home Ltd.	586		586
Ballinasloe Social Services	132		132
Ballincollig Senior Citizens Club Ltd.	360		360
Ballyboden Children's Centre	128		128
Ballyfermot Advanced Project Ltd.	0	531	531
Ballyfermot Home Help	2,131		2,131
Ballyfermot Star Ltd.	61	304	365
Ballymun Day Nursery (Tir na nOg)	271		271
Ballymun Local Drugs Task Force	132	270	402
Ballymun Youth Action Project (YAP)	540	52	592
Ballyowen Meadows Childrens Residential Centre	908		908
Ballyphehane and Togher Community Rescource Centre	127		127
Barnardos	8,639	348	8,987
Barretstown Camp	151		151
Barrow Valley Enterprises for Adult Members with Special Needs Ltd. (BEAM)	378		378
Base Youth Centre	190		190
Beacon Medical Group	153		153
Beaufort Day Care Centre	176		176
Beaumont Hospital	261,006		261,006
Before 5 Nursery and Family Centre	135		135
Belong to Youth Services Ltd.	201		201
Belvedere Social Service	547		547

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Bergerie Trust	306		306
Bernard Van Leer Foundation	112		112
Blakestown and Mountview Youth Initiative (BMYI)	502	65	567
Blanchardstown and Inner City Home Helps	3,796		3,796
Blanchardstown Local Drugs Task Force	0	200	200
Blanchardstown Youth Service	159	66	225
Bluebird Care	4,608		4,608
Bodywhys The Eating Disorder Association of Ireland	257		257
Bon Secours Sisters	1,055		1,055
Bonnybrook Day Nursery	230		230
Brainwave – Irish Epilepsy Association	769		769
Bray Area Partnership	43	63	106
Bray Community Addiction Team	0	736	736
Bray Lakers Social and Recreational Club Ltd.	144		144
Bray Travellers Group	0	112	112
Bray Women's Refuge	583		583
Brothers of Charity Services Ireland	162,136		162,136
Bryson Charitable Group	199		199
Bushy Park Treatment Centre	50	57	107
Cabra Resource Centre	155	36	191
Cairde	379		379
Cairdeas Centre Carlow	285		285
Camphill Communities of Ireland	1,000		1,000
Cancer Care West	500		500
Cappagh National Orthopaedic Hospital	25,667		25,667
Cara Housing Association	175		175
Care at Home Services	179		179
Care Of the Aged, West Kerry	110		110
CareBright	2,911		2,911
Carecall In Home Care Ltd.	108		108
Caredoc GP Co-operative	6,951		6,951
Careline	105		105
Caremark Ireland	1,862		1,862
Carers Association Ltd.	4,406		4,406
Careworld	669		669
CARI Foundation	252		252
Caring and Sharing Association (CASA)	233		233
Caring For Carers Ireland	863		863
Caritas	2,054		2,054
Carlow Institute of Technology	100		100

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Carlow Regional Youth Service	146		146
Carlow Social Services	431		431
Carlow Women's Aid	124		124
Carlow/Kilkenny Home Care Team	218		218
Carnew Community Care Centre	138		138
Carrickmacross Parent and Friends Association	846		846
Carriglea Cairde Services Ltd. (formerly Sisters of the Bon Sauveur)	8,647		8,647
Carrigoran Nursing Home – Day Care Centre	103		103
Casadh	0	200	200
Casla Home Care Ltd.	124		124
Castle Homecare	584		584
Catholic Institute for Deaf People (CIDP)	1,081		1,081
CAWT (Cooperation And Working Together)	0	1,353	1,353
CDA Trust Ltd. (Cavan Drug Awareness)	0	213	213
Central Remedial Clinic	16,149		16,149
Centres for Independent Living (CIL)	10,676		10,676
Charleville Care Project Ltd.	151		151
Cheeverstown House Ltd.	22,101		22,101
Cheshire Ireland	21,233		21,233
Childrens Sunshine Home	3,875		3,875
ChildVision (St. Joseph's School For The Visually Impaired)	4,097		4,097
Chrysalis Community Drug Project	0	261	261
Cill Dara Ar Aghaid	0	250	250
Clann Mór	1,071		1,071
Clare Youth Services	106		106
Clarecare Ltd. Incorporating Clare Social Service Council	5,995		5,995
Clarecastle Daycare Centre	412		412
Clarehaven Women and Children Refuge Centre	473		473
Clareville Court Day Centre	149		149
CLASP (Community of Lough Arrow Social Project)	116		116
Clondalkin Addiction Support Programme (CASP)	542	306	848
Clondalkin Drugs Task Force	114	81	195
Clondalkin Tus Nua Ltd.	122	327	449
Clones Branch of the Mentally Handicapped	225		225
Clonmany Mental Health Association	101		101
Clonmel Community Resource Centre	155		155
Clontarf Home Help	1,671		1,671
CLR Home Help	2,091		2,091
CLUB 91 (Formerly Chez Nous Service), Sligo	125		125
Co-Action West Cork	6,100		6,100

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Cobh General Hospital	943		943
Comfort Keepers Ltd.	11,060		11,060
Community Creations Ltd.	271		271
Community Games	200		200
Community Home Maker and Family Support Service	265		265
Community Nursing Unit NW	850		850
Community Response, Dublin	202	112	314
Community Substance Misuse Team Limerick	1	430	431
Connaught St. Family Centre	427		427
Console (Living with Suicide)	597		597
Contact Care	762		762
Coolmine Therapeutic Community Ltd.	624	859	1,483
Coombe Women's Hospital	52,526		52,526
COPE Foundation	44,116		44,116
COPE Galway	2,233		2,233
Cork Alzheimers Home Support (CAHS)	112		112
Cork Association for Autism	3,653		3,653
Cork Family Planning Clinic	290		290
Cork Foyer Project	288		288
Cork Mental Health Association	129		129
Cork Social and Health Education Project (CSHEP)	445		445
Cork University Dental School and Hospital	1,948		1,948
Cottage Home Child and Family Services	1,700		1,700
County Limerick VEC	115		115
County Wexford Community Workshop, Enniscorthy/New Ross Ltd.	3,823		3,823
Cox's Demense Youth and Community Project Ltd.	140		140
CPL Healthcare	1,991		1,991
CROI (West of Ireland Cardiology Foundation)	175		175
Crosscare	4,515		4,515
Crumlin Home Help	2,977		2,977
Cuan Mhuire	1,149		1,149
Cuan Saor Women's Refuge and Support Service	434		434
Cuanlee Ltd.	194		194
Cumas Teo	281	201	482
Cunamh	384		384
Cura	961		961
Curam Clainne Ltd.	120		120
Cystic Fibrosis Registry of Ireland	140		140
Dara Residential Services	1,755		1,755
Darndale Belcamp Child Care	369		369

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Darndale Belcamp Drug Awareness	84	52	136
Darndale Belcamp Resource Centre	214		214
Daughters of Charity	108,461		108,461
Deafhear.ie	4,477		4,477
Deansrath Family Resource Centre	243		243
Delta Centre Carlow	2,754		2,754
Depaul Ireland	2,167		2,167
Derralossary House	847		847
Diabetes Federation of Ireland	266		266
Disability Federation of Ireland (DFI)	1,511		1,511
Dóchas	405	50	455
Dolmen Clubhouse Ltd.	153		153
Domestic Violence Advocacy Service	291		291
Don Bosco Teenage Care Housing Association	2,447		2,447
Donegal Women's Refuge Group (DDVS)	444		444
Donegal Youth Services	116		116
Donnycarney Youth Project Ltd.	263	77	340
Donnycarney/Beaumont Home Help	1,239		1,239
Donnycarney/Beaumont Local Care	105		105
Donore Community Development	0	164	164
Doras Buí	134		134
Down Syndrome Ireland	140		140
Drogheda Community Services	115		115
Drogheda Homeless Aid Association	181		181
Drogheda Women's Refuge	455		455
Dromcollogher and District Respite Care Centre	360		360
Drumcondra Home Help	1,315		1,315
Drumkeerin Care Of The Elderly	197		197
Drumlin House Training Centre	162		162
Dublin AIDS Alliance (DAA) Ltd.	359	71	430
Dublin City Council Homeless Agency	625		625
Dublin City University	150		150
Dublin Dental Hospital	6,071		6,071
Dublin North East Drugs Task Force	84	297	381
Dun Laoghaire Home Help	811		811
Dun Laoghaire Rathdown Community Addiction Team	0	482	482
Dun Laoghaire Rathdown Outreach Project	188	157	345
Early Childhood Ireland	199		199
Edenmore Day Nursery	291		291
Edward Worth Library	140		140

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Empowerment Plus	462		462
Enable Ireland	35,216		35,216
Ennis Community Development Project	143		143
Errigal Truagh Special Needs Parents and Friends Ltd.	152		152
Extern Ireland	5,288		5,288
Extra Care (ROI)	359		359
Familiscope	79	71	150
Father McGrath Multimedia Centre (Family Resource Centre)	156		156
Fatima Home, Tralee	220		220
Ferns Diocesan Youth Services (FDYS)	276		276
Festina Lente Foundation	384		384
Fettercairn Drug Rehabilitation Project	110		110
Fighting Blindness Ireland	111		111
Fingal Home Care	4,982		4,982
Finglas Addiction Support Team	0	442	442
Finglas Home Help/Care Organisation	2,076		2,076
First Step Trust	261		261
Focus Ireland	4,534		4,534
Fold Ireland	1,868		1,868
Foróige	3,024		3,024
Friedreich's Ataxia Society in Ireland	125		125
FRS Homecare	468		468
Fusion CPL Ltd.	0	114	114
Gaelic Athletic Association (Alcohol and Substance Abuse Prevention Programme)	275		275
Galway Hospice Foundation	3,364		3,364
Genio Trust	5,800		5,800
Gheel Autism Services Ltd.	5,821		5,821
GLEN – Gay and Lesbian Equality Network	259		259
Good Morning Inishowen	105		105
Good Shepherd Sisters	2,120		2,120
Graiguenamanagh Elderly Association	172		172
Greater Blanchardstown Response to Drugs	95	71	166
GROW	1,352		1,352
Guardian Ad Litem and Rehabilitation Office (GALRO)	1,773		1,773
Hail Housing Association for Integrated Living	382		382
Hands On Peer Education (HOPE)	0	109	109
Headstrong	877		877
Headway the National Association for Acquired Brain Injury	2,396		2,396
Helping Hands Adoption Mediation Agency (HHAMA)	200		200

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Hesed House	109	137	246
Holy Angels Carlow, Special Needs Day Care Centre	817		817
Holy Family School	111		111
Holy Ghost Hospital	152		152
Home Again (Formerly Los Angeles Society)	1,927		1,927
Home Care Plus	130		130
Home Help Services Ballymun	1,625		1,625
Home Instead Senior Care	10,155		10,155
Home Youth Liaison Service	526		526
Homecare Independent Living Ltd.	2,975		2,975
HomeCare North East Bay Ltd.	1,033		1,033
Homecare Solutions Ltd.	266		266
Homeless Girls Society Ltd.	686		686
HP Medical Services	250		250
IADP Inter-Agency Drugs Project UISCE	0	325	325
Immigrant Counselling and Psychotherapy (ICAP)	387		387
Inchicore Community Drugs Team	254	165	419
Inchicore Home Help	1,215		1,215
Inclusion Ireland	431		431
Incorporated Orthopaedic Hospital of Ireland	7,321		7,321
Inspire Ireland Foundation Ltd.	267		267
Institute of Community Health Nursing	126		126
Ire Services	253		253
Irish Advocacy Network	816		816
Irish Association for Spina Bifida and Hydrocephalus (IASBH)	958		958
Irish Association of Young People in Care (IAYPIC)	350		350
Irish Cancer Society	300		300
Irish College of General Practitioners	406		406
Irish Family Planning Association (IFPA)	1,289		1,289
Irish Foster Care Association (IFCA)	359		359
Irish Guide Dogs for the Blind	770		770
Irish Haemophilia Society (IHS)	633		633
Irish Heart Foundation	314		314
Irish Homecare Services	6,492		6,492
Irish Kidney Association (IKA)	187		187
Irish Motor Neurone Disease Association	281		281
Irish Prison Service	256		256
Irish Society for Autism	3,910		3,910
Irish Society for the Prevention of Cruelty to Children (ISPCC)	646	149	795
Irish Sudden Infant Death Association (ISIDA)	246		246

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Irish Travellers Movement (ITM)	5,691	137	5,828
Irish Wheelchair Association (IWA)	35,422		35,422
Jack and Jill Childrens Foundation	641		641
Jobstown Assisting Drug Dependency Project (JAAD Project)	194	82	276
K Doc (GP Out of Hours Service)	1,888		1,888
Kalbay Ltd.	1,975		1,975
KARE Plan Ltd.	1,350		1,350
KARE, Newbridge	14,759		14,759
KASMHA (Kilkenny Association for Severely Mentally Handicapped Adults)	1,014		1,014
Kerry Diocesan Youth Service	294		294
Kerry Parents and Friends Association	7,973		7,973
Kilbarrack Coast Community Programme Ltd. (KCCP)	270	57	327
Kilbarrack/Foxfield Day Centre	148		148
Kildare and West Wicklow Community Addiction Team Ltd.	0	387	387
Kildare Youth Services (KYS)	893	88	981
Kilkenny Leader Partnership	101		101
Killinarden (KARP)	143		143
Kilmaley Voluntary Housing Association	153		153
Kingsriver Community	306		306
L&B Home Respite Services Ltd.	115		115
L'Arche Ireland	2,644		2,644
Leitrim Association of People with Disabilities (LAPWD)	504		504
Leitrim Development Company	246		246
Leopardstown Park Hospital	13,202		13,202
Letterkenny Women's Centre	312		312
Letterkenny Youth And Family Service	110		110
Liberties and Rialto Home Help	1,046		1,046
Life Pregnancy Care Service	454		454
Lifestart Foundation	847		847
Limerick Social Services Council	1,293		1,293
Limerick Youth Service Community Training Centre	395		395
Link (Galway) Ltd.	156		156
Liscarne Court Senior Citizens	115		115
Little Angels Hostel Letterkenny	112		112
Lochrann Ireland Ltd.	133		133
Longford Community Resources Ltd.	164		164
Longford Social Services Committee	201		201
Longford Women's Centre	115		115
Lorcan O' Toole Day Care Centre	113		113
Loughboy Child Care Project	182		182

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Lourdes Day Care Centre	161		161
Macroom Senior Citizens Housing Development Sullane Haven Ltd.	104		104
Mahon Community Creche	137		137
Mahon Family Resource Centre	230		230
Marian Court Welfare Home Clonmel	128		128
Marian Day Nursery and Family Centre	159		159
Marino Institute of Education	105		105
Marino/Fairview Home Help	870		870
Mater Misericordiae University Hospital Ltd.	240,305		240,305
Matt Talbot Adolescent Services	1,279		1,279
Mayo Women's Support Services	406		406
Mead Village Day Care Centre	214		214
Meath Accessible Transport t/a Flexi Bus	162		162
Meath Partnership	32	463	495
Meath Womens Refuge and Support Services (MWRSS)	249		249
Mental Health Associations (MHAs)	1,617		1,617
Mental Health Ireland	164		164
Merchant's Quay Ireland (MQI)	1,949	58	2,007
Mercy Family Centre Ltd.	368	24	392
Mercy University Hospital, Cork	66,738		66,738
MIDWAY – Meath Intellectual Disability Work Advocacy You Ltd.	2,014		2,014
Mid-West Regional Drugs Task Force	60	369	429
Migraine Association of Ireland	177		177
Milford Care Centre	11,679		11,679
Miss Carr's Housing Association Ltd.	353		353
Moatview Day Nursery	139		139
Moorehaven Centre Tipperary Ltd.	1,049		1,049
Mount Cara House	180		180
Mount Carmel Home, Callan, Co Kilkenny	160		160
Mounttown Neighbourhood Youth Project	172	19	191
Mountview/Blakestown Community Drugs Team	130	81	211
MS Ireland – Multiple Sclerosis Society of Ireland	2,645		2,645
Muintir na Tire Ltd.	122		122
Mulhuddart/Corduff Community Drugs Team	244	80	324
Multiple Sclerosis North West Therapy Centre Ltd.	254		254
Muscular Dystrophy Ireland	1,179		1,179
Mymind Ltd.	112		112
National Association of Housing for the Visually Impaired Ltd.	480		480
National Council for the Blind of Ireland (NCBI)	6,554		6,554
National Federation of Voluntary Bodies in Ireland	295		295

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
National Maternity Hospital	47,907		47,907
National Office of Victims of Abuse (NOVA)	778		778
National Rehabilitation Hospital	26,817		26,817
National Suicide Research Foundation (NSRF)	1,086		1,086
National Youth Council of Ireland	145		145
Nazareth House, Mallow	1,679		1,679
Nazareth House, Sligo	732		732
New Beginnings Childcare and Residential Service	697		697
New Ross Community Hospital	244		244
Newbridge and Dun Laoghaire Community Training Centre	120		120
Newbury House Family Centre, Mayfield, Cork	130		130
Newport Social Services, Day Care Centre	242		242
Nightingale TLC	157		157
No Name Youth Club Ltd.	165		165
North and West Connemara Rural Project	129		129
North Dublin Inner City Homecare and Home Help Services	1,974		1,974
North Tipperary Community and Voluntary Association (CAVA)	538		538
North Tipperary Disability Support Services Ltd.	606		606
North Tipperary Leader Partnership	513		513
North West Alcohol Forum	466	70	536
North West Parents and Friends Association	1,930		1,930
North West Regional Drugs Task Force	0	123	123
Northside Community Health Initiative (NICHE)	294		294
Northside Homecare Services Ltd.	1,038		1,038
Northside Inter-Agency Project (NIAP)	250		250
Northside Partnership	311	95	406
Northstar Family Support Project	2	165	167
Northwest Hospice	1,114		1,114
Nua Healthcare Services	876		876
Nurse on Call – Homecare Package	1,883		1,883
O'Connell Court Residential and Day Care	245		245
Offaly Local Development Company	162		162
One Family	410		410
One in Four	525		525
Open Door Day Centre	362		362
Open Heart House	252		252
Order of Malta	490		490
Ossory Youth Services	139		139
Our Lady's Children's Hospital, Crumlin	125,878		125,878
Our Lady's Hospice, Harold's Cross	27,373		27,373

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Our Lady's Nursery Ballymun Ltd.	330		330
Outhouse Ltd.	190		190
Outreach Project Network – OASIS Project	476		476
Pact	350		350
Parents First Cork Ltd.	105		105
Parentstop Ltd.	102	18	120
Patient Focus	216		216
Paul Partnership Limerick	75	137	212
Peacehaven Trust	630		630
Peamount Hospital	23,832		23,832
Peter McVerry Trust (previously known as The Arrupe Society)	868	91	959
PHC Care Management Ltd.	1,182		1,182
Phoenix Community Resource Centre	112		112
Pieta House	511		511
Positive Action	244		244
Post Polio Support Group (PPSG)	364		364
Prague House	118		118
Praxis Care Group	3,171		3,171
Presentation Sisters	325		325
Private Home Care, Lucan	305		305
Prosper Fingal Ltd.	6,887		6,887
RAH Home Care Ltd. t/a Right At Home	181		181
Raheny Community Nursing Unit	5,848		5,848
Rape Crisis Network Ireland (RCNI)	3,946		3,946
Rathmines Home Help Services	298		298
Red Ribbon Project	324		324
Regional and Local Drugs Task Forces	227	358	585
Rehab Group	42,242		42,242
Resilience Ireland (Resilience Healthcare Ltd.)	739		739
Respond! Housing Association	610		610
Rialto Community Development	174		174
Rialto Community Drugs Team	231	209	440
Rialto Community Network	87	45	132
Rialto Partnership Company	323	386	709
Right of Place Second Chance Group	172		172
Ringsend and District Response to Drugs	237	98	335
Roscommon Home Services Co-op	3,037		3,037
Roscommon Partnership Company Ltd.	296		296
Roscommon Support Group Ltd.	978		978
Rosedale Residential Home	166		166

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Rotunda Hospital	47,763		47,763
Rowlagh Day Nursery	161		161
Royal College of Physicians	529		529
Royal College of Surgeons in Ireland	1,026		1,026
Royal Hospital Donnybrook	18,142		18,142
Royal Victoria Eye and Ear Hospital	21,269		21,269
Ruhama Women's Project	119	101	220
S H A R E	202		202
SAFE Ireland	472		472
Salesian Youth Enterprises Ltd.	316	35	351
Salvation Army	2,923		2,923
Samaritans	556		556
Sandra Cooneys Homecare	704		704
Sandymount Home Help	358		358
Sankalpa	236		236
Saoirse Housing Association Ltd.	699		699
SAOL Project	252	60	312
SCJMS/Muiriosa Foundation	38,934		38,934
SDC South Dublin County Partnership (formerly Dodder Valley Partnership)	121	284	405
Servisource Recruitment	972		972
Shalamar Finiskilin Housing Association	163		163
Shannondoc Ltd. (GP Out Of Hours Service)	4,828		4,828
SHINE	1,613		1,613
Simon Communities of Ireland	7,688		7,688
Sisters of Charity	16,044		16,044
Sisters of Charity St. Marys Centre for the Blind and Visually Impaired	3,195		3,195
Sisters of La Sagesse Services	12,676		12,676
Sisters of Mercy	456		456
Slí Eile Support Services Ltd.	222		222
Sligo Family Centre	151		151
Sligo Family Support Ltd.	214		214
Sligo Social Services Council Ltd.	948	49	997
Smyly's Trust Services	2,149		2,149
Snug Community Counselling	0	147	147
Society of St. Vincent De Paul (SVDP)	3,044		3,044
Sonas Housing Association	1,265		1,265
Sophia Housing Association	740		740
South Doc GP Co-operative	8,082		8,082
South Infirmary Victoria University Hospital	50,449		50,449
South West Counselling Centre	144		144

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Spinal Injuries Ireland	301		301
Spiritan Asylum Services Initiative (SPIRASI)	430		430
Springboard Projects	2,333		2,333
St. Aengus' Community Action Group	141		141
St. Aidan's Services	3,700		3,700
St. Andrew's Resource Centre	354	53	407
St. Anne's Day Nursery Ltd.	203		203
St. Anne's Youth Centre Ltd.	283		283
St. Bridget's Day Care Centre	118		118
St. Carthage's House Lismore	236		236
St. Catherine's Association Ltd.	6,344		6,344
St. Catherine's Community Services Centre Carlow	213		213
St. Christopher's Services, Longford	8,152		8,152
St. Cronan's Association	815		815
St. Dominic's Community Response Project	160	82	242
St. Fiacc's House, Graiguecullen	350		350
St. Francis' Hospice	7,041		7,041
St. Gabriel's School and Centre	1,858		1,858
St. Helena's Day Nursery	311		311
St. Hilda's Services For The Mentally Handicapped, Athlone	4,060		4,060
St. James' Hospital	324,085		324,085
St. James' Hospital, Jonathan Swift Hostels	4,444		4,444
St. John Bosco Youth Centre	104	57	161
St. John of God Hospitaller Services	128,370		128,370
St. John's Hospital	18,599		18,599
St. Joseph's Foundation	11,821		11,821
St. Joseph's Home For The Elderly	681		681
St. Joseph's Home, Kilmoganny, Co.Kilkenny	156		156
St. Joseph's School For The Deaf	1,838		1,838
St. Kevin's Home Help Service	392		392
St. Laurence O' Toole SSC	900		900
St. Lazarian's House, Bagenalstown	301		301
St. Luke's Home	2,678		2,678
St. Luke's Hospital (UK)	261		261
St. Mary's School For The Deaf	1,178		1,178
St. Michael's Family Resource Centre	57	45	102
St. Michael's Hospital, Dun Laoghaire	27,662		27,662
St. Michael's House	72,016		72,016
St. Michael's Day Care Centre	174		174
St. Monica's Community Development Committee	299	73	372

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
St. Monica's Nursing Home	124		124
St. Mura's Adoption Society	115		115
St. Patrick's Hospital	190		190
St. Patrick's Special School	157		157
St. Patrick's Wellington Road	8,155		8,155
St. Vincent's Hospital Fairview	14,156		14,156
St. Vincent's Trust, St. Mary's Day Nursery	248		248
St. Vincent's University Hospital, Elm Park	217,644		217,644
Star Project Ballymun Ltd.	137	106	243
Stella Maris Facility	150		150
Stewart's Hospital	43,502		43,502
Stillorgan Home Help	565		565
Streetline	610		610
Suicide or Survive (SOS)	187		187
Sunbeam House Services	19,461		19,461
Tabor House, Navan	108		108
Tabor Lodge	503		503
Tabor Society	652		652
Tallaght Home Help	1,230		1,230
Tallaght Hospital	196,868		196,868
Teach Mhuire Day Care Centre	145		145
Teach Tearmainn, Kildare	182		182
Tearmann Domestic Abuse Service, Monaghan	140		140
Teen Challenge Ireland Ltd.	0	388	388
Temple Street Children's University Hospital	84,111		84,111
Templemore Day Care Centre	167		167
Terenure Home Care Service Ltd.	896		896
The Beeches Residential Home	134		134
The Care People	105		105
The Cavan Centre	272		272
The Gateway Project	160		160
The National Federation of Arch Clubs	181		181
The Oasis Centre	4	169	173
The Sexual Health Centre	278		278
The Sexual Violence Centre	285		285
Thurles Community Social Services	317		317
Tintean Housing Association Ltd.	138		138
Tipperary Association for Special Needs	131		131
Tipperary Hospice Movement	220		220
Togher Pre School and Family Centre	147		147

Name of Agency	Revenue Grants 2013 €000's	Other Grants* 2013 €000's	Total Grants** 2013 €000's
Tolka River Project	0	139	139
Transfusion Positive	190		190
Treoir	454		454
Tribli Limited, t/a Exchange House National Travellers Service	704	92	796
Trinity College Dublin	358		358
Tullow Day Care Centre	196		196
Turas Counselling Services Ltd.	3	220	223
Turners Cross Social Services Ltd.	200		200
University of Limerick	115		115
Valentia Community Hospital	601		601
Village Counselling Service	115		115
Vita House Family Centre, Roscommon	117		117
Walkinstown Association For Handicapped People Ltd.	4,002		4,002
Walkinstown Greenhills Resource Centre	0	239	239
Wallaroo Pre-School	122		122
Waterford and South Tipperary Community Youth Service	607		607
Waterford Association for the Mentally Handicapped	2,104		2,104
Waterford Hospice Movement	217		217
Well Woman Clinics	546		546
Wellsprings	613		613
West Cork Carers Support Group Ltd.	131		131
West Limerick Resources Ltd.	180		180
West Of Ireland Alzheimer Foundation	1,605		1,605
Westdoc (GP Out Of Hours Service)	1,327		1,327
Western Care Association	27,944		27,944
Westmeath Community Development Ltd.	273		273
Wexford Homecare Service	202		202
Wexford Women's Refuge	336		336
White Oaks Housing Association Ltd.	255	49	304
Wicklow Community Care Home Help Services	5,357		5,357
Windmill Therapeutic Training Unit	511		511
Women's Aid	691		691
Womens Aid Dundalk Ltd.	425		425
Young Men's Christian Association (YMCA)	364		364
Youth Action Programmes	219		219
Youth Advocacy Programme	2,357		2,357
Youth For Peace Ltd.	139		139
Total Grants to Outside Agencies (see Note 8)	**3,458,633**	**18,515**	**3,477,148**

* 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.

Appendix 2

Analysis of Capital Grants to Outside Agencies

(Capital Income and Expenditure Account)

Name of Agency	Capital Grants 2013 €000's
Total Grants under €100,000 (11 Grants)	**399**
Ability West Ltd.	138
Beaumont Hospital	8,110
Brothers of Charity Services Ireland	478
Cappagh National Orthopaedic Hospital	3,232
Coombe Women's Hospital	724
Curraheen Hospital	3,800
Incorporated Orthopaedic Hospital of Ireland	850
Mater and Children's Hospital Development Ltd.	17,325
Mater Misericordiae University Hospital Ltd.	4,273
Mercy University Hospital, Cork	2,179
National Maternity Hospital	469
National Paediatric Hospital	1,213
National Rehabilitation Hospital	1,044
Our Lady's Children's Hospital, Crumlin	996
Prosper Fingal Ltd.	216
Rotunda Hospital	1,131
Royal Hospital Donnybrook	163
Sisters of Mercy	135
South Infirmary Victoria University Hospital	538
St. James' Hospital	7,359
St. John's Hospital	141
St. Michael's Hospital, Dun Laoghaire	100
St. Vincent's University Hospital, Elm Park	3,963
Tallaght Hospital	6,359
Temple Street Children's University Hospital	3,175
Western Care Association	365
Total Capital Grants to Outside Agencies (Note 19(b))	**68,875**

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