Health Service Executive

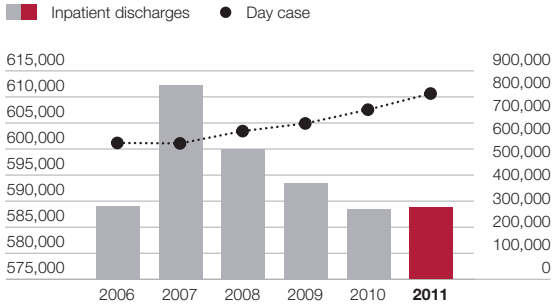
Annual Report and Financial Statements
2011

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Facts and Figures 2011 **Key Service Activity**

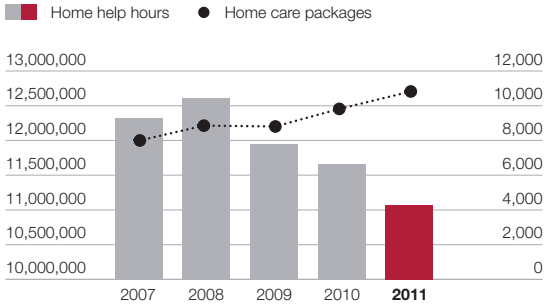
- Nearly 4.59 million people live in Ireland
- Life expectancy for men is 76.8 years and 81.6 for women
- Over 75% of the population or over 3.4 million people avail of services through 425 Primary Care Teams
- Almost 950,000 contacts were made with GP out of hour services
- Approximately 1.7 million people have medical cards
- Over 17 million prescriptions were filled for over 54 million items
- Over 1.39 million people received inpatient or day case treatment
- Over 1 million people attended Emergency Departments
- Demand for elective procedures increased by 22%
- While the number of adults waiting more than 6 months for elective inpatient and day case treatment continued to increase, 95% of hospitals achieved the end of year SDU target that no patient should wait more than 12 months
- 73,092 babies were born in our maternity hospitals
- 42,000 referrals were made to cancer clinics for breast, prostate and lung cancers
- Referrals to child and adolescent mental health services increased by 10%
- 24% more disability assessments for children under 5 years were completed than in 2010 but, of these, only 23% were completed within regulatory timelines
- There has been a 16% increase in the number of children in care since 2007
- 22,327 people were supported under the Nursing Homes Support Scheme, 629 more than in 2010
- The number of home help hours delivered reduced by 5%, but the number of people in receipt of a home care package increased by 10% against 2010
- Since 2005, there has been a 52% rise in people entering drug treatment and a 42% increase in numbers treated for alcohol problems

Inpatient and Day Case Activity 2006-2011



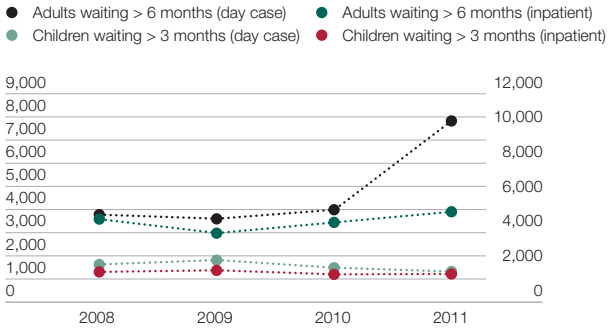
Data source: HSE Performance Reports

No. of Home Help Hours and Home Care Packages 2007-2011



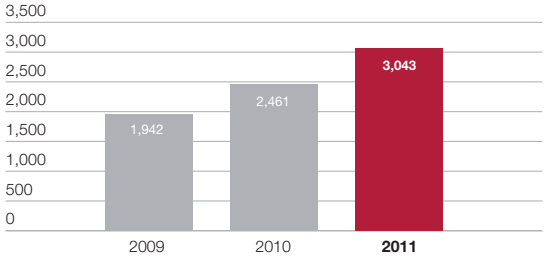
Data source: HSE Performance Reports

No. waiting more than 6 months (adults) and more than 3 months (children) for inpatient and day case treatment 2008-2011



Data source: HSE Performance Reports

Disability assessments completed for children under 5 years of age 2009-2011



Data source: HSE Performance Reports

HSE Facts and Figures 2011 **Workforce**

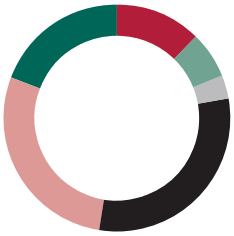
- The number employed in the health sector at end of 2011 was 104,392 whole time equivalents (WTE)
- This was 1,042 WTEs below the approved employment ceiling
- There were 3,580 less WTEs employed at the end of 2011 compared to 2010
- Since September 2007, overall staff numbers have fallen by 8,379 WTEs
- Staff categorised as administration/management fell by 1,318 (7.6%) in 2011. Since September 2007 numbers for this category have fallen by 13%
- Medical/dental category was the only staff category to increase in numbers in 2011 (3%)
- 46.7% of staff work in hospitals and 47.6% of staff work in community settings
- 5.7% work in other areas such as the ambulance service, public health, national cancer control programme and national corporate shared services
- Absenteeism rate is 4.9% against a target of 3.5%

HSE Pay Expenditure by Staff Category 2011

Nursing	30%
Medical/Dental	15%
Other Patient and Client Care	13%
Health and Social Care	12%
Management/Administration	12%
Superannuation	11%
General Support Staff	7%

Data source: HSE Corporate Finance

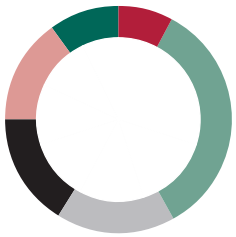
Agency Staff Cost by Category (€m) 2011



Health and Social Care	21.8m
General Support Staff	11.8m
Management/Administration	5.7m
Medical/Dental	53.7m
Nursing	49.9m
Other Patient and Client Care	33.7m

Data source: HSE Corporate Finance

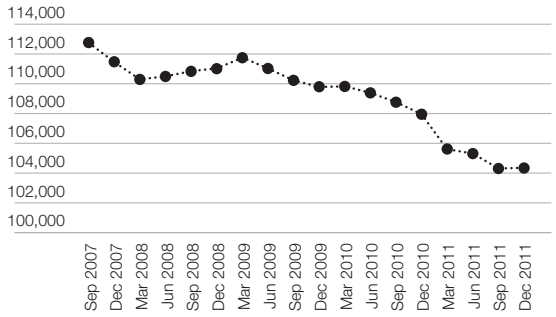
WTEs by Discipline December 2011



Medical/Dental	8%
Nursing	34%
Other Patient and Client Care	17%
Health and Social Care	16%
Management/Administration	15%
General Support Staff	10%

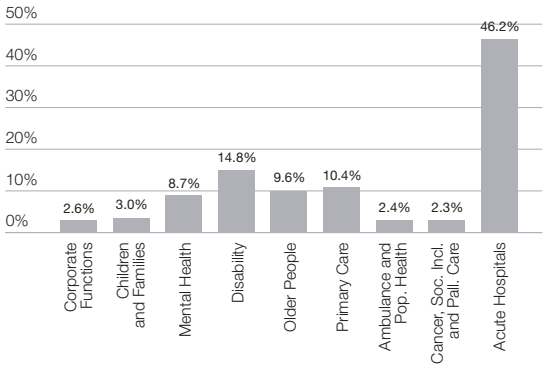
Data source: Health Service Personnel Census

WTE trends 2007-2011



Data source: Health Service Personnel Census

WTEs by Care Group December 2011



Data source: Health Service Personnel Census

HSE Facts and Figures 2011 **Finance**

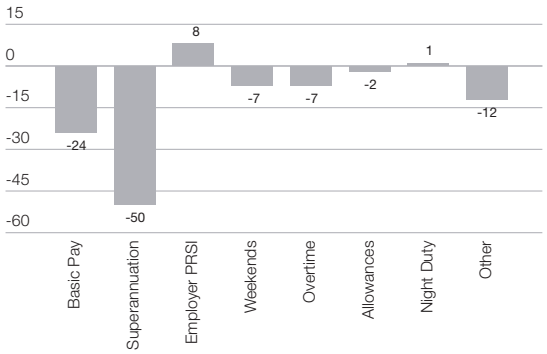
- The HSE's expenditure for 2011 was €13.588 billion
- €5.064 billion (37%) spent in hospital services, €4.683 billion (34%) in community services
- Just under €318 million was spent on maintaining and developing the capital infrastructure
- Since 2007 there has been in excess of €862 million cost reduction savings achieved
- HSE spend per capita has reduced by 11% in the two years to the end of 2011
- There has been a 23% reduction in contract costs for legal services from 2010 to 2011
- Primary Care Reimbursement Services (PCRS) payments in the year exceeded €2.517 billion
- Fees and allowances paid to doctors totalled €476 million with €1.934 billion payments to pharmacies (including PCRS)
- Non pay operating costs have reduced by €23 million (5%) in the two years to the end of 2011
- There was an 18% reduction in catering costs over the same period
- Non pay clinical costs reduced by €436 million (14%), including €363 million (17%) reduction in actual drug costs
- Pay, excluding superannuation, has reduced by 8% over a two year period

HSE Payroll Data Changes 2011 v 2010

Category	€000s
Medical/Dental	8,204
Nursing	-30,782
Health and Social Care Professional	22,927
Management/Administration	-23,576
General Support Staff	-23,612
Other Patient and Client Care	4,205
Superannuation	-50,379
Total	-93,013

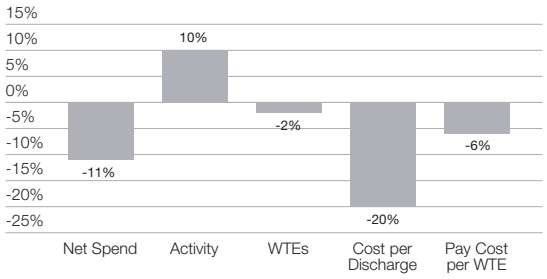
Data source: HSE Corporate Finance

HSE Pay Cost Change 2011 v 2010 (€m)



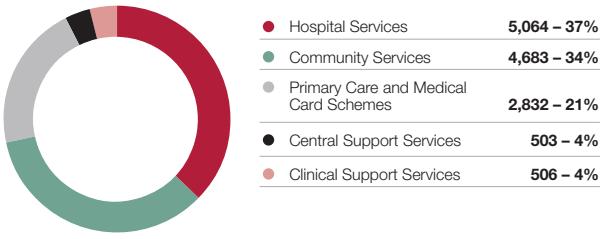
Data source: HSE Corporate Finance

Acute Hospital % changes in 2 years to end 2011



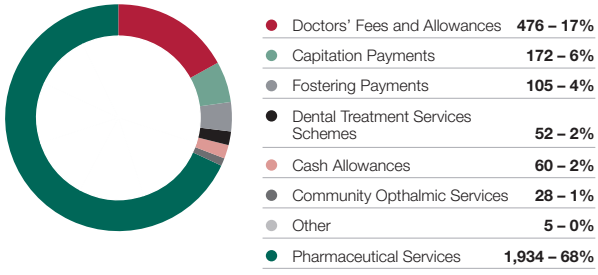
Data source: HSE Corporate Finance

Breakdown of Total Expenditure by Service (€m and %) 2011



Data source: HSE Corporate Finance

Primary Care and Medical Card Schemes Expenditure (€m and %) 2011



Data source: HSE Annual Financial Statements

Contents

Introduction

Chairman's Statement

2011 was a year of significant change for the health services. The general election brought a change of Government with a new policy direction and a programme of reform. The Programme for Government commits to the development of a universal, single tier health service, supported by Universal Health Insurance, guaranteeing access to medical care based on need, not income. An Implementation Group on Universal Health Insurance has been established to support the Government in delivering on this commitment as has a Universal Primary Care Project Team charged with overseeing the introduction of universal primary care. This new direction combined with the country's economic circumstances presented many challenges for us all in 2011 and, I think I can safely say, will do so again in 2012!

The reform programme is not just about access to services. Patients accessing care in an appropriate setting is a fundamental part of the programme and this means not only focusing on acute hospitals but developing other structures. The improvement of community based services through a primary care setting will be a key driver of the reform. Also, it is about standards and safety and I acknowledge the work which has been done to improve the quality of care we deliver to our patients.

New models of care will be introduced across all services, which will treat patients at the lowest level of complexity and provide quality services at the least possible cost. This programme of work is ongoing and will inform the most appropriate structure, staffing and organisation of services. The roll-out of the National Clinical Care Programmes and Special Delivery Unit initiatives will also deliver greater productivity.

For HSE staff, the Public Service Agreement (Croke Park deal) may mean changes to how they work. It will bring about greater flexibilities in work practices and rosters and will maximise redeployment to achieve more efficient delivery of services. For patients, this will mean an ability to allocate staff resources to areas of greatest priority and this will greatly enhance the level of care and service we provide.

Frontline staff, in the local areas, are attuned to what people need and how we can best deliver this. The regional health fora are a crucial contributor to this process and I want to thank their members for their assistance and support as they work with us, reminding us constantly of who we serve and how best to do so.

I want to commend all the staff of the HSE for the commitment, dedication and diligence shown, not just in 2011, but in previous years. I also want to acknowledge and thank the members of the Board including those who stepped down in 2011. I would like to express my appreciation to the CEO Mr Cathal Magee and also to two of my predecessors, Dr Frank Dolphin and Mr Michael Scanlan, former Secretary General of the Department of Health.

The appointment of the Secretary General of the Department as Chair of the HSE Board clearly signalled the closer working relationship between the two organisations and that should be welcomed. Closer ties and an improved dynamic will be key to delivering the patient centred, top class health service we all deserve.

I look forward to working with all health service staff and stakeholders in 2012 and beyond.

Dr. Ambrose McLoughlin
Chairman
Health Service Executive

Board Membership

As at 31st December, 2011

Dr. Frank Dolphin

Dr. Dolphin was appointed Chairman of the HSE in August 2010. He is the Chairman of Rigney Dolphin Ltd, a business services company he founded in Waterford in 1990. Dr. Dolphin stepped down from his role as Chairman on 31st December 2011.

Mr. Cathal Magee

Mr. Magee, the Chief Executive Officer of the HSE, took up his appointment in early September 2010. He is a former Managing Director of Eircom's portfolio of retail businesses.

Mr. Paul Barron

Mr. Barron is an Assistant Secretary in the Department of Health where he has responsibility for Primary Care, the National Drugs Strategy and Eligibility.

Dr. Martin Connor

Dr. Connor is the Senior Adviser to the Special Delivery Unit in the Department of Health. He has worked in health reform since 2001 at Health Authority and Strategic Health Authority level in Manchester and as Adviser to the Northern Ireland Department of Health from 2005-2008.

Dr. Philip Crowley

Dr. Crowley is HSE National Director of Quality and Patient Safety since January 2011. Prior to this, he held the post of Deputy Chief Medical Officer with the Department of Health.

Mr. Brian Gilroy

Mr. Gilroy is HSE National Director of Commercial and Support Services and has responsibility for the HSE Estate, Procurement, ICT and legal support services.

Dr. Tony Holohan

Dr. Holohan was appointed Chief Medical Officer at the Department of Health in December 2008 having worked, since 2001, as Deputy Chief Medical Officer.

Ms. Laverne McGuinness

Ms. Laverne McGuinness is HSE National Director of Integrated Services, and is responsible for the delivery of all health and personal social services across hospitals, and primary and community services.

Ms. Bairbre Nic Aongusa

Ms. Nic Aongusa was appointed in January 2008 as the first Director of the Office for Disability and Mental Health in the Department of Health.

Mr. Michael Scanlan

Mr. Scanlan is the Secretary General of the Department of Health since 2005. Mr. Scanlan took up office as Chairman of the HSE in January 2012.

Dr. Barry White

Dr. White is HSE National Director of Clinical Strategy and Programmes. He is on secondment from St. James's Hospital, Dublin where he is a Consultant Haematologist and Director of the National Centre for Hereditary Coagulation Disorders.

Mr. Dara Purcell

Mr. Purcell continued as Secretary to the Board in 2011.

Introduction from the Chief Executive Officer

The significant stakeholder interest in our health services reflects the importance of healthcare in the lives of Irish people and the level of public investment in its provision. The reason it is so important is because it affects every single person in our society. In a time of economic crisis, pressures on the health system become increasingly evident as the imperative of containing and reducing expenditure impacts on the level of services available to the public.

Our health services are facing challenges on a scale never experienced before. The fall out from Ireland's economic downturn has hit our health services hard. Over the last two years, total budget reductions in the HSE of €1.75 billion have been implemented. The total cost reduction target in 2012 is a further €750 million. Staff levels have been reduced by over 8,700 since peak employment levels in 2007. This contraction of resources is taking place at a time of accelerating demand for the provision of health and social care services. The cost reductions in the HSE to date have been delivered while maintaining and growing the service levels to patients and clients for our major service areas.

The funding outlook is unlikely to improve in the short term and further significant reductions will be required under the *Comprehensive Expenditure Report 2012-14*. As resources continue to reduce, health policy decisions will need to be more specific about healthcare service priorities in resource allocation. Equally, greater transparency in the performance management and reporting of costs and quantum of services delivered is required to demonstrate and challenge the value for money and efficiency imperative.

Increasing Demand

Demand for health services continues to grow as a result of population increases, demographic changes, economic changes and medical advancements.

A growing population places additional demands on the health system. Our population has grown by 17% since 2002. We have the highest birth rate in the EU, increasing numbers of older people, which will increase by about 295,000 people or 60% in the next thirteen years, and the number of adults with chronic conditions will increase by 40% or 289,000 people by 2020. These are all contributing to increased demand for our services which is evident in our activity levels.

The rate of unemployment has risen from 4.6% in 2007 to 14.3% (December, 2011). Over 1.7 million individuals or 37% of the population are now eligible for the range of health services covered by medical cards. This is a 50% increase since 2005 and is the highest number of people ever recorded in receipt of a medical card. There is an established correlation between income levels and health status demonstrated by higher death rates and more chronic illness among those with least disposable income.

The economic environment has significant impact on the numbers of people who previously were in a position to contribute towards the cost of their health care, but are no longer in that position. It equally has an impact on demand for public hospital services and in parallel, reduces the income from privately insured patients.

Supporting Service Delivery

Employment levels decreased by 3,580 staff in 2011. Under the 'Grace Period' Retirement Scheme, a further 4,515 have left the HSE which essentially brings health sector employment back to 2005 levels. Service activity levels, however, are considerably higher than those provided in 2005 and have in fact increased by over 30% for combined inpatient and day case treatment. These staff reductions are significant and have required and continue to require staff to work in ways which increase overall productivity.

The HSE has achieved a balanced financial outturn in each of the last three years and has expended €13.588bn in 2011. A supplementary estimate of €148m was voted by Government to the HSE towards the end of the year. The delivery of such a strong in-year cost management performance against such challenging economic conditions is a significant achievement. Very stringent cost containment plans operated throughout the year in all services as well as approximately €360m in expenditure reductions in the Primary Care Reimbursement Services.

For the first time in 2012 the budget reductions are impacting directly upon frontline staff numbers and by implication service levels. We are becoming increasingly dependent upon frontline pay savings, policy measures and income generation to maintain public services. Any failure to deliver upon these will jeopardise service provision. Furthermore, the accumulative impact of the reductions delivered in the last three years and the legacy effect of deficits carried forward in the hospital system, will mean that some hospitals will not be able to meet their financial targets in 2012. This will be addressed by the Board of the HSE in the course of 2012.

Hospitals

Five per cent or 70,000 extra people were treated as an inpatient or day patient in 2011. There was a stabilisation for the first time in the number of people treated as inpatients in our acute hospitals while the numbers seen as day patients, the preferred international model for acute care, rose by 9% a 44% increase since 2006. The early months of 2012 are demonstrating high levels of activity in our acute services.

Over 370,000 emergency admissions were made to acute hospitals during the year, 3,000 more than in the previous year. The numbers of people presenting at Emergency Departments (EDs) decreased by 1% and there was a 5.6% increase in the number of people contacting the GP out-of-hours service (949,703 contacts). This demonstrates more appropriate use of EDs and general practitioner (GP) services. Of concern however was the 2.3% increase in deliberate self-harm presentations to EDs.

There was increased demand for elective procedures as the number of people listed grew on average by 22% compared to the previous year.

While the numbers of those waiting more than six months for both day case and inpatient treatment did increase since the previous year, the numbers of those waiting over 12 months saw a very significant decrease from 1,083 to 372 people.

Community and Primary Care

Over 75% of the population, or over 3.4 million people, availed of services through 425 primary care teams. Over 17 million prescriptions were filled for over 54 million items.

There was a 10% increase in referrals to the Child and Adolescent Mental Health service, while the number waiting over 12 months for an appointment has decreased by nearly 30% due to an intensive focus on reducing waiting lists. There was a 24% increase in the number of disability assessments completed for children less than five years of age.

22,327 people were supported under the Nursing Homes Support Scheme, 629 more than the previous year. There was a 10% increase in the number of people receiving a Home Care Package. There was also a 5% increase in the number of referrals to the elder abuse service.

In recognition of some of the service and demographic pressures, additional funding of €56 million was made available by Government to progress specific initiatives in the areas of suicide prevention, disability services, children and family services, cancer services and older people services. These are outlined in the relevant care group sections.

Delivering Safe Services

During 2011, we continued to focus on the development and implementation of safe quality healthcare. Critical to making this happen was the appointment of a National Director of Quality and Patient Safety in January. This new directorate has ensured a strong focus is being placed on delivering safe and patient focused services. Its comprehensive programme of work includes the roll out of the Patient Charter, development and implementation of standards and codes of practice, effective quality and risk management processes including the development of quality indicators, targeted initiatives in the areas of clinical governance, medication safety, healthcare acquired infections and healthcare audit as well as the effective management and learning from complaints and adverse events.

Change

In order to meet demand within the context of a reducing resource we must continue to maximise services through fast tracking new, innovative and more efficient ways of doing business, including how we deliver healthcare, continue to make efficiencies, improve productivity and synergy, develop more streamlined patient pathways and make our processes simpler and easier for patients to access and use services. This level of change must accelerate.

Implementation of the National Clinical Programmes is driving a re-engineering of traditional models of care and of service delivery. This is both in terms of condition specific programmes with a single pathway (such as heart failure, stroke and diabetes) and process driven programmes with multiple pathways (such as Emergency Medicine, Acute Medicine etc). All of these are being designed and implemented by clinically led multidisciplinary teams. I would like to recognise the outstanding and significant contribution, leadership and commitment of all clinical staff involved in the delivery of these programmes.

Much progress has been made during 2011 including implementing the Acute Medicine Programme in twelve sites, opening seven stroke units and activating heart failure units in seven sites.

Outcomes are showing real reductions in the average length of stay for elective 'day and stay' procedures, improved day of surgery admission rates and increased number of patients treated as day cases.

Moving Towards Further Health Reform

In March 2011, the Government announced radical reform measures for the health services, which will ultimately lead to the introduction of Universal Health Insurance by 2016. A significant change which has already commenced is the establishment of the Special Delivery Unit (SDU) in the Department of Health in order specifically to target service improvement within hospitals.

Work commenced during the year to disaggregate child protection and welfare services from the HSE to a new Children and Families Support Agency.

Aside from structural changes, we know that if the cost base within the health service is to be adjusted in line with the requirements of the *Comprehensive Expenditure Report 2012-14*, the focus must be on reconfiguration, greater productivity and challenging traditional cost structures and models of service delivery.

It is notable that reform is costly and that successful reform is best carried out in a stable environment to lead to sustainable platforms. Structural change and managing the risk of such change in the current health services environment presents significant challenges. At a time of very considerable reductions in funding and resources, the risks associated with major structural change are multiplied.

Much has been learned in our health system about the impacts of structural change when the health boards were abolished and the HSE created. This learning must be leveraged as the challenges of the years following the introduction of the HSE reflects international experiences of such reform programmes.

Governance and Accountability

Since its establishment, the HSE has placed an important emphasis on quality and patient safety with the aim of achieving excellence in clinical governance.

The HSE underwent an assessment of its governance arrangements during 2011, which resulted in a revised HSE Code of Governance adopted by the Board and approved by the Minister in July.

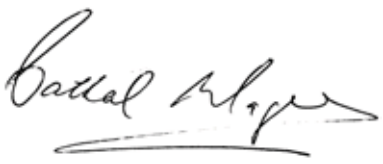
In times of reform, change and uncertainty, effective governance and accountability are more important than ever. Governance needs to be at the heart of health sector reform. It is vitally important that as we move towards new operating models that there is due diligence in the way we transition in order that patient safety is maintained.

The performance of the organisation is monitored at all levels in the system, corrective actions identified and implemented, a critical review of decisions made. The management and control processes of the HSE ensure proper governance, accountability and transparency of decision making. Monthly performance reports for the organisation are published on www.hse.ie

Thank You

On behalf of the Management Team, I would like to thank the Board of the HSE, particularly its Chairman, Dr. Frank Dolphin, for their diligence and commitment to the HSE in what was a very difficult year. I would also like to thank Mr. Michael Scanlan, Secretary General, Department of Health, who took over from Dr. Dolphin as Chairman in January, 2012 and to acknowledge his officials who provided support to the HSE throughout 2011.

The continued delivery of safe and quality services to patients and clients is dependent, more than ever, on the professionalism and extra commitment of our staff. It is through their tireless efforts in 2011 that we have been able to deliver increased levels of service to our patients and clients, in spite of reduced resources. This is exemplary performance that deserves recognition.



Mr. Cathal Magee
Chief Executive Officer
Health Service Executive

Senior Management Team

As at 31st December, 2011

Mr. Cathal Magee

Chief Executive Officer

Ms. Jane Carolan

National Director, Corporate Planning and Corporate Performance

Mr. Paul Connors

National Director, Communications

Dr. Philip Crowley

National Director, Quality and Patient Safety

Mr. Michael Flynn

National Director, Internal Audit

Mr. Brian Gilroy

National Director, Commercial and Support Services; Integrated Services Directorate, Reconfiguration

Mr. Gordon Jeyes

National Director, Child Protection and Welfare Services

Mr. Sean McGrath

National Director, Human Resources

Ms. Laverne McGuinness

National Director, Integrated Services Directorate, Performance and Financial Management

Dr. Susan O'Reilly

National Director, National Cancer Control Programme

Dr. Barry White

National Director, Clinical Strategy and Programmes

Mr. Liam Woods

National Director, Finance

Mr. Dara Purcell

Secretary to the Senior Management Team

Setting the Scene

Our Organisation

Introduction

The core purpose of our health system 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 HSE did in 2011 in order to meet our objectives. It sets out progress against the *HSE National Service Plan 2011* and what we have achieved within the longer term agenda as stated in our *Corporate Plan 2008-2011*.

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.

The structure of the organisation at the end of 2011 can be seen in Appendix 1.

The Changing Environment

In March 2011, the Government published its *Programme for Government* which detailed its intentions to introduce significant and far reaching reform measures. Under this extensive and ambitious programme, a universal single-tier health service, guaranteeing access to medical care based on need, and not income, will be available. It is the Government's intention that, by 2016, a system of Universal Health Insurance (UHI) will be introduced, which will provide guaranteed access to care for all. These far reaching changes require a major overhaul of existing legislation and will take some time to implement. The timeframes for achieving UHI are set out in the *Programme for Government* and *Government for National Recovery 2011-2016*.

During 2011, the HSE worked with Government to begin to lay the foundations for this major health reform programme. We are committed to continuing this work to modernise, streamline, and reorganise health services to ensure that patient centred, accessible, affordable and sustainable services are available to the whole population.

Service Delivery Model 2011

The HSE's main objective in 2011 was to continue to deliver services to our patients and clients with minimum disruption. The model of service that we deliver is based on all services, community and hospital, being linked to local populations with effective integration arrangements at all levels. Patients requiring a routine, straightforward level of care can be safely provided with treatment delivered at home or as close to home as possible. The minority of patients who require more complex or critical care are safely managed in a designated acute centre, where the relevant clinical expertise is concentrated so that consultant-led high-quality care is available.

Our services are organised into four regions within a national framework. The regions are subdivided into 17 areas with acute and community services delivered to a defined population. More complex care is delivered through national models based on international best practice, for example cancer services.

Providing Health and Personal Social Services

Services in the community include:

- Health promotion, prevention, and protection services
- Primary and community care services
- Services for children and families
- Services for older people
- Services for persons with disabilities
- Mental health services
- Palliative care services
- Services for persons with chronic illness
- Oral health and audiology services
- Environmental health services
- Social inclusion services
- Civil registration services.

Services are also provided by independent contractors (such as GPs, pharmacists, optometrists, dentists), non-statutory, voluntary, and community groups on behalf of the HSE.

In our hospitals:

- Acute services were delivered through 49 acute hospitals in 2011. These hospitals provide a comprehensive range of assessment, diagnosis, treatment, and rehabilitation services on a regional, an extended regional (supra-regional), or national basis.
- More complex procedures are provided in supra-regional centres, including neurosurgery, cardiac surgery, complex cancer treatments, and radiotherapy.
- Designated national specialist services incorporate areas of care such as organ transplantation, spinal injuries, paediatric cardiac services, and medical genetics.
- In addition, there are a number of arrangements in place with other service providers in Ireland for the delivery of specific services, such as renal dialysis and radiotherapy.
- Hospitals also play a key role in undergraduate and postgraduate training, the education of medical and health service professionals, and essential clinical and related research with universities.

We also provide pre-hospital emergency care services (ambulance and emergency response services). Information on how to contact hospital or regional services can be found in Appendix 2.

Our People

During 2011 there was very positive engagement in implementing major change programmes across all areas of the HSE. Staff pro-actively responded to the reform agenda, with a developing awareness that each staff member has a contribution to make to the viability of our services and in maximising sustainable employment.

The Public Service Agreement (PSA) continues to provide the framework to introduce new ways of working. We will continue to work closely with staff and their staff associations through a detailed information and consultation process at regional and local level. Our focus is on maximising new and innovative service delivery options, with a shared ownership of the reform agenda. The challenge will be to continue to introduce new models of care across all services which deliver complex and non-complex care at the lowest level of unit cost.

As the pace of change increases, it is fundamental that full engagement on the reform agenda continues with all of our staff, to allow us to further transform and modernise the health services.

During the year, in line with Government policy, the work force continued to reduce in numbers. Under the 'Grace Period' Retirement Scheme, extended to the end of February 2012, an additional 4,515 people or approximately 3,986 whole time equivalents (WTEs) will leave the HSE (*HSE Performance Report, February 2012*). The greatest number of retirements will occur in acute hospitals (approximately 34%). Approximately 47% of those retiring are nurses. As health services are predominantly dependent on the people who deliver services, these staff reductions are significant and have required, and continue to require, staff to work in ways which increase overall productivity.

Employee Numbers

At the end of December 2011, the health sector employed 104,392 WTEs, 1,042 WTEs below the end-of-year approved employment ceiling. This was a reduction of 3,580 WTEs or 3.3% compared to the end of 2010.

Table 1: Health Service Personnel Census December 2010 v December 2011

Category	WTE Dec '10	% of Total	WTE Dec '11	% of Total	WTE change 2010-2011
Medical/Dental	8,096	7.5%	8,331	8%	+235
Nursing	36,503	34%	35,902	34%	-601
Health and Social Care Professionals	16,355	15%	16,217	16%	-138
Management/Administration	17,301	16%	15,983	15%	-1,318
General Support Staff	11,421	10.5%	10,450	10%	-971
Other Patient and Client Care	18,295	17%	17,508	17%	-787
TOTAL	**107,972**	**100%**	**104,392**	**100%**	**-3,580**

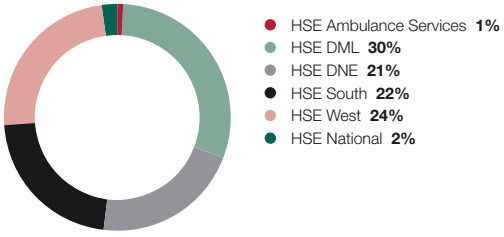
Data source: Health Service Personnel Census

Note: Information in table has been rounded

Staff categorised as management/administration fell by 1,318 WTEs compared to the previous year. This staff category is now below levels recorded at the establishment of the HSE in 2005 – reduced by 2,438 WTEs (or 13%) since its peak in September 2007. This has been achieved despite increased staff numbers added to the HSE ceiling from numerous subsumed agencies over the years. The majority of staff in this category are employed in front line services with direct contact with the public (such as medical secretaries, receptionists in clinics, clerical staff in hospital wards, EDs, health centres etc.)

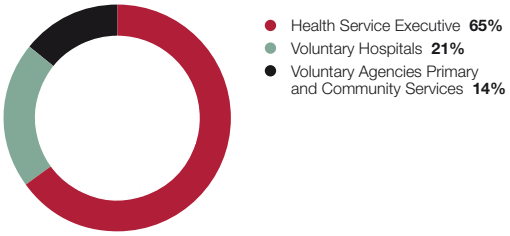
With the exception of medical/dental (up 235 WTEs or 3%) all staff categories were below last year's levels. The full impact of the 2010 voluntary early retirement scheme and voluntary redundancy scheme (VER/VRS) was seen in 2011 in the exit of 2,006 staff, equating to 1,626 WTEs at the start of the year. These schemes targeted staff in management/administration and general support staff with a divide of two thirds to one third in staff exiting the health sector.

Figure 1: % WTEs by Region December 2011



Data source: Health Service Personnel Census

Figure 2: HSE and other Providers 2011



Data source: Health Service Personnel Census

At the end of 2011:

- Staff turnover during the year amounted to approximately 7,000 WTEs (including resignations, retirements, termination of contracts, etc.)
- 370 WTE new positions commenced during the year.
- Grades with exempted status from the general moratorium on recruitment grew by 676 WTEs from the 2009 baseline used by the DoH to set the targets:
  - There were 2,474 WTE consultants (2.4% of the total workforce). This reflects a growth of 6.8% from 2009.
  - Social workers stood at 2,400 WTEs, reflecting a growth of 261 WTEs or 12.2% from the 2009 baseline.
  - There were 3,565 WTE health and social care professionals, reflecting a growth rate of 6.5% or 217 WTEs from the end of 2009.
- 46.7% of staff worked in hospitals.
- 47.6% of staff worked in the community.
- 5.7% worked in other areas such as the ambulance service, public health, national cancer control programme and national corporate shared services (finance, procurement, HR, etc.)

Table 2: Health Service Absenteeism Rates 2008-2011

Year	2008	2009	2010	2011
Absenteeism Rates	5.8%	5.1%	4.7%	4.9%

Data source: HSE Performance Reports

Absenteeism

Absenteeism in the health services remains a challenge due to the very nature of its high staff resource dependent service. However, over the past number of years there has been a particular management focus on reducing the levels of absenteeism in order to reach a target of 3.5%. Rates of absenteeism have reduced from 5.8% in 2008 to 4.9% in 2011. In 2011, 85% of all absenteeism was certified.

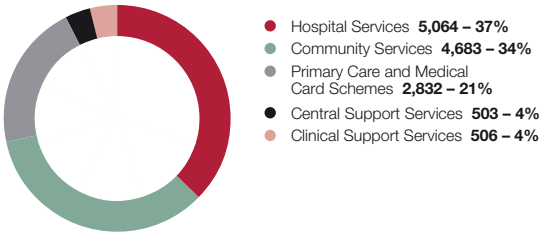
Our Finances

The financial results at year end showed that the HSE delivered on its commitments and achieved a balanced vote in what was a very challenging year for health.

The total HSE revenue expenditure in 2011 was €13.588bn for the delivery and contracting of health and personal social services. A supplementary estimate of €148m was also voted by Government to the HSE at the end of the year.

The main areas of expenditure are set out in Figure 3.

Figure 3: Breakdown of Total Expenditure by Service (€m and %) 2011



Data source: HSE Corporate Finance

As can be seen, €5.064bn (37%) was spent on our hospital services, €4.683bn (34%) on community services, €2.832bn (21%) on primary care and medical card schemes and the remainder (8%) on either central or support services.

Just under €318m was spent on maintaining and developing the capital infrastructure of the health system.

Full details on the finances of the HSE can be found in the HSE Annual Financial Statements, 2011.

Primary Care Reimbursement Service (PCRS)

Expenditure in PCRS amounted to €2.517bn, a saving of €360m on the start of the year's forecasted expenditure of €2.877bn. A number of cost management initiatives were set out in the HSE National Service Plan 2011. These initiatives generated reductions totalling €243m. These included:

- Changes to pharmaceutical pricing and reimbursement regimes
- Changes to GP fees
- Introduction of a prescription charge which delivered demonstrable cost savings.

Other initiatives improved the efficiency and effectiveness of operations and influenced contractor/client behaviour which impacted positively on the resulting demand for services and the financial outturn by year end.

Table 3 provides a breakdown of the savings achieved by initiative during the year. Further information on the PCRS can be found on pages 37-39.

Table 3: Breakdown of PCRS savings achieved

YTD December 2011	Savings €m
Full year effect of 2010 schemes	29
Efficiencies and control including probity and fees	51
Full year 2010 savings – Prescription charges	27
Drug price reductions	131
Efficiencies in high tech drugs	4
Total	**243**

Data source: PCRS Statistical Analysis
Note: Information in this table has been rounded

Table 4: Cost Reductions Achieved against Target end 2011

Category	€m Total Reduction Required 2011	€m Total Reduction Achieved 2011	% of Target Achieved
Pay	41.7	32.1	77%
Non Pay	118.9	111.6	94%
Discretionary Spend	42.2	34.7	82%
TOTAL	**202.8**	**178.4**	**88%**

Data source: HSE Corporate Finance

Strengthening Governance Arrangements with the Non-Statutory Sector

The HSE provided funding of €3.45bn to non-statutory agencies to deliver health and personal social services. In total 2,878 agencies were funded, with over 3,879 separate funding arrangements in place.

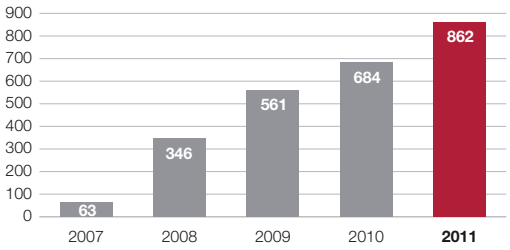
- Acute Voluntary Hospitals €1.76bn (51%)
- Non-Acute Agencies €1.69bn (49%)

The level of funding provided by the HSE to individual agencies varied from €100 to €329m, with nine agencies accounting for over 50% of the funding and 91 agencies accounting for over 90% of the funding.

Continued Cost Management in 2011

Over the last number of years we have been actively engaged in a programme to reduce our cost base, ensuring that the resources used provide real value for money (VfM). A cost reduction target for the four year period 2007-2010 was set at €500m. At the end of 2010, a cumulative total of €684m savings had been achieved. Considerable input from services and management was required to manage financial resources in the most efficient and effective way possible during 2011 while maximising the level of service. Rigorous attention ensured that significant savings achieved in previous years were maintained. Cost reductions of €178.4m, against a target of €202.8m were delivered in 2011. The range of reductions agreed for 2011, reflect the outcome of a process where the HSE focused on maximising the financial impact of nationally led programmes and processes to ensure the least impact on levels of service in meeting financial breakeven requirements.

Figure 4: Cumulative VfM delivered €m



Data source: HSE Corporate Finance

In addition to savings in pay, these reductions also included the management and delivery of procurement and logistics, estates, and education/training activities, as well as a national approach to managing discretionary expenditure under a number of headings such as maintenance, furniture and vehicles. The delivery of non-pay savings required not only significant engagement and negotiation with the HSE's supplier base in seeking to reduce prices and control volumes of stock of supplies and services, but also considerable attention by services and managers to maximise the efficient use of non-pay resources while responding to an increased demand for services.

These further economies were challenging not only because of the requirement to maintain VfM from previous years and to continue to manage cost growth, but also, and very significantly, in the context of managing areas of increasing spend, increasing service activity, and delivering on our broader service reconfiguration and improvement priorities.

There is also evidence of significant efficiencies achieved through the management of non-pay cost growth and the resulting **cost avoidance**. Services are being delivered more efficiently by not growing costs and between 2008 and 2011 this saving amounted to €1.2bn. For example, if medical and surgical cost growth had not been managed between 2010 and 2011, the projected opening cost for 2012 would be nearly €22m or 5% higher. Equally, catering would be €3m or 3.8% higher or office, rents and rates costs would be €13m or 7% higher.

Listening to Users of our Services

Introduction

your service your say

At some stage every year, most people in Ireland will have used one or more of the health or personal social services provided by the HSE or a voluntary service provider. Whether the service is delivered in a hospital, health facility or community setting, the HSE values the views of the people who use our services, their family, advocates and the public.

By responding to the knowledge and experience of service users combined with the expertise of staff, the organisation can proactively develop more personal, effective and safe services. In 2011 we:

- Developed and supported the implementation of best practice models of customer care within the health service.
- Promoted the capture and use of service user feedback for service evaluation, design and delivery of services.
- Reviewed the *National Healthcare Charter, You and Your Health Service*. The charter outlines what service users can expect and what their responsibilities are when they use health services.
- Administered *Your Service Your Say* complaints, public representatives' queries, and requests for reviews of complaints received nationally.

Implementation of the *National Healthcare Charter, You and Your Health Service*

The *National Healthcare Charter*, *You and Your Health Service – What you can expect from your health service and what you can do to help* and the patient feedback leaflet *Your Service Your Say* were revised in conjunction with stakeholders including HSE staff, service users, the DoH and the Health Information and Quality Authority (HIQA). Work continues on implementing both the charter and the *National Strategy for User Involvement*.

At the 2nd Annual Conference for Advocates for Older People are Mary Nally, Third Age; Greg Price, Director of Advocacy and Emily O'Reilly, Ombudsman.

Third Age National Advocacy Programme

Third Age National Advocacy Programme was appointed as the service provider to deliver the National Advocacy Programme. This programme aims to deliver an advocacy service to older people, particularly those who are vulnerable as a result of cognitive impairment.

250 volunteer advocates received a qualification through the Level 6 FETAC National Advocacy Programme Alliance. The programme delivered services in 89 of the 618 nursing homes and community units throughout the country and is provided free of charge to the homes.

Service User Involvement

In partnership with the National University of Ireland, Galway and the Centre for Participatory Strategies, work commenced to enable a critical analysis of user involvement projects in Ireland and abroad. Work continued on capturing the impact of service user feedback through 'You Said…We Did'. In addition, e-training tools were developed with www.HSELanD.ie, the HSE online resource for learning and development.

Service User Involvement in Clinical Care

A national patient forum was established to ensure service users have the opportunity to inform the design, delivery and evaluation of national clinical care programmes.

Mapping commenced of existing self-management support services and programmes for people living with chronic conditions and their families. This work is being finalised in partnership with national patient support organisations. The information generated will inform and guide the development of a generic framework for self-management support for national clinical care programmes.

Patient Safety Champions

A steering group was established to progress the Patient Safety Champions initiative. Patient safety champions work with health care professionals to help raise awareness of and promote international patient safety standards. This initiative is based on the World Health Organisation (WHO) model of Patients for Patient Safety.

Open Disclosure/Mediation

Open disclosure is an open, timely and consistent approach to communicating with patients and their families when things go wrong in healthcare. In 2011, we worked with the State Claims Agency to develop and pilot new guidance on Open Disclosure at two sites, the Mater Misericordiae University Hospital and Cork University Hospital. Learning from these pilots will inform national guidance on open disclosure for implementation across all of our health services.

Work commenced to explore and develop the use of mediation in relation to the management of complaints as set out in Part 9 of the *Health Act 2004*.

Universal Access

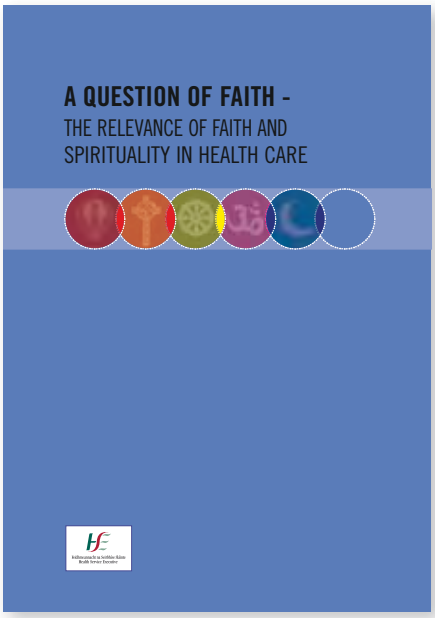
Guidance, advice and strategic support were provided in the promotion of access for people with disabilities in mainstream health services. Support was also provided on compliance with Part 3 of the *Disability Act 2005*.

Work commenced during the year on developing a plan to achieve compliance with Part 3 of the *Disability Act 2005*. Next year, a network of designated access officers will be developed throughout the country in order to comply with Section 26 of the *Disability Act 2005*.

Work continued in developing policy and practice on a range of equality issues including Lesbian, Gay, Bisexual and Transgender health.

Complaints under the Disability Act 2005

The *Disability Act 2005* provides for a special complaints and appeals procedure for those who are unhappy with their child's assessment of need or service statement. It also provides a process for dealing with complaints about access for people with a disability. In 2011, there were 90 complaints.



Resources Developed

A number of documents were developed, in conjunction with relevant stakeholders, to support the principles of the National Healthcare Charter:

- *A Service User Involvement and Primary Care National Framework*
- *National Guidelines for the Reimbursement of Service User Expenses*
- *A Question of Faith* – research project into the role of spirituality and faith in the provision of healthcare.

These documents are all available online at www.hse.ie

Compliments and Complaints

In 2011, 5,250 compliments were logged, however many more go unrecorded. Work will continue next year to support staff to implement the National Healthcare Charter. This includes encouraging staff to acknowledge and record positive feedback which can be used to identify and replicate what we are doing well.

Information gained from managing complaints helps to improve the quality of our services. In 2011, 7,449 complaints were recorded and managed by complaints officers. Of this number, 5,623 complaints (75%) were responded to within 30 working days.

Some complaints raise multiple issues and therefore fall into a number of categories. The 7,449 complaints received were logged under 15 categories with 7,953 entries. The key categories used to log complaints regarding HSE services were delays/waiting times 2,435 (31%), treatment/service delivery 2,388 (30%), communication 672 (8%), staff attitude/manner 653 (8%) and facilities/buildings 285 (4%).

Table 5: HSE Complaints by Region 2011

Geographical Area	2010	2011
Dublin Mid-Leinster	3,826	2,093
Dublin North East	1,987	2,116
South	1,014	1,163
West	1,607	1,743
Primary Care Reimbursement Service	N/A	334
Total	**8,434**	**7,449**

Data source: HSE National Advocacy Unit

Table 7: HSE Complaints received and % dealt with within 30 working days

	No. of complaints received	No. and % dealt with within 30 working days
2010	8,434	6,489 (77%)
2011	7,449	5,623 (75%)

Data source: HSE National Advocacy Unit

Table 6: HSE Complaints received broken down by category

Category	2010	2011	% change	Difference
Delays/Waiting times	3,640	2,435	-33%	-1,205
Treatment/Service delivery	2,240	2,388	+7%	+148
Communication	521	672	+29%	+151
Staff attitude/Manner	661	653	-1%	-8
Facilities/Buildings	419	285	-32%	-134
Other	655	888	+36%	+233
Cancellations	140	138	-1%	-2
Clinical judgement	120	116	-3%	-4
Hospital accommodation/Food	100	137	+37%	+37
Infection control	95	85	-11%	-10
Pre-school	45	64	+42%	+19
Nursing homes/Residential care for older people	34	29	-15%	-5
Trust in care	22	26	+18%	+4
Vexatious complaints	12	21	+75%	+9
Children First	9	16	+78%	+7

Note: Some complaints raise multiple issues and therefore fall into a number of categories. Not all complaints are dealt with using the Your Service Your Say policy and procedures. For certain types of complaint there are other policies which are followed, i.e. Trust in Care policy and Children First.

Data source: HSE National Advocacy Unit

Healthcomplaints

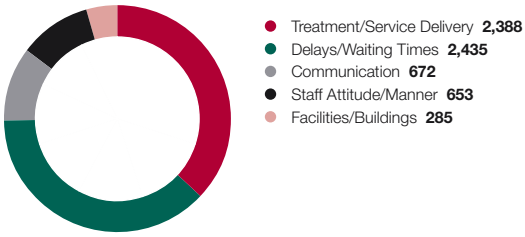
Healthcomplaints is an initiative to help members of the public understand where and how to complain about health and personal social care services. It also provides direction on who to contact for more information or support and helps people understand the roles of various agencies, including the HSE, the Ombudsman and the various Regulators.

Healthcomplaints is a collaborative effort between complaints handling bodies (Ombudsman and Ombudsman for Children), health and social care providers (HSE), regulators of services (HIQA, Mental Health Commission), professional regulators (The Medical Council, An Bord Altranais, Coru, Pre-Hospital Emergency Care Council) and service users representatives (the Irish Patients' Association).

Healthcomplaints consists of a toolkit developed for people who use health and social care services in Ireland and their families, care-givers, those who advocate on their behalf and those who work in this sector. The toolkit is made up of a guide for the public, a leaflet, a poster, a guide for employees and the website www.healthcomplaints.ie

The website www.healthcomplaints.ie provides greater detail on all the organisations featured in the guide, what their complaint procedures are, and other organisations who service users can contact if they want help raising an issue regarding their health or social care.

Figure 5: HSE top 5 complaint categories 2011 (excluding category 'Other')



Data source: HSE National Advocacy Unit

Complaints – Voluntary Hospitals and Agencies

In accordance with the *Health Act 2004*, the HSE also collects information from the voluntary hospitals and agencies. In 2011, 6,726 complaints were recorded in voluntary hospitals and agencies, logged under 15 categories with 7,138 entries.

Of the 6,726 complaints recorded, 3,863 (57%) of these were addressed within 30 working days and 1,744 complaints were dealt with informally. Where reported, the top categories used were treatment/service delivery 1,927 (27%), communication 1,091 (15%), delays/waiting times 946 (13%), staff attitude/manner 722 (10%), facilities/buildings 369 (5%) and other 1,465 (21%).

In 2011, eight hospitals were involved in a project to review the headings used to categorise complaints under the principles of the *National Healthcare Charter*. These hospitals will pilot data collection next year. The output of this work will be evaluated in tandem with a project to review the categorisation of compliments and complaints in all healthcare settings.

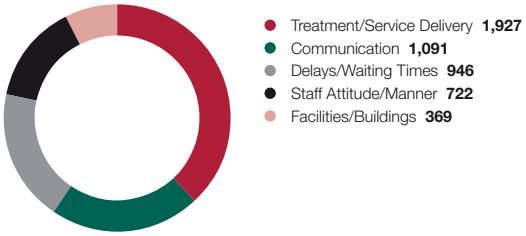
14,806 compliments were recorded in voluntary hospitals and agencies.

Table 8: Voluntary Hospital and Agency Complaints 2011

	No. of complaints received	No. and % dealt with within 30 working days
2010	6,181	4,860 (79%)
2011	6,726	3,863 (57%)

Data source: HSE National Advocacy Unit

Figure 6: Voluntary Hospital and Agency top 5 complaint categories 2011 (excluding category 'Other')



Data source: HSE National Advocacy Unit

Reviews

In 2011, 10 new review officers were appointed and trained under Part 9, *Health Act 2004*. Training and capacity building will continue next year. There were 168 requests for a review in 2011. As in 2010, 2% of complainants requested a review of their complaint.

Freedom of Information

The *Freedom of Information (FOI) Act* permits access to information held by the HSE and contracted public bodies, which is not routinely available through other sources. In 2011, there were 6,141 requests made under FOI legislation, an increase of 14% over last year.

Parliamentary and Regulatory Affairs

2,520 Parliamentary Questions (PQs) were received in 2011, a 1% decrease on the amount received in 2010. 96% of the PQs received were answered at year end.

National Information Line

Table 9: Calls received by National Information Line

	No. of calls received
2009	167,645
2010	141,450
2011	134,046

Data source: HSE National Advocacy Unit

Making a Comment, Compliment or Complaint

Did you know...?

In the HSE, we want to give you the best possible care and treatment. There may be times, however, when you think we could do better and sometimes you may even want to tell us about something we have done well.

Whatever age you are, you have rights when it comes to your health including:

- the right to have your say and be listened to
- the right to complain if you are not happy about something we have done.

We want you to tell us if you have a comment, compliment or complaint about your health or personal social care.

You can contact us by **email** (yoursay@hse.ie), by **phone** (Advocacy Unit on 045 880400 or lo-call 1890 424555), or by completing **feedback forms** that can be found in all HSE locations.

Our Population

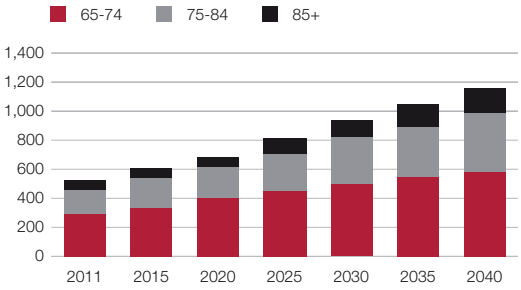
Introduction

The number of people living in Ireland has been increasing over the last number of years and is now nearly 4.59m people, an increase of 348,404 or 8% on the 2006 Census. The largest increase occurred in the 0-14 year age group (12%) and the over 65 age group (11%). Both of these groups have very significant demands in terms of health care dependency. However, the real burden in terms of health care provision is in respect of the increasing number of people with chronic illness.

Health of the Nation

Ireland has the highest **fertility rate** amongst EU countries which means that the population aged five to 12 years will increase by at least another 10% in the next decade. The rates of infant mortality and premature death have both fallen and are now below the EU-15 average. A total of 73,092 babies were born in our hospitals in 2011 with approximately 30,186 deaths registered.

Figure 7: Older Age Groups Population 2011 and Projected Population 2015-2040 ('000s)



Data source: Health in Ireland, Key Trends 2011 (DoH)

Over the past decade, Ireland has achieved an improvement in **life expectancy**. Men should expect to live, on average 76.8 years and women 81.6 years.

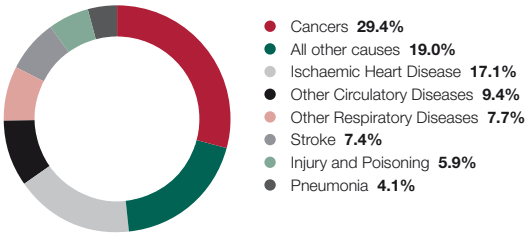
Each year the total number of people aged 65 years and over grows by around 20,000 persons. The population aged 65 years and over will more than double over the next 30 years to over 1m people with the largest proportional increase in those aged over 85 years.

In 2011

- Nearly 4.59m people live in Ireland, an 8% increase since 2006.
- The number of people aged 65 years and over is projected to increase by around 20,000 persons each year.
- Men should expect to live, on average, 76.8 years and women 81.6 years.
- Mortality from circulatory system diseases has fallen by 40% since 2001 with cancer death reduced by over 15%.
- Irish fertility rate is the highest in the EU.
- 73,092 babies were born in our hospitals in 2011 and approximately 30,186 deaths registered.
- 26% of nine year old children have a body mass index outside the 'healthy' range.

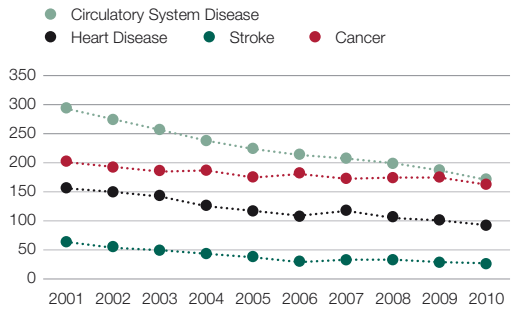
Mortality from circulatory system diseases fell by almost 40% since 2001 and cancer death rates reduced by over 15%. Between them, these two causes accounted for 63% of all deaths. Transport accident mortality fell by nearly 60%, suicide rates by nearly 20% over the period 2001 to 2010 and infant mortality by 33%. The greatest gains have been achieved in the older age groups reflecting decreasing mortality rates from major diseases. Cancer survival has improved over time. For all cancer combined and for the four main cancer sites (colorectal, lung, female breast and prostate) five-year relative survival has improved significantly between 1994 and 2007 and 2003 and 2007. However, survival in Ireland is still up to 10% behind that of the best performing cancer control systems for many cancers.

Figure 8: Deaths by Principal Causes, % Distribution



Data source: Health in Ireland, Key Trends 2011 (DoH)

Figure 9: Age-Standardised Mortality Rates (per 100,000 population) for Selected Causes in Ireland 2001-2010



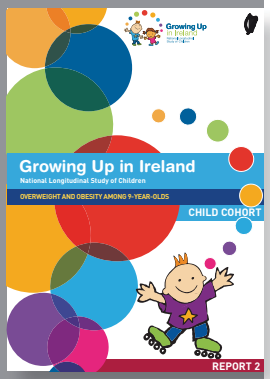
Data source: Health in Ireland, Key Trends 2011 (DoH)

The current **lifestyle-related risk factor** profile of the Irish population is a major concern. Levels of smoking, while improving, are still relatively high, while levels of obesity and physical inactivity have increased.

Increased morbidity and mortality are strongly related to lifestyle health determinants such as smoking, alcohol consumption and obesity. While alcohol and cigarette consumption are both at somewhat lower levels then they were ten years ago, they remain areas of concern which have the potential to jeopardise many of the health gains achieved in recent years.

As mortality rates have reduced, demand on health services has intensified as we respond to the needs of a population which is living longer but with a growing burden of **chronic illness**. Almost 47% of males and 54% of females aged 65 years and over report suffering from a chronic illness or condition. It is anticipated that common chronic diseases such as cancer, diabetes, hypertension, coronary heart disease, stroke and heart failure will all see substantial increases in the number of cases year on year unless there is a determined attempt to use evidence based interventions to significantly reduce the prevalence of key risk factors for these conditions within the population.

Childhood Obesity



Childhood obesity is rapidly increasing worldwide. Doing less exercise and eating more high energy foods are key factors contributing to a ten-fold increase in obesity levels in Ireland since the 1970s. The health care and personal costs are enormous with both immediate and long term health risks. The Department of *Children and Youth Affairs' report Growing Up in Ireland – Overweight and Obesity Among 9-year olds*, which was launched in November, examines the patterns of overweight and obesity among children in Ireland. The study followed the progress of almost 20,000 children and their families, a child cohort of 8,500 children interviewed at nine years and 13 years of age and an infant cohort of 11,100 children participating at nine months and three years of age.

Key findings include:

- 26% of nine-year old children had a body mass index (BMI) outside of the 'healthy' range. Of these, 19% were defined as overweight and 7% obese.
- Girls were significantly more likely to be overweight or obese than boys.
- Children from unskilled manual working class households were significantly more likely to be overweight or obese than their peers from professional households.
- Parents and children were poor at recognising child overweight and obesity. 54% of parents of overweight children and 20% of parents of obese children reported that their child was 'about the right weight' for their height.
- 11% of children watched television for three or more hours on an average weekday.
- Low levels of physical exercise and high levels of sedentary activities were both associated with a higher risk of overweight and obesity.
- Childhood overweight was associated with significantly lower self-esteem around physical appearance and popularity and worse emotional and behavioural problems.

The *HSE Framework for Action on Obesity 2008-2012* aims to address the broader determinants of obesity and health inequalities. A welcome development is that Ireland is now part of the WHO Childhood Obesity Surveillance Initiative which means that obesity levels will be monitored in Ireland on an ongoing basis.

Driving National Standards and Best Practice

Promoting and Protecting Health

Introduction

Promoting, protecting and improving health and reducing health inequalities continue to be our key priorities. To do this, we must re-orientate our health services from a curative focus towards one of preventing ill health and promoting positive health. Evidence shows that the most effective practices are achieved through approaches that influence the determinants of health and health inequalities. These include ethnicity, race, gender, life style factors, education, socio-economic status, environment, and living conditions.

Immunisation

Childhood vaccinations continue to be one of the most cost-effective public health interventions and while we are showing significant improvements in uptake over the decade, we need to address particular geographic areas where uptake rates are not improving at the same level.

Dr. Brenda Corcoran, National Immunisation Office with Leonore Brichard Rooney at the launch of the HSE's new information booklet Your Child's Immunisation – a Guide for Parents.

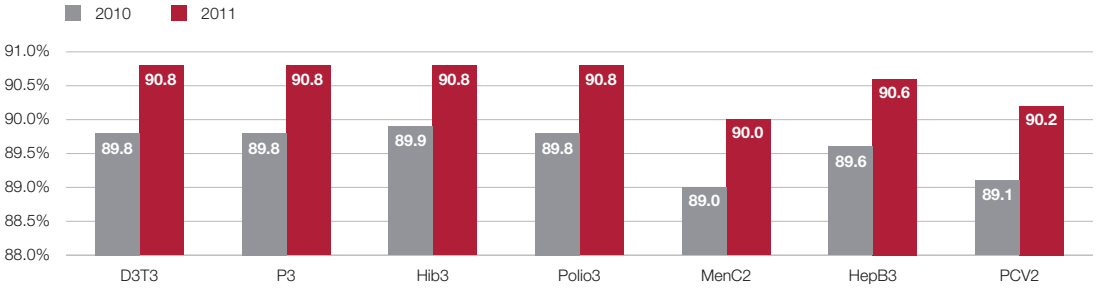
In 2011

- On average there was a 90% uptake of all childhood immunisations at 12 months.
- Uptake for 1st dose MMR vaccine reached 93%, but over 300 measles cases were reported.
- 82% (48,501) of 1st and 2nd year girls completed their HPV vaccine course.
- Uptake of the influenza vaccine was 64% but the target of 75% was not reached.
- Over 82% of children received their 7-9 month developmental screening on schedule.
- 84% of newborn babies were visited by a Public Health Nurse within 48 hours of discharge.

The national targets for all childhood vaccines are 95%. For children aged 24 months, the national uptake for the 3rd dose of diphtheria, tetanus and pertussis (whooping cough) vaccine (DTP3) was 95.6%, while 3rd dose Meningococcal C vaccine (MenC3) uptake was 84.8% and 1st dose measles, mumps and rubella vaccine (MMR1) was 92.5%. Uptake rates of over 95% are required to prevent outbreaks of these diseases. There is concern that there has been a drop in some of the uptakes for vaccines recommended at 12 and 13 months, which may be related to parents not attending for the required five GP visits.

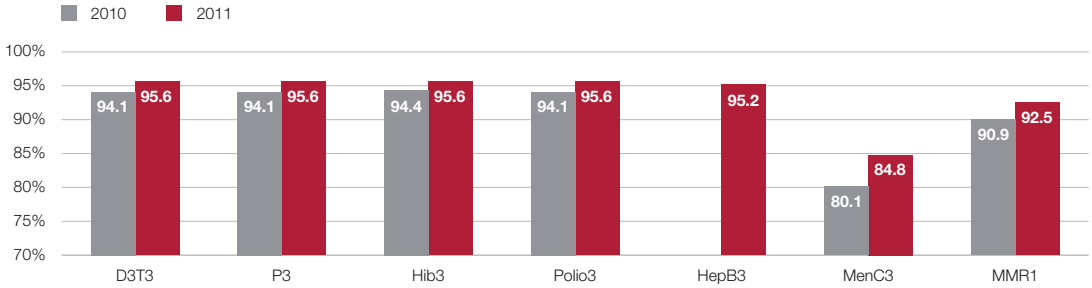
To mark the European Immunisation Week in April, an updated immunisation guide was issued following focus group discussions with parents. The guide highlights the importance of the five GP visits and answers common queries parents have about the diseases and the vaccines to prevent them as well as the vaccine schedule and vaccine safety. Support materials (posters, fridge magnets and immunisation "passports" record cards) were also produced. Further information and copies of these materials are available at www.immunisations.ie

Figure 10: Childhood Immunisation Uptake at 12 months (Q3, 2010 v Q3, 2011)



Data source: HSE Performance Reports

Figure 11: Childhood Immunisation Uptake at 24 months (Q3, 2010 v Q3, 2011)



Note: HepB3 uptake at 24 months not available for 2010

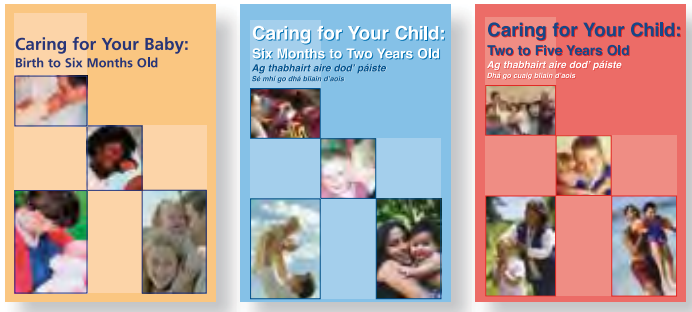
Data source: HSE Performance Reports

Over 300 cases of measles were reported, most of which were in children who had not received the recommended two doses of MMR vaccine at 12 months and four to five years of age.

Uptake rates for the first year of the **HPV vaccination** programme showed that the programme was very well received with an uptake rate of 82% in its first year, exceeding the target of 80% and equal to or greater than those achieved in the first year of programmes in other countries such as the UK and Australia. In 2010/2011 the programme targeted almost 60,000 schoolgirls in first and second year of second level schools as well as those attending special schools or home-schooled. The vaccination programme involved the administration of three doses of HPV vaccine scheduled at zero, two and six months. The routine HPV vaccination programme continued from September 2011 for first year girls and, in addition, there is a catch up programme for all sixth year girls, which will continue until the end of 2013/2014 academic year.

The target uptake for the **flu vaccine** in those aged over 65 years is 75% and for the period 2010/2011 the uptake was 64%. The 2011/2012 annual flu vaccination campaign began in September and this year new regulations were enacted to allow community pharmacists to administer the vaccine. Almost 700,000 doses of flu vaccine were distributed to 1,524 GP practices and 666 pharmacies.

Child Health Screening



Keeping young children safe, healthy and well can be challenging for parents. Through the Child Health Information Services Project (CHISP), a number of packs have been re-launched which provide easy-to-read information to help parents care for themselves and their child during the first five years. The suite of information comprises three resource packs and will continue to be delivered nationwide by public health nurses during three of the five recommended child health screening and surveillance programme checks.

Health Promotion

- Smoking is the single biggest cause of illness, disability and death in Ireland. A new health education campaign was introduced, aimed at encouraging smokers to quit. The new **QUIT campaign** is based on a stark fact that one in every two smokers will die of a tobacco related disease. By encouraging smokers to quit and reducing the numbers of smokers in Ireland, the level of illness and deaths caused by tobacco use can be reduced together with the cost of treating those illnesses. Among smokers, 80% say they want to quit and 40% try to quit every year. The campaign is aimed at making people realise the effect smoking has on their health and that of their loved ones and offers encouragement and help to QUIT.

Pauline Bell (with Dr. Fenton Howell) whose story features in the HSE's QUIT campaign television advertisements.

- A new campaign was launched to raise awareness on the **correct use of antibiotics** supported by the Irish College of General Practitioners (ICGP), the Royal College of Surgeons in Ireland and the Irish Pharmacy Union (further information available at www.hse.ie/go/antibiotics and leaflets and posters available from www.healthpromotion.ie)
- The HSE launched its updated website, www.getirelandactive.ie a one stop information source on how to get involved in **physical activity** in Ireland. With three out of four Irish adults and four out of five Irish children not sufficiently active for health benefits, the website is designed to encourage people to become more active. A special feature of the website is the well designed search facility which allows users to search for activities throughout Ireland by type of activity, date, age group, ability or cost. There is a section for event organisers, where they can promote their activity to the online audience.

Sam and Luke O'Neill from Co. Wexford at the HSE Community Games National Finals in Athlone.

HSE Community Games

Almost 9,000 children and young people from all around the country took part in the 2011 National Finals of the HSE Community Games in Athlone Institute of Technology. Young people attended the National Finals on one weekend in May and two weekends in August. Over 200,000 children from across Ireland take part in the games each year.

The motto of the games is 'a healthy mind in a healthy body', an ethos that works in harmony with the health promoting aims of the HSE. By providing health promotion guidance and support to the HSE Community Games, the games can be delivered in a healthy way. Through initiatives like 'Little Steps' and 'Get Ireland Active', advice is offered for all the family to look after their health by making small changes such as choosing healthier options and increasing activity levels. Physical activity plays a vital role in our overall health and well-being and is a key factor in the prevention of obesity and overweight. The games help children, families and communities to be more active and healthy through participating in the games or volunteering.

Get Ireland Active
Promoting Physical Activity in Ireland

Aisha Pabon at the launch of the Get Ireland Active campaign.

- First ever **nutrition and cookery programme** for male family carers was delivered in Galway by the HSE West Carers Department and Dietetic Services Department, in conjunction with the Carers Association and Galway-Mayo Institute of Technology. This was organised in response to a survey which found that cooking meals was identified as the most commonly undertaken task by carers with over half of the carers indicating that they required training in relation to nutrition and cooking meals.

HSE Crisis Pregnancy Programme

- The HSE **Crisis Pregnancy Programme** published new *b4udecide* relationship and sexuality education lesson plans for use in schools and youth work settings. The resource materials complement a web-based education initiative that aims to encourage young people to make healthy, responsible decisions about relationships and sexual health. This initiative was developed in response to extensive research, which found that young people are having sex at an earlier age than in previous generations. There were 67,000 visitors to the site in 2011. Providing sex education, in school and in the home, is the single most important thing which can be done to prevent unplanned pregnancies and the spread of sexually transmitted infections. These lesson plans and other resource materials for GPs, teachers, youth workers and parents can be ordered directly from www.healthpromotion.ie
- The **THINK Contraception** social marketing campaign is recognised by 90% of 18-24 year olds. Over 120,000 THINK Contraception Protection Packs containing a condom and a sexual health information leaflet were distributed at key events throughout the year. The packs were designed to highlight the importance of using contraception to prevent unplanned pregnancies and protect against sexually transmitted infections.
- The public health campaign, **Positive Options**, was redeveloped to raise awareness of the free, trustworthy, state-funded services, which offer help and support to those experiencing a crisis pregnancy. For more information, visit www.positiveoptions.ie

Prevention of Health Care Associated Infections

Tackling Health Care Associated Infection (HCAI) and antimicrobial resistance is one of the key patient safety and clinical quality priorities for the HSE. HCAI is not an inevitable consequence of healthcare and many HCAIs can be prevented. In conjunction with the Royal College of Physicians in Ireland (RCPI) a HCAI national clinical programme has been established. This programme will build on previous work outlined in the *Strategy for the Control of Antimicrobial Resistance in Ireland (SARI) 2001* and the HSE's *Say No To Infection* campaign. The goal of the HCAI programme is to prevent every patient from acquiring a preventable HCAI during all stages of their care and treatment and to ensure that antimicrobials are used appropriately. The core objectives are:

- Use antimicrobials appropriately (antimicrobial stewardship)
- Prevent medical device-related infections, such as IV lines and urinary catheters
- Improve hand hygiene by healthcare staff.

In order to track improvements, key HCAI surveillance measures will be monitored. This includes antimicrobial consumption rates in hospitals and the community, *Clostridium difficile* infection rates, Methicillin-resistant Staphylococcus Aureus (MRSA) bloodstream rates and hand hygiene compliance by healthcare staff. In addition, HCAI and antibiotic use in long term care was evaluated in over 100 Irish long term care facilities in May. Guidelines for management of urinary infection in long term care were produced as a result, and incorporated into the updated primary care antibiotic prescribing guidelines.

Health Care Associated Infection

Health Care Associated Infection (HCAI) is an infection that someone acquires as a result of coming into contact with the healthcare system. While not all HCAI is preventable, it is accepted that between 30-50% may be preventable. MRSA rates in Ireland are at their lowest rates since surveillance began in 1999. Latest figures (2010) show that MRSA bloodstream infections fell 14% in 2010 with 305 cases notified compared with 355 cases in 2009.

Cases of Clostridium difficile-associated disease fell by 11% in 2010 with 1,696 cases notified compared with 1,897 cases in 2009. Overall outpatient antibiotics consumed in 2010 fell by 2% compared with 2009. However, hospital antimicrobial consumption rose by 4% for the same period. Overall consumption of antibiotics in Ireland remained mid-to-high in comparison with other European countries. A recently launched HSE initiative on reducing unnecessary antibiotic usage aims to improve these figures.

On 5th May (WHO Hand Hygiene Day) the *Clean Hands Save Lives* information leaflet was produced. This leaflet is aimed at healthcare staff, patients, visitors and residents of all healthcare facilities. This is a reminder that proper hand hygiene is one of the most simple and effective ways to reduce HCAIs, which affect hundreds of millions of patients around the world every year. To date, 80 Irish healthcare facilities have signed up to the WHO campaign to save lives through hand hygiene. In 2011, an overall compliance rate of nearly 80% was reported in respect of rates of hand hygiene compliance. This was a significant improvement against the target set for 2011 of 75% compliance.

Environmental Health Services

Environmental health services play a key role in protecting the population through enforcement of legislation and the promotion of activities to assess, correct, control and prevent those factors in the environment which can potentially adversely affect the health of the population. This includes the areas of food, tobacco, international health, cosmetic product and pest control, poisons licensing, environmental impact assessment and waste licensing assessment, fluoridation and safety of drinking water supplies on behalf of the HSE and external agencies.

Progress was made in the following areas:

- A new service contract was signed with the Food Safety Authority of Ireland in December.
- Sampling was completed as part of the HSE involvement in the EU wide pilot study to determine levels of key environmental pollutants in the Irish population through the Bio Monitoring Project Democophes.
- A contract was signed for the development of the Environmental Health Information System which will be implemented next year.
- Due to the increased concern about the potential for invasive species of mosquito to arrive in Ireland, a pilot surveillance project commenced.
- The Office of Tobacco Control was merged into the HSE in January.

Environmental Health Activity in 2011	
Food Safety	• There were 23,498 high risk premises and 21,010 inspections carried out which is 90% against the target. • 27,055 establishments were inspected of which 4,437 or 16% committed infringements. • 46,456 food safety inspections were conducted, and 11,757 food samples were taken and investigated to assess the safety of food on the Irish market. • 1,511 food business complaints were investigated, as well as 454 food complaints, 458 non-confirmed food borne illnesses, 4,491 pest control complaints, 284 tobacco control complaints and 243 early years service complaints. 481 sporadic cases of foodborne illness were investigated as well as 122 outbreaks affecting 1,123 people.
Tobacco Control	• A total of 258 sales to minors test purchases were carried out by year end, with 88% compliance. • 15,679 tobacco control inspections were completed with 98% compliance in relation to smoke free requirements. • The advertising and display of tobacco products had a 95% compliance level. Overall, 29 prosecutions were taken in relation to non-compliance with tobacco control legislation.
Cosmetic Products	• 1,740 cosmetic product safety inspections were completed and 656 cosmetic samples were taken. • Sample numbers for both cosmetic products and food products exceeded targets set out in the sampling plan.
Import control	• 100% of the 320 food consignments imported, which were subject to additional controls, received the controls required. • All eight designated ports and airports received an inspection to audit compliance with the *International Health Regulations 2005*.
Infectious Disease Investigations	• Environmental Health Officers were involved in 95 infectious disease investigations with a suspect source other than food or drinking water.
Safety of Drinking Water Supplies	• 8,479 samples of drinking water were taken. • 2,679 water samples were taken and analysed to verify compliance with the legal parameter for fluoride in drinking water.
Environmental Impact Assessment	• Environmental health services commented on 65 environmental impact statements in relation to environmental health aspects. 98 Integrated Pollution Prevention Control (IPPC) licences and 35 waste and waste water licences were notified to the service.
Early Years Services	• As well as carrying out routine inspections and 583 advisory visits of early years services, 21 services were prosecuted for non-compliance with the *Childcare (Pre-school Services) Regulations 2006 (No. 2)*.

Valuing Our Staff

Bernard Twomey

Community Health Worker
North Lee Community Work Department, HSE South

As a community health worker in the Glen area of Cork City I work in partnership with other HSE staff and those in other statutory and voluntary agencies such as the RAPID Programme, third level colleges, Cork City Council, the Gardaí and local community volunteers. The RAPID (Revitalising Areas by Planning, Investment and Development) programme is aimed at improving the quality of life and the opportunities available to residents of the most disadvantaged communities in Irish cities and towns. The area I work in has also been designated as a Health Action Zone (HAZ), an area where we focus on health inequalities and are developing a range of health services tailored to meet the needs of people in those areas. The HSE South employs community health workers as a dedicated resource to develop and implement sustainable community health programmes in HAZ areas.

One of the highlights for us in 2011 was when Cathal Magee, CEO of the HSE and Pat Healy, Regional Director of Operations, HSE South paid us a visit. This enabled us to showcase work done to date and to reinforce the value of working in partnership with key players to improve the health and well-being of our community. For those working with us at local level the visit highlighted the interest that senior HSE decision makers have in our work.

During the year, despite budget difficulties, we have been able to maintain the HAZ budget and develop new initiatives which contribute to long term health improvements. These included developing an evaluation tool kit for our Fundamental Movement Skills Programme (FMSP). College students studying sports and physical education run an activities programme with pre-school, primary and post primary students in their own schools.

We also developed a rain harvesting project alongside an existing community garden for practical and educational purposes. We developed a new area to include a sensory garden, which will provide a relaxing space for garden members and the wider community, and extended existing supports from Cork City VEC by increasing horticulturalist hours available to support the group in its work.

Another area of work during the year was with the National Cancer Screening programmes with local women participating in peer-to-peer training on BreastCheck and CervicalCheck. Some women participated in survey training, which they then carried out in their local community, giving a huge boost to their self-confidence and self-esteem.

Since 2005 we have worked with area based public health nursing teams, delivering heart and lifestyle health checks in community based settings (such as a local barber shop). To date over 600 men and women have availed of this free service with some being referred on to their GP for further examination resulting in health risks being detected which otherwise may not have been. Others have made positive lifestyle changes in relation to smoking, alcohol intake, diet and exercise as a result of such checks.

The challenge for us in these times of economic downturn and decreasing resources is the prioritisation of work – deciding what projects to run, what projects to hold etc. Furthermore is the need to advocate positively on behalf of the HSE, and in responding to issues my role is to accept that, yes, challenges do exist in the HSE but equally to highlight positively improvements that are taking place across our health services.

Through joint support with the local community, the voluntary and the statutory sector, engagement in the work of HAZ by the wider community continues, and we really look forward to developing this further in 2012.

Supporting People in Primary Care Settings

Introduction

Primary care services aim to support and promote the health and well-being of the population by making people's first point of contact easily accessible, integrated and locally based.

The aim is to provide 90% of health and social care in local communities through an increase of services in primary care settings, and to re-focus health services away from acute hospitals to the community.

People with additional or complex needs will have plans of care developed with the local Primary Care Team (PCT) who will co-ordinate all care required with specialist services in the community and for hospital attendance, through integrated care pathways.

The availability of chronic disease programmes and diagnostic services in primary care, where appropriate, will ensure that patients do not need to attend hospital for these services.

Primary Care Teams and Primary Care Centres

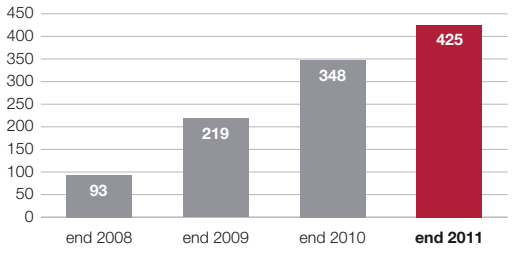
There were 425 PCTs in operation at the end of 2011 with 3,117 staff members and over 1,592 GPs participating. Over 3.4m people or 74% of the population can now avail of services through PCTs. However, the pace of development has been slower than anticipated. The 425 PCTs are at various stages of maturity and development. Resource allocation has historically been focused on curative services with less emphasis on the potential of primary prevention and health promotion. However, the implementation of care pathways for chronic diseases will lead to improvements in integration with hospital services and will simplify access for patients.

In parallel with the development of PCTs, initiatives to procure appropriate Primary Care Centres to accommodate these teams have been pursued. Having all PCT members located in one centre is the preferred option allowing services to be delivered on a single site, providing a single point of access for users and encouraging closer team working with health professionals. There are 39 Primary Care Centres accommodating 55 PCTs in place or due to open imminently.

In 2011

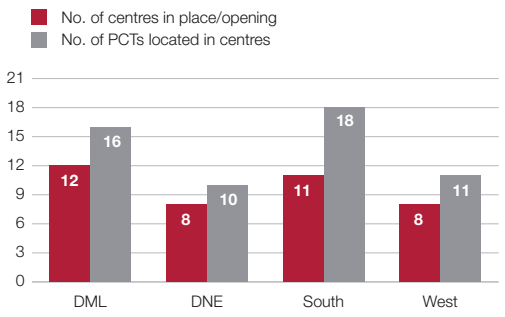
- There were 425 PCTs providing services to almost 3.4m people.
- 3,117 staff were assigned to PCTs.
- Over 1,592 GPs were participating on PCTs.
- Over 949,000 contacts were made with GP Out of Hours services.
- Over 728,000 adult ophthalmic services and over 67,000 child ophthalmic services were provided.

Figure 12: No. of PCTs in Operation 2008-2011



Data source: HSE Performance Reports

Figure 13: Primary Care Centres accommodating PCTs 2011



Data source: HSE Performance Reports

Working For You

Did you know...?

A DVD entitled *Working For You* highlights the workings and benefits of a PCT. The DVD is just one of the steps underway to improve the functioning of PCTs. It is intended to benefit all teams but particularly those in the early stages of development.

For more information on the DVD or to obtain a copy, please contact the National Primary Care Office on 091-775908 or visit www.hse.ie/go/primarycare

Work progressed on developing **electronic referral systems** from primary care to the acute sector. Initial pilots were put in place in HSE South (Cork and Kerry) and Tallaght, Dublin. In addition, four PCTs have been identified to pilot the referral of information between PCT members through **Healthlink**. This is a secure web-based messaging system which allows secure transmission of clinical patient information between hospitals and GPs. Healthlink already provides electronic services between 32 hospitals and 2,532 GPs operating from 1,091 GP practices. This has been very successful and has provided scope for expansion of the messaging system from laboratory only information to other services. Through Healthlink, cancer referrals for breast, lung and prostate are available electronically via GP practice management software systems and are delivered to cancer teams within hospitals, who respond within five working days.

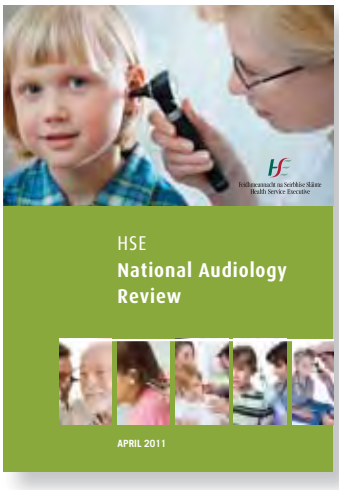
Chronic Disease Management

PCTs create a supportive environment to facilitate structured approaches to chronic disease management, enhanced multidisciplinary working, shared care arrangements and integration between primary, secondary and tertiary services. The challenge of improving quality and reducing costs has initially been focused on five chronic diseases which account for 70% of healthcare spending (stroke, heart disease, asthma, Chronic Obstructive Pulmonary Disease (COPD) and diabetes). The national diabetes/primary care programme has developed a model of care which is due to be rolled out in 2012 and this will form the basis of methodologies for other chronic illnesses. For further information see page 49.

GP Out of Hours Services

There were 949,703 contacts made with GP out of hours services during 2011 which is over 50,000 or 5.6% more than in the previous year. Over 61% of these were through GP treatment centres, 27% through triage and over 9% were home visits.

Audiology Services



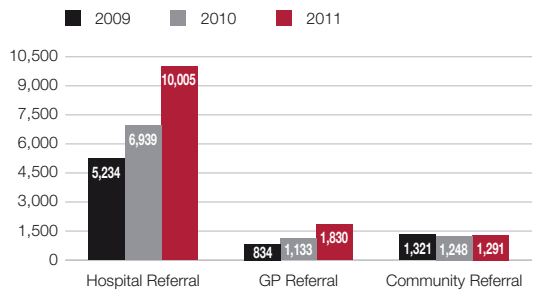
The *National Audiology Review Report 2011* was launched in April and is the most extensive examination to date of audiology services in Ireland. The review examined audiology services provided to children and adults nationwide and assessed the needs of the population. Recommendations included the implementation of a national newborn hearing screening programme, a restructuring of services and staffing to provide better integrated teams together with a workforce review. Implementation of the recommendations of the report has commenced.

Community Intervention Teams

There were six Community Intervention Teams (CITs) in place at end 2011 (Dublin North, Dublin South, Limerick, Clare, North Tipperary and Cork). These teams have a significant impact on enabling early discharge from hospital and admission avoidance. In 2011, there were 13,126 referrals compared to 7,389 referrals in 2009, which was in respect of four CITs in place at that time. In 2011:

- 10,005 patients (76%) were accepted following referral from EDs or hospital avoidance/early discharge.
- 1,830 patients (14%) were accepted by GP referral.
- 1,291 patients (10%) were accepted following a referral from the community.

Figure 14: CIT referrals accepted 2009-2011



Data source: HSE Performance Reports

New Hearing Screening Programme for Newborns

Baby Rebekah Gubbins having a hearing screening test done by Emma Hogan at CUMH. Also pictured are Rebekah's parents, Noel and Sarah Gubbins, and (from L-R) Dr. Brendan Murphy, Consultant Neonatologist; Mr. Peter O'Sullivan, Consultant Ear, Nose and Throat Surgeon; and Ms. Maria O'Donovan, Clinical Nurse Manager.

Cork University Maternity Hospital (CUMH) became the first hospital in the country to implement a new national Newborn Hearing Screening Programme in April. All new born babies at CUMH are now offered a free hearing screening test prior to being discharged. The earlier that a hearing loss can be picked up in a baby the better the outcome that baby will have. It is very important to screen all babies at an early stage. In Ireland, one to two babies in every 1,000 are born with a hearing loss in one or both ears.

Newborn hearing screening is now also in place in Wexford and Waterford maternity hospitals. This amounts to coverage of approximately 19,384 births, including home births, in the HSE South which is 26% of the national birth rate.

Rollout of the Newborn Hearing Screening Programme to all maternity hospitals is underway.

Civil Registration Service

Did you know...?

The *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010* came into effect on the 1st January 2011. This legislation provides for same sex couples to enter into a civil partnership in Ireland. In 2011, 715 couples notified the Registrar of their intention to enter a civil partnership and 536 civil partnerships were registered.

'Life Events' registered during the year included:

- **74,817 Births and 325 Stillbirths**
- **30,186 Deaths**
- **21,114 Marriages**
- **536 Civil Partnerships**

Also:

- **21,484 Marriage Notifications created**
- **715 Civil Partnership Notifications created**
- **6,305 Civil Marriage and Partnership ceremonies took place**

Valuing Our Staff

Thomas Walsh

Superintendant Registrar,
Cork and Kerry
Civil Registration Service,
HSE South

I have been working in the role as Superintendent Registrar for the Civil Registration Service (CRS) in Cork and Kerry since April 2010 but have been working for the health services all my adult life in a number of different roles. The CRS has eight regional areas and is responsible for the registration of all life events in the State. Operated through the HSE, we are also accountable to the Office of the Registrar General under the Department of Social Protection. Working with me in Cork and Kerry, I have 14.7 WTE Registrars and 3 WTE administrative staff, working in nine locations, including Cork University Maternity Hospital.

We provide an important personal service at critical times in a person's life, for example, registering a birth or a death, claiming child benefit, or applying for a passport. We are also responsible for the solemnisation and registration of civil marriages/ civil partnerships and for maintaining the registers of all religious marriages within the State. Since 2007 civil ceremonies can be held in an approved venue outside the registry office, for example in hotels. This has led to significant change and transformation within the CRS to respond to service demands, which can be very challenging at times, in order to meet the statutory obligations to the public. The volume of civil marriages conducted by Registrars now accounts for 30% of all marriages in the State. From the 1st January 2011, activity increased following the enactment of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010 which provides for same-sex couples to enter into a civil partnership. In 2011, 715 couples notified the CRS of their intention to enter a civil partnership and 536 civil partnerships were registered.

I really enjoy the variety of the work. The majority of the time, all the staff are involved directly with the public, sensitively supporting them through what can often be complicated, and sometimes stressful, legal processes. This includes, for example taking notices for civil and church marriage ceremonies or helping them re-register a birth due to changed circumstances, or to obtain certificates they may need for documentary evidence for official, legal, and commercial purposes. An interesting aspect of our work involves coming into contact with people tracing their family history or genealogy. When time and resources allow, we also provide a supervised family research facility in our main office in Cork. This interest is increasing year on year.

In recent times, our staff resources have come under some strain, with some of the smaller peripheral facilities having to either close or provide a reduced service. This has also necessitated us to review and reorganise our existing resources to increase productivity and meet public demand.

Since the introduction of the *Civil Registration Act 2004*, the CRS has undergone a major modernisation programme. For example, the introduction of electronic registration has allowed each office detailed access to the records of all life events in the State. This benefits our clients in that their requests can be dealt with quickly and efficiently, with a significant reduction in the amount of time required to search for and issue certificates and serve notice for marriages and civil partnerships.

Another major project to benefit both the CRS and its service users was the initiation of the Online Certificate Application System, managed out of the CRS Dublin office. It facilitates customers who wish to purchase certificates of life events online at www.certificates.ie Orders for certificates have been received from over 70 countries worldwide to date. An exciting development commenced this year – the National Online Appointments System which is due to go live in 2012. It will provide an alternative means of access to our services. The system will be used by both staff and service users alike to book appointments.

Thomas (left) officiating at the civil wedding of Maggie Goggin and Michael Rice, Cork.

Providing Community (Demand-Led) Schemes

Introduction

The Primary Care Reimbursement Service (PCRS) provides a wide range of primary care services to the general public, through over 6,660 primary care contractors across 12 community health schemes. These services form the infrastructure through which the Irish health system delivers a significant proportion of primary care to the public.

In 2011 PCRS handled over 77.9m transactions, an increase of 2.8m transactions over the previous year. These were services provided to over 3.4m people in their community by doctors, pharmacists, dentists and opticians with an associated expenditure of €2.517bn.

The main tasks undertaken in 2011 were:

- The centralisation of medical card processing as part of the plan to provide a more streamlined, equitable and customer focused application process.
- Supporting the applications and claims in relation to the record numbers of medical cards issued as well as all other schemes.
- Delivering very considerable cost management initiatives of €360m. This was the greatest contribution to the HSE managing within the 2011 vote.
- The collation and publication of a range of primary care scheme statistics and trends to inform our stakeholders.
- Continuing the development of primary care service provision including supporting community pharmacists who participated in the national seasonal **influenza vaccination programme** and the introduction of a new vaccination claiming system for doctors. From a clinical perspective, this development ensured the proposed vaccination service had not already been provided by another health care professional.

In 2011

- **1.694m people were covered by a medical card including discretionary medical cards of 74,281. This represents a net increase of 78,254 people covered since December 2010.**
- **125,657 people were covered by GP Visit Cards including discretionary GP Visit Cards of 16,251. This represents a net increase of 8,234 people covered since December 2010.**
- **18.7m GMS prescriptions were claimed which is a 7% increase on the previous year.**
- **868,134 Long Term Illness claims were processed which is broadly in line with last year's outturn.**
- **3.3m Drug Payment Scheme claims were processed which is a 14% decrease on the previous year.**
- **728,453 treatments were provided under the Community Ophthalmic Services Scheme, a 4.5% increase on the previous year.**
- **1,017,367 treatments were provided under the Dental Treatment Services Scheme which is a 31% reduction when compared to the 2010 outturn.**

Cost Management Initiatives

At the beginning of 2011, PCRS forecast expenditure of €2.877bn being incurred if no actions were taken to reduce expenditure. Expenditure outturn for PCRS was in fact €2.517bn indicating an overall reduction in spend of €360m during the year. A number of cost management initiatives were set out in the National Service Plan 2011 and these initiatives generated specific cost reductions totalling €243m. Other initiatives improved the efficiency and effectiveness of operations and influenced contractor/client behaviour which impacted positively on the resulting demand for services and the financial outturn by year end. This is a significant achievement in the context of a funding reduction applied at the beginning of the year, the challenging economic conditions experienced in 2011, the subsequent increase in Live Register numbers and

the commensurate impact such factors had on demand for schemes such as Medical Cards and GP Visit Cards during the year.

Table 10 provides a breakdown of the savings achieved by initiative during the year which included:

- Changes to pharmaceutical pricing and reimbursement regimes
- Changes to GP fees
- Introduction of a prescription charge which delivered demonstrable cost savings.

Table 10: Breakdown of savings achieved, 2011

YTD December 2011	Savings €m
Full year effect of 2010 schemes	29
Efficiencies and control including probity and fees	51
Full year 2010 savings – Prescription charges	27
Drug price reductions	131
Efficiencies in high tech drugs	4
Total	**243**

Data source: PCRS Statistical Analysis
Note: Information in this table has been rounded

A clinical focus was applied to all **licensed drugs or medicines** reimbursed for appropriateness and those medicinal products that can be described as less suitable for prescribing, were identified. Work is continuing in relation to such prescribing based on need and will be further progressed when the current Irish Pharmaceutical Healthcare Association (IPHA) agreement expires.

A **prescribing feedback** module was developed. Engagement is underway with the Irish College of General Practitioners regarding rollout next year.

Work continued in streamlining **out of hours services** through implementation of the recommendations from the GP Co-Op Review. Out of hours grant payments ceased with effect from 1st January, 2011, and all claim reimbursements are now made through the PCRS. All regions are ensuring that plans are in place to deliver the balance of recommendations from the review.

A **pharmacy probity** work programme became fully operational. Consultation in relation to the development of a dental services inspectorate is ongoing with expressions of interest completed and agreed.

Centralisation of Medical Card Processing

A major change programme centralising the processing of medical cards took effect from 1st July. Centralisation facilitates a more streamlined and faster system of processing medical cards, providing the general public with more options on how they can apply for and get further information on their medical card.

Medical Cards

Did you know…?

New applicants for medical cards can submit completed forms, along with the required documentary evidence, either to their local health office, online at www.medicalcard.ie

or by posting their application directly to the central office at
Client Registration Unit
P.O. Box 11745
Finglas
Dublin 11

The centralisation of medical card processing has enabled PCRS to deliver a number of customer focused efficiencies as follows:

- On-line medical card application and review process available with on-line information, query processing and printable forms.
- SMS acknowledgement and application update service developed.
- Local health offices have online visibility of the national database, in line with appropriate data access protocols, to support their engagement with the general public.
- A local call triage system has been developed.
- A dedicated query response team has been established to address enquiries from public representatives.
- A national emergency process for use in circumstances of terminally ill clients to ensure provision of eligibility within 24 hours of notification.
- Continued systems integration with GPs and Pharmacists to support eligibility confirmation at point of services is progressing.
- Braille medical cards have been developed for visually impaired service users.

Since the 1st July, the Medical Card Office has processed 362,874 medical card forms and has issued 722,455 medical cards. Attempts were made to ensure that all medical cards were processed within 15 days but due to the high volume of applications received, together with the large number of incomplete applications, delays were encountered causing distress to some patients. Revised processes are being put in place to ensure systems are simplified and any potential inconvenience to applicants is minimised. PCRS plan to undertake a review of the centralised process with the assistance of PricewaterhouseCooper (PwC) in January, 2012.

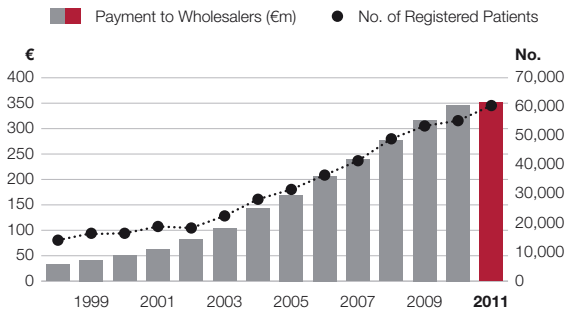
High Tech Medicines

The High Tech Arrangements provide for the supply and dispensing of High Tech Medicines through community pharmacies. Examples of high tech medicines are anti-rejection drugs for transplant patients, chemotherapy and growth hormones. Medicines are purchased by the HSE and supplied through community pharmacies for which pharmacies are paid a patient care fee by the PCRS each month.

Two changes in the high tech arrangements were introduced during 2011. The wholesaler margin in relation to high tech medicines was aligned with other medicinal products supplied by community pharmacists and set in Regulations by the Minister for Health. Suppliers of high tech medicines commenced electronic invoicing in March, which, it is anticipated, will facilitate further efficiencies in stock management for 2012.

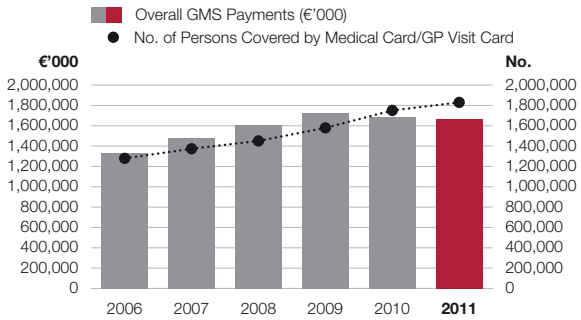
A Drugs Group was established in late 2011 to consider how new medicines can be introduced into clinical care pathways as and when resources become available in 2012. Some of these medicines involved complex clinical pathway changes and work is underway to ensure that all appropriate arrangements and controls are in place to support optimal use and that best value is achieved.

Figure 15: High Tech – Payments to Wholesalers (€m) and No. of Registered Patients 1998-2011



Data source: PCRS Statistical Analysis

Figure 16: Overall GMS Payments (€'000) and No. of Persons covered by Medical Card/GP Visit Card (including discretionary cards) 2006-2011



Data source: PCRS Statistical Analysis

Medical and GP Visit Cards

At the end 2011:

- The total number of persons eligible for medical cards (including discretionary medical cards) was 1.694m, representing almost 37% of the total population. This is a 46% increase over 2005 and is the highest number of people ever recorded in receipt of a medical card. There has been a net increase of 78,254 people covered by a medical card since December 2010.
- The total number of GP Visit Cards reached 125,657, representing approximately 2.7% of the population.

Summary of payments

- PCRS made payments totalling €2.517bn in 2011.
- Claim data was processed and payments were made by the PCRS under the following primary care schemes:
  - General Medical Services (GMS) including Medical Cards and GP Visit Cards
  - Drugs Payment Scheme (DPS)
  - Long Term Illness Scheme (LTI)
  - Dental Treatment Services Scheme (DTSS)
  - European Economic Area (EEA)
  - High Tech Drugs (HTD)
  - Primary Childhood Immunisation
  - Health (Amendment) Act 1996 (HAA)
  - Methadone Treatment Services Scheme (MTSS)
  - Community Ophthalmic Services Scheme (COSS)
  - Discretionary Hardship Arrangements
  - Immunisations for certain GMS Eligible Persons
- At year end there were 3.8m people registered as being eligible to benefit under the GMS, DPS and LTI schemes.
- PCRS handled 77.9m transactions, an increase of 2.8m transactions over the previous year.

Maximising Hospital Services

Introduction

In 2011 a range of services including assessment, diagnosis, treatment and acute rehabilitation were provided throughout our 49 acute hospitals. Hospitals are providing more services each year as a result of increased demand resulting from demographic changes and clinical advancements. A more diverse population base, and an older population is driving increased activity levels and higher patient acuity in hospitals.

A significant focus in 2011 was the introduction of care programmes to ensure best quality outcomes for patients and best value for money for health services.

Activity Levels

- Over 1.392m people received inpatient or day case treatment in 2011, a 5% increase over that provided in 2010.
- There was a stabilisation in the number of people treated as inpatients, with treatment being provided to 588,623 patients similar to that provided in 2010.
- Our ongoing policy of moving from inpatient to day case treatment where possible ('stay to day') has meant that over 69,000 more patients were treated on a day care basis in 2011 than in the previous year with day case treatment being provided to 804,274 people. This is 6.5% over the 2011 target and 9% over levels provided in 2010.
- Day of surgery admission rates were 49%, similar to 2010 but considerably lower than our target of 75%.
- The percentage of day case surgeries improved across all regions from 70% nationally in 2010 to 73% in 2011, moving closer to our target of 75%.
- There were 73,092 babies born in our hospitals during the year, of which 27% were delivered by caesarean, a slight increase against the 26% delivered by caesarean in 2010.

In 2011

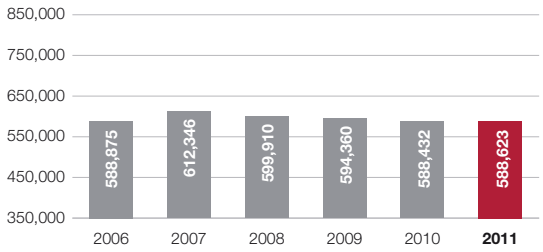
- **Almost 1.4m people received planned inpatient or day case treatment.**
- **Over 1.1m people received emergency care services in our hospitals.**
- **Over 3.5m bed days were used with an average length of stay of 6 days.**
- **49% of all planned elective inpatient procedures were conducted on day of admission.**
- **78% of all inpatient stays and 84% of all day case treatments were public patients.**
- **69% of hospital activity related to emergency care services.**
- **11,688 adults were waiting over 6 months for planned inpatient or day case treatment at the end of December, compared to 7,402 at end 2010.**
- **2,513 children were waiting over 3 months for planned inpatient or day case treatment, compared to 2,618 at the end of 2010.**
- **95% of hospitals achieved the end of year SDU target, introduced in August, whereby no patient should wait more than 12 months for treatment. This is a 66% decrease on the numbers waiting longer than 12 months at the end of 2010.**
- **73,092 babies were born, 27% of which were delivered by caesarean.**

Table 11: Hospital Activity 2006 to 2011

	2006	2007	2008	2009	2010	2011	No. (%) change 2006-2011	% change 2010-2011
Inpatient discharges	588,875	612,346	599,910	594,360	588,432	588,623	-252 (0%)	0%
Day case	558,813	583,369	641,974	675,162	734,967	804,274	+245,461 (+44%)	+9%
ED presentations	1,116,784	1,191,347	1,206,929	1,181,230	1,180,897	1,168,253	+51,469 (+5%)	-1%
Births	62,740	69,998	74,000	74,617	74,437	73,092	+10,352 (+16%)	-2%

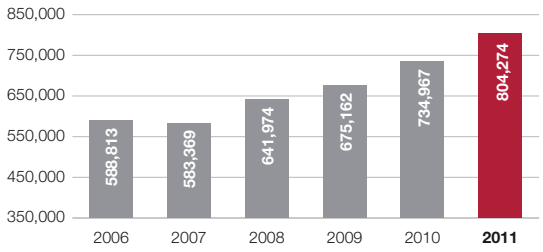
Data source: HSE Performance Reports

Figure 17: Inpatient Discharges 2006-2011



Data source: HSE Performance Reports

Figure 18: Day Case Activity 2006-2011



Data source: HSE Performance Reports

The **Outpatient Data Quality Programme** was introduced in hospitals in January. The objective of this programme is to establish the numbers referred to, and waiting for, outpatient appointments in our hospitals. Significant changes were required in hospitals, especially on IT and business processes, to enable reporting on this data. It is expected that by mid 2012 all hospitals will be reporting on this new dataset. Preliminary data based on sixteen hospitals is available in respect of the last quarter of 2011 and provides a snapshot of what will be available for all hospitals next year. This indicates that a total of 102,806 referrals were received in that period. Just over half or 53,156 were directed toward five specialties.

A total of 478,848 outpatient attendances took place during the quarter in 40 hospitals, of which 134,270 were new attendances while 344,578 return attendances took place. Patients who do not attend appointments (DNA) continue to present challenges. During quarter four, there were 90,509 DNAs which represented nearly 16% of all attendances.

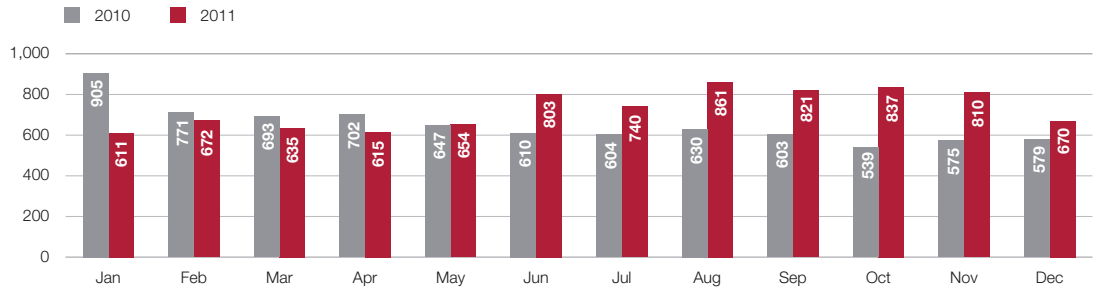
Table 12: Outpatient Referrals. Preliminary data (based on 16 Hospitals) – Q4, 2011

Specialty	No. of referrals	% of total referrals
General Surgery	19,428	18.9%
Orthopaedics	12,244	12.0%
ENT	8,147	8.0%
Ophthalmology	6,772	6.6%
Dermatology	6,565	6.4%

Data source: Outpatient Data Quality Programme

Improving Access

Figure 19: Delayed Discharges at last week of each month 2010 v 2011

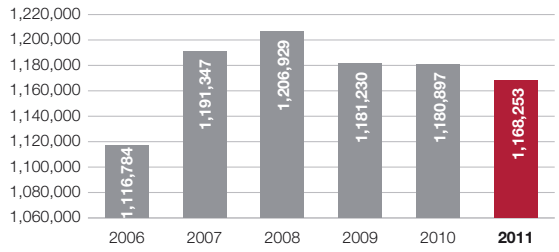


Data source: HSE Performance Reports

Waiting Times

- Managing delayed discharges remains a challenge for us and while these reduced considerably in the first few months of 2011 against levels in 2010 (at no point were numbers as high as those recorded in January 2010) they deteriorated considerably from June onwards and were particularly an issue during the winter months. Hospital Winter Capacity Plans were put in place. This intensive focus on the numbers of patients waiting led to improved performance in December and this targeted approach will continue in 2012.
- Over 1.1m people presented to hospitals as emergency presentations during 2011 of which 1.09m presented to our 32 Emergency Departments (EDs).

Figure 20: Emergency Presentations 2006-2011



Data source: HSE Performance Reports

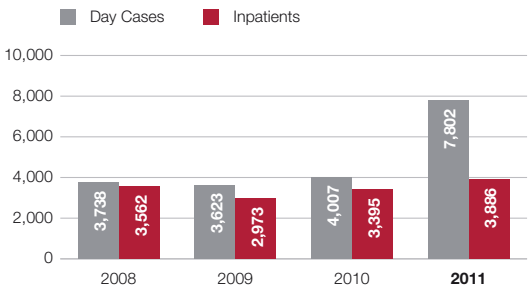
- There were 372,462 emergency admissions, almost 3,000 more than in the previous year.
- The target in 2011 was to ensure that patients did not wait longer than six hours from registration to discharge from EDs. By end of December over 46% of people attending EDs completed their visit within the six hour target time. A system is being implemented to record patients' total experience time in EDs. Information collated by end 2011 in respect of 23 hospitals indicated that 67% of patients admitted to, or discharged from, hospital spent less than six hours in ED from their time of arrival to their departure.

Waiting Lists

Demand for elective procedures increased as the number of people listed for procedures grew on average by 22% from June to December 2011 compared to the previous year. This led to an increase in the numbers waiting more than six months. At the end of December:

- 9,786 **adults** were waiting less than six months for planned inpatient treatment which was almost 72% of the overall numbers waiting. About 28% or approximately 3,886 of adults were waiting more than six months which was a 14% increase on the numbers waiting more than six months in the previous year.

Figure 21: Adults waiting more than 6 months 2008-2011



Data source: HSE Performance Reports

Table 13: Adult and Children Waiting Lists

Adults waiting more than six months

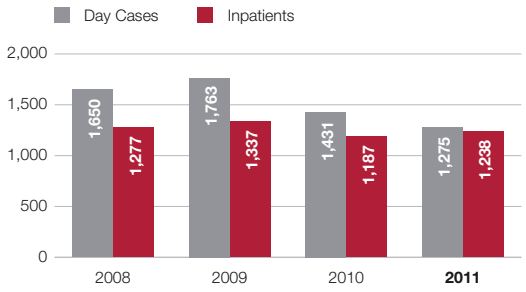
	2008	2009	2010	2011	% Var 2008 v 2011	% Var 2010 v 2011
Day Case	3,738	3,623	4,007	7,802	+109%	+95%
Elective Inpatient	3,562	2,973	3,395	3,886	+9%	+14%

Children waiting more than three months

	2008	2009	2010	2011	% Var 2008 v 2011	% Var 2010 v 2011
Day Case	1,650	1,763	1,431	1,275	-23%	-11%
Elective Inpatient	1,277	1,337	1,187	1,238	-3%	+4%

- 33,752 adults were waiting less than six months for planned day case treatment, which was almost 82% of the overall numbers waiting. About 18% or approximately 7,802 of adults were waiting more than six months. This was a 95% increase on the numbers waiting more than six months in the previous year.
- Overall there were 11,688 adults waiting more than six months for planned inpatient and day case treatment at the end of 2011. This was an additional 4,286 adults or a 57% increase on the previous year.

Figure 22: Children waiting more than 3 months 2008-2011



Data source: HSE Performance Reports

- 843 **children** were waiting less than three months for planned inpatient treatment which was over 40% of the overall numbers waiting. About 60% or approximately 1,238 children were waiting over three months. This was a 4% increase on the numbers waiting more than three months in the previous year.
- 1,250 children were waiting less than three months for planned day case treatment, which was almost 50% of the overall numbers waiting. About 50% or approximately 1,275 children were waiting over three months. This was an 11% decrease on the numbers waiting over three months in the previous year.
- Overall there were 2,513 children waiting more than three months for planned inpatient or day case treatment at the end of 2011. This was 105 less children or a 4% decrease on the previous year.
- The DoH established a Special Delivery Unit (SDU) in 2011 to develop new approaches to deliver performance improvement on inpatient and day surgery waiting lists. The SDU introduced an end of year target in 2011 that no patient should wait more than 12 months for treatment. This target was achieved by 95% or 39 hospitals with 372 people waiting over 12 months at 31st December. This was a 66% decrease on the numbers waiting at the end of the previous year or 711 less people.

Valuing Our Staff

Rosie Quinn

Musculoskeletal Clinical Specialist Physiotherapist Emergency Department, Our Lady of Lourdes Hospital, Drogheda

I work as a Musculoskeletal Clinical Specialist Physiotherapist in Our Lady of Lourdes Hospital in Drogheda. Since 2005, I have been based in the Emergency Department (ED) which is a relatively new area for physiotherapists to work from. My primary function is the assessment, management, triage and onward referral of soft tissue injuries presenting to a Consultant Led Soft Tissue Injury Clinic.

Our ED is one of the busiest in the country with nearly 54,000 attendances in 2011, an 8% increase on the previous year. We are always looking for new and innovative ways of dealing with the increasing numbers of patients presenting to the ED which leads to unacceptable waiting times for patients and frustration for the ED staff.

I was aware of the potential contribution of physiotherapy in an ED environment to improving patient pathways for mobility patients. With the support of the ED team, my manager and physiotherapy colleagues, a pilot physiotherapy mobility project was introduced. An audit of this pilot project showed a 70-80% discharge rate of patients referred for mobility assessment. This was greatly enhanced by the support from the public health liaison nurse based in ED and the introduction of a community response team (CRT). The development of the CRT has been pivotal as they guarantee to see patients within 24 hours of discharge, which is an excellent support. As a result of this project, a further physiotherapy post has been allocated to the ED allowing us to offer extended hours of cover and to further develop our ED physiotherapy service. We now offer assessment and treatment of soft tissue injuries during and outside clinic time, and also assessment of respiratory conditions. We continue to develop patient pathways and act as an educational resource to other staff.

One of the frustrating aspects of my role is that despite a new ED there is frequently not enough appropriate physical space to see patients, which further contributes to patient waiting times. However, I believe due to the diversity, flexibility and expanding roles of the physiotherapy professions, we can significantly improve patient satisfaction, facilitate discharge, reduce overcrowding and re-attendances for soft tissue injuries. We are continuing to audit and re-evaluate our ED physiotherapy assessment and treatment service.

The aim of the ED team is to improve patient access, offer equity of service and provide value for money, which ultimately improves patient satisfaction and patient outcomes. On the positive side, I am working with a strong, resilient, highly motivated multi-disciplinary team, with strong governance, which supports my role within the team. One of the most significant challenges we face is reducing overcrowding and ensuring the patient pathway is not hampered by the unavailability of a specific team member or resource. As acting therapy lead in the Emergency Medicine Programme, I see the expansion of therapy services in ED as an integral part of optimising patient care and contributing to the reduction of waiting times.

Nurse of the Year 2011

Clara Murtagh, Nurse of the Year 2011.

In November, Clara Murtagh of Children's University Hospital, Temple Street, Dublin, was recognised as Nurse of the Year at an award ceremony in Dublin. Clara, from Oranmore, Co Galway, was honoured for her empathy, compassion, commitment, insight, flexibility, innovation and willingness to deliver the highest standard of patient care, which were recognised as key components in the delivery of a holistic family centred approach at the hospital.

A number of initiatives took place during 2011. Other developments can be found in the regional sections of this report.

- **An endoscopy department at Connolly Hospital, Blanchardstown** was officially opened. This is one of the largest endoscopy facilities in Ireland. The department receives over 100 referral letters every week. In addition to providing rapid access endoscopy referral for patients presenting to the ED, the department operates a centralised endoscopy waiting list to manage urgent referrals within 28 days and the majority of all non-urgent referrals within three months of referral.
- A new **Medical Assessment Unit opened in Our Lady of Lourdes Hospital, Drogheda**. The unit allows for the rapid assessment and referral of acute medical patients and for prompt access to diagnostics and reviews. It also reduces pressure on the ED and helps to decrease patient wait times, while reducing the number of inappropriate admissions to inpatient beds.
- The **Midland Regional Hospital** in Tullamore was officially opened in March. Built at a cost of €150m the new hospital has 247 beds currently in operation spread across the specialties including a 21 bed day hospital. It is the regional centre for orthopaedics and ENT and also provides specialised services such as oncology/haematology, coronary care and renal dialysis. It has four operating theatres along with two day theatres, an endoscopy unit and a minor procedures room.
- A new **Paediatric Assessment Unit opened at Cavan General Hospital** in July providing a child-friendly environment where all acutely ill children up to 15 years can be treated for urgent illnesses.
- A new **Children's Intensive Care Unit in Our Lady's Children's Hospital, Crumlin** was officially opened in March at a cost of €9.8m to provide care for critically ill children and adolescents. It has more than doubled each bed area size providing better patient care and infection control and matches the best available care internationally.
- The **Cardiology Department in University Hospital Galway** became the first department in Ireland to use ground-breaking cardiology technology, which collects images from the inside of the coronary arteries in order to detect vulnerable fat-rich blockages.
- An **Acute Medical Unit at Cork University Hospital** was officially opened in January. The new €1.4m 23 bed unit is part of the HSE national Acute Medicine Programme and is open 24 hours a day, seven days a week, providing for acute treatment and/or observation and investigation of patients, where the estimated length of stay is less than 48 hours.
- A **new CT scanner** was officially opened and €20m funding announced to proceed with the development of a new ED, concourse and theatre/delivery suite at the hospital at **Wexford General Hospital**.
- Cork University Maternity Hospital was designated the first **European Robotic Gynaecological Epicentre** becoming the only hospital in Europe to perform both cancer and non-cancer procedures using sophisticated robotics with the da Vinci Surgical System.
- A new **Haemophilia Centre at Cork University Hospital** was officially opened in July. Prior to the opening of the centre, people would either have to be treated in the ED or admitted as an inpatient.

Catholic Archbishop of Dublin, Diarmuid Martin, accompanies the then President Mary McAleese at the official opening of Our Lady's Children's Hospital, Crumlin Cystic Fibrosis inpatient facility.

Cystic Fibrosis (CF)

A **CF Inpatient Unit** was opened by then President Mary McAleese at Our Lady's Children's Hospital, Crumlin in October. The new facility provides four single isolation rooms with en suite facilities, a parent's lounge, and a pull-down bed and TV and entertainment system in each room. Internationally, the standard of care is that inpatients with CF are cared for in isolation and the new rooms that have been added to St. Michael's Ward are specialised isolation rooms that enable the hospital to reduce the spread of harmful bacteria between patients. The total cost of the project was €1.4m all of which was raised through donor support and corporate partnerships.

Construction of a **new ward block at St. Vincent's University Hospital** in Dublin was progressed. The new development will replace existing bed capacity and a specialist unit will provide 100 single en suite rooms to accommodate cystic fibrosis, liver disease, oncology and other specialties. It will also provide ancillary support accommodation, including a 10-bedded day unit for patients with CF. The development will make a major contribution to improving patient care.

Since July, the National Newborn Bloodspot Screening Programme, or 'heel prick' test, which screens all newborn babies for a range of rare inherited conditions, includes a test for CF. The screening test is done within the first five days of birth, usually at home by the Public Health Nurse (PHN).

Ireland has a high incidence of CF compared to other EU countries and early identification and care is of great benefit to children. Screening for CF along with the existing five conditions aids early detection and helps babies to begin treatment as soon as possible.

In 2011

Calls responded to by a first responder in less than 8 minutes:

- **1,349 calls or 52% of Clinical Status 1 – ECHO calls**
- **20,162 calls or 28% of Clinical Status 1 – DELTA calls**

Calls responded to in less than 19 minutes by a patient-carrying vehicle:

- **1,790 calls or 69% of Clinical Status 1 – ECHO calls**
- **48,306 calls or 67% of Clinical Status 1 – DELTA calls**

Note: ECHO – calls reporting an immediate life-threatening cardiac arrest or respiratory arrest

DELTA – calls reporting an immediate life-threatening illness or injury

Pre-Hospital Emergency Care

The National Ambulance Service (NAS) provides pre-hospital emergency care services and ambulance services throughout the country. Innovations in ambulance service provision, such as the introduction of the advanced paramedic training programme and a system of up-skilling for the 1,200 paramedics, have produced significant improvements in the quality and safety of patient care. A clear vision for the future of NAS will ensure it continues to progress towards the provision of clinically appropriate call handling, alternative referral pathways, emergency life saving advice, and safe and effective mobile healthcare with a future focus on treating more patients in the community rather than transporting patients to an ED.

Progress was made in the following areas during the year:

- A contract was signed for the construction of a **new Ambulance Station** adjacent to the Community Hospital of the Assumption in Thurles, Co. Tipperary. The new base will accommodate up to six ambulances and provide a modern working environment for staff serving the needs of clients in the catchment area.
- 50 new defibrillators with capacity for 12 Lead ECG and other diagnostic functions were purchased. This new equipment will enable paramedics and advanced paramedics to deliver the pre-hospital emergency care elements of the **Acute Coronary Syndrome (ACS) Programme**. Preparatory work included the development and accreditation of a programme of education to enable paramedics and advanced paramedics to identify patients in the community setting which will improve the quality and safety of care given to patients suffering from ACS.
- In addition, a **new fleet** of 16 state-of-the-art Rapid Response Vehicles were purchased at an investment of approximately €600,000 in fleet replacement. Three new purpose built driver training vehicles were also purchased to support the national rollout of driver training, initially for 180 new student paramedics.

- Work continued with staff and stakeholders towards achieving the **new HIQA standards** which amongst other targets, require a response rate of 75% of immediately life threatening calls within eight minutes. A Performance Improvement Action Plan is being implemented to work towards improvements against these targets.
- The reconfiguration of **ambulance command and control centres** is being progressed under the Public Service Agreement. Moving from eight regional centres to two national centres, one live and one back-up centre, will ensure that a nationally configured service can be provided which is not restricted by county or regional boundaries. This means that the nearest available resource with the most appropriately skilled paramedic or advanced paramedic will be dispatched based on the patient's clinical need.
- A National Aero-Medical Co-ordination group completed the preparatory work required to facilitate the establishment of a **National Aero-Medical Co-ordination Centre**.

Emergency Exercise

A major emergency exercise for trainee paramedics was held at the Ballinasloe Showgrounds in June. The exercise, which is required training for trainee paramedics, included off-duty paramedics, advanced paramedics, emergency medical controllers, ambulance officers along with the Galway County Council Fire Service, Gardaí and the Irish Coast Guard. In total, 48 members of the emergency services and 34 volunteers took part in the response, which dealt with a mass casualty situation.

Neil Johnson, CEO Croi; Marcella Gemmell, Paramedic, NAS; Vincent O'Connor, Training and Development Officer, NAS with Lucas Grigaluinas and his mother, Sarune.

Brightening the Day

Croí launched a novel initiative in partnership with the National Ambulance Service to help reduce the fear and anxiety of young children who have to travel to, and between, hospitals by ambulance.

The scheme aims to help ambulance personnel and medical staff reassure and comfort anxious or distressed children by presenting them with a 'Certificate of Bravery' and a fun sticker!

Valuing Our Staff

Ana O'Reilly-Marshall

Senior Neonatal/
Paediatric Dietician
Nutrition and Dietetic Dept,
Galway University Hospitals

My role as a neonatal dietitian and nutrition specialist in Galway University Hospitals (GUH) involves helping premature infants, the hospital's smallest and most vulnerable patients, to survive, thrive and achieve optimal nutrition and neuro-developmental outcome.

Although these babies are the smallest patients, they have the biggest nutritional needs. Feeding babies in the Neonatal Intensive Care Unit (NICU) is a daily challenge. Increasing survival of extremely low birth weight infants weighing less than 1kg (one bag of sugar) at birth, presents us with a nutritional emergency. If the baby's digestive system is too under-developed to handle normal feeds we use parenteral solutions, which is a way of feeding through the veins.

An important development in 2011 was the introduction of a 'Starter' parenteral nutrition solution containing protein, glucose, and lipid which is given to very low birth weight babies immediately after birth instead of just glucose which was used previously. This early nutrition helps prevent excessive weight loss and maintains the fragile baby's nutritional status leading to a decreased length and cost of hospital stay. I actively encourage and support all mothers to provide breast milk for their infants as this is considered the gold standard of nutrition. As the baby is unable to suck initially, feeding tubes are used to deliver breast milk or preterm formula directly to the infant's stomach.

Close monitoring and ongoing assessment of the infant's growth, intake, output and blood electrolyte levels is essential to minimise complications and support optimal growth during the weeks and months on the Unit. Once discharged, babies are followed up in multidisciplinary neonatal outpatient clinics for up to two years.

The great appreciation shown by parents on leaving the unit with their babies gives great pride and satisfaction to all members of our team. There is nothing more rewarding than watching a premature infant grow and thrive and to know you played a part in it.

The most challenging part of my work is dealing with understaffing due to the moratorium on recruitment and the non-replacement of staff on maternity or sick leave.

At one point the Nutrition and Dietetic Department had a reduction of 3.0 WTE (25%). The arrival of a second neonatologist and the increase in NICU cots has increased the need for neonatal dietetic support. We have managed our increased caseload through good teamwork and by prioritising services.

Another challenge was the relocation of the NICU while the original unit was upgraded. This caused some upheaval which was thankfully forgotten once we moved back to the newly refurbished unit at the end of the year. We now have state of the art facilities with 17 cots to treat babies from Galway and those referred to us for specialist treatment from other hospitals in the West.

As one of just three neonatal dietitians in Ireland I have an important educational role. In collaboration with the other two dietitians we are developing comprehensive evidence-based Neonatal Nutrition Guidelines. These guidelines will ensure all Neonatal Units in Ireland have access to up to date information on neonatal nutrition and will help to standardise and optimise care for all premature infants, especially those who do not have access to a neonatal dietitian.

My wish for the future is for a fully resourced multidisciplinary neonatal team, an improved career structure to encourage retention of highly experienced allied health professionals and for more investment in dietetic staffing for maternal and child health. My personal aspirations are to use my skills to contribute to the evidence based knowledge for neonatal nutrition by participating in research.

Driving National Clinical Programmes

Introduction

National clinical programmes of care provide a national, strategic and co-ordinated approach to a wide range of clinical services. The primary aim of these is to modernise the manner in which hospital services are provided across a wide range of clinical areas. This is done through standardisation of access to, and delivery of, high quality, safe and efficient hospital services, maximising linkages to primary care and other community services.

With the assistance of the colleges and professional representative bodies, multidisciplinary teams have been developed around key clinical services and patient conditions. Reference groups for patients, nurses, allied health professionals, GPs and doctors were established so that as many people as possible could be engaged in the development of programme solutions.

A range of programmes have completed their design phase, received sign-off of their solutions and are now being implemented. Some examples of these include:

CLINICAL PROGRAMMES BEING IMPLEMENTED

- Acute Coronary Syndrome
- Acute Medicine
- Asthma
- Audiology
- Blood Transfusion
- Care of the Elderly
- COPD
- Critical Care
- Dermatology
- Diabetes
- Elective Surgery
- Emergency Medicine
- Epilepsy
- Heart Failure
- Medicine Management and Pharmacotherapeutic Interventions
- Mental Health
- Neurology
- Obstetrics and Gynaecology
- Outpatient Parenteral Antimicrobial Therapy/ IV Therapy Programme
- Orthopaedics
- Palliative Care
- Prevention of Healthcare Associated Infection and Antimicrobial Resistance
- Primary Care
- Radiology
- Rehabilitation Medicine
- Renal
- Rheumatology
- Stroke

In addition, specific progress was achieved in:

STROKE **Objective: Each day save a life from stroke through opening of stroke units, standardising existing units and having 24/7 access to stroke thrombolysis nationally.**

In 2011 stroke units were opened in:

- Midland Regional Hospital, Mullingar
- St. Vincent's University Hospital, Dublin
- Cavan General Hospital
- Mercy University Hospital, Cork
- Wexford General Hospital
- Roscommon County Hospital
- A stroke ward was opened in Our Lady of Lourdes Hospital, Drogheda
- An interim stroke unit opened in the Mid-Western Regional Hospital, Limerick
- A stroke unit is due to open in Cork University Hospital (CUH) early 2012.

HEART FAILURE	**Objective: Every patient with heart failure is managed within a structured programme through availability of heart failure units and the development of a primary care diagnostic model.**

- Heart failure units are now active in seven sites

DIABETES	**Objective: 40% reduction in annual incidents of new blindness due to diabetic retinopathy and 40% reduction in the number of lower limb amputations due to discharges – by year five.**

- National diabetic retinopathy screening service scheduled to be available nationwide to patients with diabetes in 2012.
- Implementation plans in place in 14 sites. Awaiting the appointment of the approved podiatrists next year to enable roll out of the national foot care programme.

COPD	**Objective: Save 50 deaths a year from COPD by establishment of COPD outreach centres**

- Site implementation plans have been approved with recruitment process underway to fill posts. Structured programmes are operational in 12 sites.

EPILEPSY	**Objective: Reduction in number of deaths from epilepsy by one third and rendering of 1,000 patients seizure free by establishing new regional epilepsy centres and rolling out of population-based ambulatory nursing services.**

- Six regional centres and resource requirements identified with recruitment process in place.

ELECTIVE SURGERY	**Objective: Reduce waiting time for elective surgery by implementing national targets for average length of stay and day case rates. Also roll out of productive theatre series and surgical audit.**

- Targets agreed with surgical specialties with a model of care circulated to all hospitals for implementation in 2012. Planning for establishment of a National Office of Clinical Audit well progressed with support from the RCSI. Irish Audit of Surgical Mortality IT portal design underway.

EMERGENCY MEDICINE	**Objective: Improve the safety and quality of care in EDs and reduce waiting times for patients through implementation of a standardised model of care.**

- 17 hospitals are now reporting full patient experience time (PET) with a further five hospitals moving towards it. A joint initiative commenced, between the DoH Special Delivery Unit and the HSE Business Intelligence Unit, ensuring that a systematic and standardised approach is taken to collection of this data.

ACUTE MEDICINE	**Objective: Timely assessment of patients by appropriate senior clinician to enable early discharge and reduce average length of stay through implementation of standardised acute medicine model and pathway.**

- Acute medicine programme implemented in 12 sites with 70,000 acute medical day savings since implementation.

PRIMARY CARE	**Objective: Integrate chronic disease management to reduce hospital admission through piloting of structured chronic disease management programme by GPs.**

- The national diabetes programme/national primary care programme developed a model of care which will be rolled out in 2012. This will form the methodology for other chronic illnesses.

RENAL SERVICES	**Objective: Maintain/increase the number of renal transplants performed by the National Renal Transplant Programme and implement the home haemodialysis programme nationally.**

- 192 national renal kidney transplants undertaken including eight simultaneous kidney and pancreas transplants.
- 27 were transplants from living donors, which is the highest number of transplants ever performed in Ireland in any year.
- 53% of Irish patients with end stage kidney failure now have a functioning renal transplant, and that number now exceeds 2,000.
- National home haemodialysis programme was established. 24 patients are now availing of this service with a target of 80 patients. Beaumont Hospital, Dublin, Waterford Regional Hospital and CUH are now training centres for this programme.
- Haemodialysis equipment in 10 of the 15 adult renal units has been completely replaced.

Renal Services

Did you know…?

- Chronic Kidney Disease (CKD) increases the risk of early cardiovascular (CV) disease, the commonest cause of illness and death worldwide.
- CKD increases the risk of CV in those with diabetes and high blood pressures.
- It also increases the risk even in the absence of these or other known risk factors.
- This is especially true in older adults but even in those with an average age of 45 years, the presence of CKD doubles the risk of heart attack, stroke and death from all causes.
- CKD is not rare – some 10% of adults worldwide (over 500m) have some degree of CKD – most of these are unaware of this fact. Worldwide, 12m people die prematurely every year of CV disease associated with CKD.
- Most people with early CKD are undetected but simple screening tests easily detect it. These include:
  - A routine urine test for the presence of blood or protein
  - A routine blood test to measure the level of creatinine (a substance excreted by the kidneys)
  - Measurement of blood pressure.
- Early detection is very important in high-risk groups – those with high blood pressures, diabetes, other CV disease or with a family history of CKD.

While some patients develop advanced CKD and require long-term dialysis treatment or a kidney transplant, they are only a tiny minority of all those with CKD. Worldwide, more than 1.5m people are being treated by dialysis or with a functioning transplant. In Ireland there are over 2,000 people with a functioning kidney transplant and over 1,750 people treated by long-term dialysis.

The National Renal Office endorsed the international education programme of World Kidney Day

The Programme emphasises the following 7 ‘Golden Rules’

- Kept fit and active
- Keep regular control of your blood sugar level
- Monitor your blood pressure
- Eat healthy and keep your weight in check
- Do not smoke
- Do not take over-the-counter pills on a regular basis, and
- Check your kidney function if you have one or more of the ‘high risk’ factors.

Valuing Our Staff

Mary Maxwell

Clinical Nurse Manager,
Orthopaedics
Midland Regional Hospital,
Tullamore

I have been working as a nurse for the past 30 years both here and abroad and am currently a Clinical Nurse Manager specialising in orthopaedics in the Midland Regional Hospital in Tullamore.

One of the most important parts of my job is ensuring that patients are treated with dignity and respect. Good communication is an essential part of this. Having an open, honest and consultative approach in dealing with patients and their loved ones helps everyone to achieve the best possible outcomes for all involved. It is paramount that patients are satisfied with the care they receive and that it is provided to the highest standard possible.

A team initiative which I am very proud of is the development of a Rapid Recovery Programme for elective joint replacements. We researched a similar approach used in Wrexham General Hospital in the UK which was a ground breaking initiative in the orthopaedic field.

What we learned is that we already had the basis of this programme in operation here at the hospital but not in a formal setting. It works on the principle of educating the patient on what the whole hospital experience will be like from the day of being admitted, to surgery, after care etc.

The patient feels they are in control of what is happening from speaking with the consultant, anaesthetist, nurses, physiotherapist and occupational therapist. It is early days yet but we feel it is having a very positive outcome.

A strong multidisciplinary team based approach is one which I also advocate in my work involving everyone from the consultant, to nurses, physiotherapists, occupational therapist, catering and cleaning staff.

Orthopaedics is a very busy specialty and our service provides specialist treatment and care to the Laois, Offaly, Longford and Westmeath areas. As part of prioritisng the reduction in waiting lists, and driven also by the Special Delivery Unit, 15 beds were ring-fenced in 2011 specifically for elective surgery. Consultants and other members of staff were involved in driving this initiative forward which has seen a huge improvement in services for patients awaiting elective orthopaedic surgery. It has also given staff great motivation and promoted greater teamwork.

In addition to managing increasing workloads through this initiative in reducing waiting lists, we have also maintained and managed successfully the high volume of patients in our trauma unit.

However, what is frustrating to see is the reduced availability of rehabilitation and respite services which are essential to enable patients leave hospital after emergency surgery. This is having a negative impact on the hospital's delayed discharges.

Enhancing Cancer Services

Introduction

The National Cancer Control Programme (NCCP) continued its work in 2011 to improve cancer prevention and detection, and to increase survival rates for the people of Ireland. Services in the eight designated cancer centres for individual tumour types were further enhanced, ensuring that adequate case volumes were delivered and that professional expertise and multidisciplinary specialist skills continued to be developed. Increasingly the focus of our work is the development of national policies, treatment guidelines and quality assurance programmes to ensure optimal care and outcomes for people with cancer.

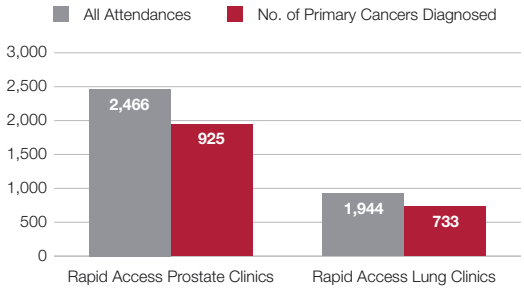
In implementing the objectives of the programme during the year, progress was made in the following areas:

- With the opening of **Rapid Access Lung Clinics** in the Mid-Western Regional Hospital, Limerick and University Hospital Galway, all eight cancer centres now provide this service. Lung cancer surgery is carried out in four designated centres: St. James's Hospital, Mater Misericordiae University Hospital, Cork University Hospital (CUH) and University Hospital Galway.
- The new **Rapid Access Prostate Clinics** became fully operational in the Mid-Western Regional Hospital, Limerick and in Waterford Regional Hospital. Services in CUH commenced at the end of the year, and will become fully operational in early 2012. It was agreed to maintain prostate cancer surgery in six centres: Cork, Galway, Beaumont, Mater Misericordiae University, St. James's and St. Vincent's University Hospitals. Discussions continued on the reconfiguration of urology cancer surgery services in HSE DML and HSE South.
- A national centre for **pancreatic surgery** was established in St. Vincent's University Hospital with a satellite unit in CUH (operational early 2012). A national oversight committee and care pathways were established. Work will continue in 2012 on a national multidisciplinary team (MDT).

In 2011

- **In total, 42,000 referrals were made to the NCCP breast, prostate and lung clinics.**
- **Electronic GP referrals for breast, lung and prostate doubled from 2,070 in 2010 to 4,305 in 2011. 10% of all breast referrals are now sent electronically.**
- **37,350 women attended symptomatic breast services.**
- **Of these, 99% of referrals deemed urgent were seen within 2 weeks and 97% of non urgent referrals within 12 weeks.**
- **CervicalCheck has over 4,600 registered smeartakers (GPs, practice nurses, and other medical practitioners) in approximately 1,350 locations.**
- **Over 7,000 people completed radiotherapy treatment.**

Figure 23: Attendances at Prostate and Lung Rapid Access Clinics 2011



Data source: National Cancer Control Programme

Graduates of the first programme with Dr. Susan O'Reilly, National Director of the Cancer Control Programme.

Community Oncology Nurse Education Programme

In March, Public Health Nurses in Donegal became the first graduates of a new Community Oncology Nurse Education Programme. They are the first nurses nationally to deliver a specific range of cancer services to patients in their own homes. The programme will ensure best practice in caring for cancer patients in the community and strengthens the linkages between primary and hospital services.

- The move towards the transfer of all **rectal cancer surgery** into eight cancer centres continued. Rectal cancer surgery was successfully transferred from Cavan General Hospital, Connolly Hospital, Blanchardstown and Our Lady of Lourdes Hospital, Drogheda into Beaumont Hospital and the Mater Misericordiae University Hospital. Delays were experienced in HSE West due to theatre capacity and moratorium issues.
- The process commenced to appoint **Consultant Dermatologists** in Limerick and Waterford.
- Nineteen out of 28 additional theatre and ICU nursing staff were appointed to support **cancer surgical services** in the designated centres. Difficulties were experienced in filling the remaining posts in HSE west, due to moratorium issues.
- Additional **Consultant Medical Oncologists** were appointed to the Mid-Western Regional Hospital, Limerick and to Letterkenny General Hospital.
- Work commenced on developing a national co-ordination and oversight mechanism for **cancer drug expenditure**.
- **BreastCheck** completed its first round of screening in the HSE West and HSE South. **CervicalCheck** completed its first three-year round of screening in August 2011. Planning commenced for the introduction of the **colorectal screening programme** in 2012. Interviews were held in December for 20 candidate Advanced Nurse Practitioners (ANPs) in colonoscopy to be appointed to the hospital based endoscopy units selected as part of the colorectal screening programme.
- A **Nurse Strategy and Educational Framework** to provide a structured approach for nurse education and patient care was developed. A **Community Oncology Nurse Training Programme** was also developed for public health and community based nurses who provide interventions in the patient's home, such as the management of infusion pumps, to reduce the number of hospital visits required by the patient. The programme, delivered in Galway and Donegal, will be further rolled out in 2012. A **Training Programme for Primary Care Nurses** was delivered in four cancer centres with a focus on prevention, early diagnosis and referral, treatment and post-acute care of common cancers. A total of 280 nurses were trained.
- **Cancer Information/training sessions** for General Practitioners (GPs) were delivered through Irish College of General Practitioners (ICGP) and Continuing Medical Education (CME) tutor groups around the country. Over 1,000 GPs attended meetings on breast, prostate, lung and skin cancers and on new electronic referral procedures. GP guidelines were developed for breast pain and melanoma. An **e-learning** initiative for GPs on brief interventions for smoking cessation was developed in association with the ICGP. **Patient booklets** for prostate assessment, rapid access lung clinics and breast pain were developed. A brief intervention programme for smoking cessation was piloted in selected primary care teams, with early results showing a quit rate of approximately 30%.
- The transfer of **National Cancer Registry Ireland** (NCRI) to the HSE was deferred by the DoH until 2012.

Although many achievements took place during 2011, it is acknowledged that many cancer centres also experienced challenges throughout the year. The financial climate and staffing pressures resulted in services becoming increasingly stretched. In particular, there were ongoing challenges filling vacant key staff posts such as mammographers, theatre nurses, pathologists, dermatologists, medical oncologists, physicists and radiation therapists.

CervicalCheck Programme

In September, the National Cancer Screening Service (NCSS) published the CervicalCheck Programme Report 2009-2010. The report provides screening statistics for the second year of the programme's operation, 1 September 2009 - 31 August 2010. During this period, the programme:

- Provided 308,130 free smear tests to 279,877 women.
- Over 85% of satisfactory smear test results in the period were negative or normal.
- 12.5% showed low grade abnormalities, 2% showed high grade abnormalities.
- 16,811 women attended a colposcopy appointment for the first time, an increase of 67% in comparison to the previous year.
- In addition, 30,884 women attended a follow-up colposcopy appointment.
- 7,546 treatments were performed at colposcopy.
- Pre-cancerous abnormalities were detected in 5,518 women.

While the purpose of cervical screening is to detect changes in the cells of the cervix before they become cancerous, 145 women were diagnosed with cervical cancer during the reporting period.

The NCCP set out to complete the transfer of rectal cancer surgery into the designated cancer centres by the end of 2011. However this was not achieved. Among the contributing factors was the inability to successfully reconfigure surgical services within the hospital networks so as to accommodate the rectal cancer surgeries in the designated centres. Lack of capacity, resources and staffing deficits are likely to continue to challenge the ongoing successful delivery of cancer services into next year and beyond.

Improving Access to Radiation Oncology

Kathleen McNicholas receives a special presentation from Grainne Gleeson Radiation Therapy Manager, St Luke's Radiation Oncology Network, St. James's Hospital after she became the first patient to complete treatment at the centre.

Our aim is to develop a National Network of Radiation Oncology services on six sites by 2016. In 2011, more than 7,000 patients completed their radiotherapy treatment in centres in Cork, Galway and at the St Luke's Radiation Oncology Network sites.

In April, two new, state of the art, purpose built, radiotherapy units on the campuses of Beaumont and St James's Hospitals started treating patients. The three Dublin radiotherapy units form the St Luke's Radiation Oncology Network and between them treated 4,000 patients during the year. The opening of these new units has provided a 25% expansion in network capacity which has reduced waiting times and improved access for patients needing radiotherapy.

In Cork, two new radiation oncologists were appointed and a procurement process commenced to develop an Intensity Modulated Radiotherapy system (IMRT) which is expected to commence in 2012.

The prostate brachytherapy programme in Galway is now a national programme, with this treatment becoming available in Dublin and Cork during 2012. A prostate brachytherapy fellowship was established between the Prostate Cancer Institute and University Hospital Galway, which will assist in the rollout of the national prostate brachytherapy programme.

In December 2011 the Radiation Oncology Centre at St James's became the first centre in Ireland to implement Rapid Arc, a highly efficient delivery mechanism for intensity modulated radiotherapy treatment which reduces the time taken to deliver radiation treatment to cancer patients. Discussions continued with the DoH in relation to progressing the next phase of the national plan.

Improving Quality

- The second annual national **Audit, Quality and Risk Conference for Symptomatic Breast Disease** (SBD) was held in October, with the *Report on Symptomatic Breast Disease Performance Indicators*, 2010 also published.
- **National Lead Clinical Groups** were established for urology, lung and gastrointestinal cancers, with **Expert National Tumour Groups** established for breast, lung, prostate, gastrointestinal (GI) and gynaecological cancers. These expert groups will have a key role in the development of site-specific, evidence based, multidisciplinary clinical practice guidelines for cancer care.
- The NCCP supported the RCPI and RCSI in the implementation of **QA programmes** in pathology and radiology. The GI Endoscopy programme was initiated in April with the release of guidelines in September.
- The community oncology team undertook reviews of **plastic surgery services** and of **bed utilisation** in St. Luke's Hospital, Dublin. A review of the **primary prevention** component of A Strategy for Cancer Control in Ireland, 2006 was also undertaken.
- A **safer and high quality referral system** has been developed with GPs now able to electronically refer patients with breast, prostate and lung symptoms to specialist cancer centres. Standardised referral forms are embedded into their GP practice management software systems. **Electronic referrals** for breast, lung and prostate cancer doubled from 2,070 in 2010 to 4,305 in 2011.
- A **Health Technology Review Committee** was established with responsibility for reviewing proposals received from industry or expert groups in Ireland for the funding of new drugs, or expanded indications for existing drugs or related predictive laboratory tests. The recommendations of the committee are based on the degree of clinical effectiveness, the acute and chronic toxicity of drugs and the cost effectiveness of the proposed technology. Recommendations are made to the NCCP Director and are communicated to the HSE Senior Management Team for potential implementation planning. **Oncotype DX** was the first test to go through this process and this test is now available to all clinically appropriate patients in the designated cancer centres.

Supporting Older People

Introduction

Our main focus in 2011 was a strong commitment to the provision of equitable community based services and home supports to enable older people to remain at home, in their own community in so far as possible.

The majority of people in Ireland over 65 years do 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 continue to provide high quality public residential care in compliance with the *National Standards for Residential Care Settings for Older People in Ireland*. The HSE also administers the Nursing Homes Support Scheme (NHSS – A Fair Deal) introduced in 2009 as a demand-led, means-tested, resource-capped national scheme.

Community Supports

An additional €8m was allocated in 2011 to enhance home care services through the provision of additional care packages. In total 11.09m home help hours were delivered to nearly 51,000 people, with a total of 15,270 people benefitting from a HCP at some point in the year (10,968 people in receipt as of end December).

Other initiatives during the year included:

- Standardising the Home Care Package Scheme and implementing the guidelines across the country. The tender process to appoint four approved providers for home care packages was also completed.
- Progressing the development of *National Quality Guidelines for Home Help Services* and also the *National Home Help Guidelines*. These will be discussed with DoH for approval in early 2012 and implementation thereafter.
- Establishing a working group to examine and select a potential assessment tool (Single Assessment Tool) for older people which will be used to determine access to a range of services for older persons. This tool will be piloted and evaluated in 2012.

In 2011

- **A total of 15,270 people benefitted from a home care package (HCP) at some point in the year.**
- **11.09m home help hours were delivered to nearly 51,000 people.**
- **99% of surveyed home help service clients were satisfied with the care they received.**
- **22,327 people were supported under the NHSS, 629 more than in 2010.**
- **There were 8,634 public beds, providing a mix of long stay, rehabilitation/ assessment, convalescent, palliative, and respite beds.**
- **25% of overall long stay beds were public and over 60% of public beds were in facilities over 100 years old.**

- Working in collaboration with other agencies, an information booklet giving advice to older people about keeping well during the winter was produced.
- Implementing the recommendations of the *Strategy to Prevent Falls and Fractures in Ireland's Ageing Population* in all appropriate older people services.

Review of Home Help Services

The home help service is one which is highly valued by service users and which helps to maintain large numbers of older people at home for longer. Without this service many older people would need to be admitted to long term residential care. The HSE is continuing to put in place systems and standards to maintain and improve the quality of home care services provided to its older people.

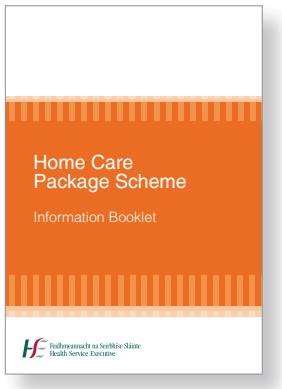


Table 14: Home Help Service and Home Care Package Scheme December 2011 (% versus December 2010)

Area	No in Receipt of HCP		New HCP Clients		Home Help Hours		Home Help Clients	
National	**10,968**	**+10.3%**	**5,740**	**+7.8%**	**11,092,436**	**-5.0%**	**50,986**	**-5.6%**
DML	2,594	+12.9%	1,394	+38.8%	2,006,675	-2.8%	11,902	-1.4%
DNE	3,652	+18.3%	1,774	+36.1%	2,034,416	-16.1%	9,629	-25.4%
South	2,424	+0.0%	1,377	-17.5%	3,777,730	-2.1%	15,899	+5.2%
West	2,298	+7.7%	1,195	-11.5%	3,273,615	-1.8%	13,556	-2.6%

Data source: HSE Performance Reports

The level of client satisfaction with home help services funded by the HSE is consistently high according to an extensive review of home help clients and home help service providers carried out in 2011. By December over 31,500 clients had their cases reviewed to ensure that they were satisfied with the standard of services being provided. This equated to 62% of all clients receiving home help services.

31,400 people of those reviewed were satisfied with the care they were receiving, with just 106 people (0.3%) expressing dissatisfaction. Forty-one formal complaints were received and followed up on a case by case basis. This resulted in 26 complaints being upheld representing just 0.1% of all clients reviewed.

Residential Care

In 2011, €1.026bn was allocated to the HSE to manage the Nursing Homes Support Scheme (NHSS – Fair Deal).

At the end of December there were 22,327 long term public and private residential places supported under the scheme, 629 more than in 2010. During the year 9,323 applications were received and 7,007 new clients supported under the NHSS in approved private nursing homes. Centralisation of the public payment process is on schedule to commence in quarter one 2012 with Government undertaking a complete review of the scheme during 2012 to check its sustainability over the longer term.

Other initiatives during the year included:

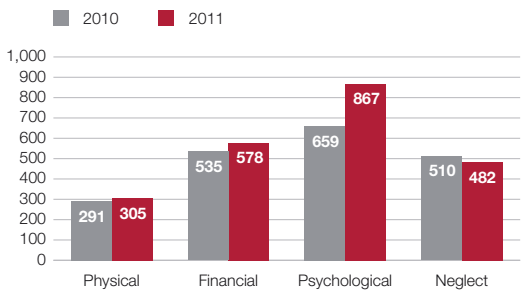
- Opening of seven newly constructed Community Nursing Units (CNUs) – Heather House (on grounds of St. Mary's Orthopaedic Hospital) and Ballincollig CNUs in Cork, St. Joseph's, Raheny, St. Vincent's, Fairview and Clonskeagh CNUs in Dublin, Beaufort CNU in Navan, County Meath and St. Brendan's CNU in Loughrea, Co. Galway.
- A capacity review at the end of the year of all HSE residential facilities for older people in relation to the *National Quality Standards for Residential Care Setting for Older People in Ireland*, local demographic pressures, and public and private provision. This was done with a view to developing an overall strategy on the continued provision of long term residential care in light of both budgetary and quality concerns in maintaining public facilities.
- A small number of public long stay units were identified for possible future closure. However, a final decision to close a unit will not be taken until a full consultation process is undertaken with residents and other key stakeholders.
- A skill mix project in conjunction with the Nursing and Midwifery Planning Delivery Unit commenced to address skill mix and efficiencies across the long term public units.
- *Towards a Restraint Free Environment in Nursing Homes*, a new national Government policy aimed at eliminating the use of all types of restraint in nursing homes, was completed following a public consultation. The policy is intended to complement the national standards and the regulations that underpin them.

Elder Abuse

The HSE received 2,228 referrals of elder abuse in 2011, an increase of 5.5% from 2010. Since the service commenced in 2007, over 6,500 cases of alleged abuse have been reported. International evidence shows that elder abuse is under-reported, therefore it is likely that the true incidence of elder abuse in Ireland is actually much higher. There are a number of types of elder abuse, including physical, psychological, financial, neglect, discrimination and sexual abuse. Elder abuse is not an issue that can be tackled by one individual or organisation but requires a societal response.

In June, a national conference was held in Dublin to mark the World Elder Abuse Awareness Day. At the conference, the *HSE Elder Abuse Services 2010 Report 'Open Your Eyes'* was launched which detailed referrals to the HSE elder abuse service in 2010.

Figure 24: Breakdown of Types of Elder Abuse 2010-2011



Data source: HSE Performance Reports

Elder Abuse

Did you know…?

- **The most common types of abuse reported are psychological and financial abuse, along with neglect (excluding self-neglect)**
- **Women are twice as likely as men to experience abuse.**
- **Those in the over 80 years age group are almost three time as likely to experience abuse as the 65 to 79 year age group.**
- **Close family members, such as son, daughter or spouse, are most likely to carry out the abuse.**
- **Anyone concerned about abuse should talk to someone they trust or can contact the HSE Information line on 1850 24 1850 or contact a health professional. For more information visit www.hse.ie**

Places to Flourish

Care home residents Joan O'Brien and Eileen Harmon with their dog Cara. Photo: Conor McCabe Photography.

In November, a new initiative called 'Places to Flourish' was launched to enable residential care settings be more of a home from home for older people. This initiative supports staff to create a new culture where older people can continue to live their lives according to their own routines and wishes, in an environment that they can call home. One of the issues addressed is the addition of pets to the care environment.

Maud White from Rathgar, Dublin.

Say No to Ageism

On its eighth anniversary in June, the HSE wanted to remind the public again that older people have the same rights as everybody else in society. Posters and leaflets were made available nationwide and HSE staff were asked to wear special pin badges to celebrate the week.

Pictured with Sarah Marsh, HSE Dedicated Officer for Elder Abuse, HSE Dublin Mid Leinster are the first prize winners – Greg Mulcahy from Clonakilty, Cork, Bernard O'Farrell from Mullingar, Co. Westmeath and Tim Shearwood from Dromiskin Co. Louth.

Open Your Eyes – Open Your Lens

In January, the winners of the HSE elder abuse short film competition, 'Open Your Eyes – Open Your Lens' were announced. The purpose of the short film competition was to raise awareness of the issue of elder abuse. The HSE invited the public to submit a short film to YouTube based on the theme 'Open Your Eyes – Open Your Lens'.

Valuing Our Staff

Maire Brady

Senior Social Worker
for the Protection
of Older People
Louth/Meath Service Area

I was appointed to this job in 2007 as part of the HSE's development of services to protect older people from elder abuse. The most rewarding part of my job is that I get to work with older people who I greatly enjoy and find to be very receptive and positive about the difference I can make to their lives.

I believe that the best impact I have made to protect older people has come about when I have worked collaboratively with other health professionals, state agencies and particularly with voluntary agencies. There are many voluntary agencies doing excellent work for older people, and I find that when I work very closely with them, I get my best results. Generally it is the simplest things that make the most difference and this is down to having an open approach with key individuals.

The most important wish for older people is that they are supported to stay at home. I work with my colleagues, other agencies and most importantly family members to help this happen. This is always the biggest challenge.

There were many positives in 2011, most specifically that the development of our service which started in 2007 has continued to mature with growing evidence of a greater awareness amongst all stakeholders of elder abuse issues. During 2011, I began to get self referrals for the first time which is very encouraging. I have been involved in some very complex case conferences in 2011 which allowed many stakeholders to work together in a way that has not always happened for the benefit of the older person.

On the negative side 2011 has been difficult as several key members of staff have left the HSE and have not been replaced. Equally, I am a single handed practitioner, which brings with it its own challenges when I am on leave or caught up when an emergency arises. As a specialist service, the lack of social workers in my local primary care teams is a big gap as I am frequently involved in cases which could have been dealt with by a primary care team. The inconsistency of available services across the country can equally be frustrating and unfair.

Improving Mental Health Services

Introduction

The HSE is committed to guiding the development of our mental health services through *A Vision for Change*, a progressive, evidence-based and pragmatic policy document which proposes a new 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 and sets out a comprehensive change programme for our mental health services.

In 2011, we sustained the pace of change in what was a difficult year for all health services.

Striving for Excellence

In January, at Dublin Castle we marked the half-way point achievements in the implementation of *A Vision for Change*. At the same event, the National Service User Executive (NSUE) held an inaugural awards ceremony, acknowledging the achievements in service delivery as decided by service users. The Best Community Mental Health Team Award went to Loughrea/Athenry Community Mental Health Service. The Best Day Hospital/Day Centre award went to Tara Suite Mental Health Day Centre in Dunshaughlin and the Most Improved Service Award went to West Cork Mental Health Services. The NSUE survey and awards have identified services as examples of good practice, in the opinion of those who use the services, and are an invaluable indicator of progress by services in the implementation of *A Vision for Change*.

West Cork Mental Health Services receiving a commendation for 'Best Public Health Initiative' at the 10th Annual Irish Healthcare Awards for their project Making the "Vision" a Reality.

In 2011

- **There were 61 Child and Adolescent Mental Health Teams (CAMHTs) consisting of 56 Community, 3 Liaison and 2 Day Teams – an additional six community teams since 2010.**
- **12,798 referrals were received and 8,663 referrals were accepted to the child and adolescent services during the year.**
- **The number of children waiting over 12 months to be seen decreased by 29% against 2010 figures.**
- **69% were offered an appointment within 3 months, with 61% being seen within 3 months.**
- **There was a 4% decrease in the number of admissions to adult acute inpatient facilities.**
- **Median length of stay as an inpatient was 10.5 days.**
- **Over 7,700 counselling sessions were given to over 317 adults with a history of institutional abuse in childhood.**

Implementing Service Change

In maintaining our focus on increasing community based mental heath care in line with the recommendations of *A Vision for Change*, there was a further reduction in acute inpatient capacity from 1,187 beds in 2010 to 1,070, a reduction of 117 beds.

Martin Rogan, Assistant National Director for Mental Health, HSE; Jennifer Kelly, Chair, National Service Users Executive; Cathal Magee, CEO, HSE; Bairbre Nic Aongusa, Director for Disability and Mental Health, DoH; and Dr. Ian Daly, National Clinical Programme Director for Mental Health, HSE.

Further progress was also made in reconfiguring to Community Mental Health Teams (CMHT), for example:

- As part of the reconfiguration of mental health services in Carlow/Kilkenny and South Tipperary, existing teams were enhanced following reduction in inpatient capacity. By the end of December, amalgamation of existing CMHTs was completed, and team co-ordinators appointed. The Home Based Treatment Team also became operational.
- 7.5 WTEs were redeployed to advance CMHTs in Galway following the closure of a long stay ward in St. Brigid's Hospital, Ballinasloe. There was no net gain to the service as a result of retirements and the recruitment moratorium.

Table 15: Adult Acute Mental Health Inpatient Services 2010-2011

	2010	2011	Variance
Total no. of admissions	14,474	13,938	-3.7%
First admissions	4,552	4,418	-2.9%
Re-admissions	9,922	9,520	-4.1%
Re-admissions (as % of total admissions)	69%	68%	-1.4%
Involuntary admissions	1,355	1,512	+11.6%
Median length of stay	10.9	10.5	-4.0%
Acute places	1,187	1,070	-9.9%

Data source: Health Research Board

In addition:

- Through the allocation of innovation funding to Genio in 2011, the HSE contributed to a number of **innovative projects** in mental health to progress the recommendations in A Vision for Change including supporting a number of individuals to transition from supported hostel environments to living independently in their own community.
- €1.8m once-off funding was made available to the **HSE's National Counselling Service (NCS)** which provides counselling to adults with a history of institutional abuse in childhood. The NCS provided over 7,700 counselling sessions to over 317 individuals in 2011 with this additional resource.
- The **National Mental Health Clinical Programme** plan was drafted and developed in consultation with the College of Psychiatry of Ireland, Irish College of General Practitioners and all relevant professional and service user organisations. This five year plan will develop three clinical programmes in year one, early intervention for first episode psychosis, early detection and intervention in eating disorders (in collaboration with primary care) and the management of self harm presentations to EDs to ensure engagement, consistency of response and adequate follow-up. These programmes will be implemented in 2012.

Child and Adolescent Mental Health Services (CAMHS)

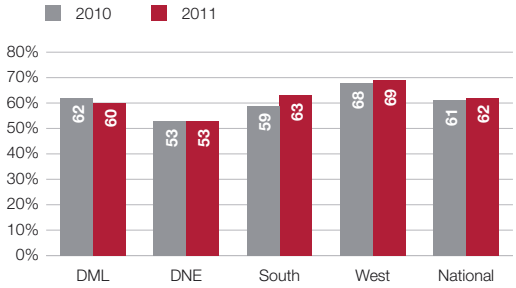
A Vision for Change identified mental health services for children and young people as a priority area for development. The HSE has placed a particular emphasis on developing child and adolescent mental health teams, improving inpatient access and addressing waiting times for assessment.

There are 61 Child and Adolescent Community Mental Health Teams in place, an additional six teams since 2010. Of these, 56 teams are community teams, 2 day hospital teams and 3 paediatric hospital liaison teams. These teams saw 7,849 new referrals to the service in the year period to September 2011. Over half of these were seen within one month of referral. All community teams screen children and adolescents referred to the service on the basis of the urgency of need.

Other CAMHS initiatives included:

- The *Third Annual Child and Adolescent Mental Health Service Report 2010-2011* was published in December building on work over the previous years and is available on www.hse.ie
- Additional child and adolescent acute inpatient capacity has been provided in new bespoke units in Bessboro, Cork and Merlin Park, Galway. The unit in Galway opened to full 20-bed capacity in December and the Bessboro unit is planned to open to full capacity in early 2012, with 12 beds commissioned at present.
- An interim child and adolescent inpatient unit on the site of St. Loman's Hospital, Palmerstown is in development and planned to be commissioned in early 2012.
- Additional capacity in phase 2 of St Joseph's inpatient unit in St. Vincent's Hospital, Fairview is expected to come on stream in mid 2012.
- The Jigsaw Galway premises opened in July. An additional €1m innovation funding was allocated to extend the Jigsaw model to six new communities – Donegal, Offaly, Tallaght, Clondalkin, Balbriggan and Blanchardstown over three years.

Figure 25: % offered first appointment and seen by CAMHS within 3 months 2010-2011



Data source: HSE Performance Reports

National Forensic Services

The Government approved the capital investment to provide a new 120-bed Central Mental Hospital at the site of St. Ita's Hospital, Portrane, four Intensive Care Rehabilitation Units (one in each Region) and forensic provision for CAMHS, and for individuals with a mental health and an intellectual disability.

A 10-12 bed high support hostel and outreach service for people granted conditional discharge by the courts under the *Criminal Law (Insanity) Act 2006* commenced on a phased basis in 2011 and will be fully operational by quarter two 2012.

The provision of barricade/siege support to the Gardaí in line with the recommendations of the *Barr Tribunal Report 2006* is in place since January.

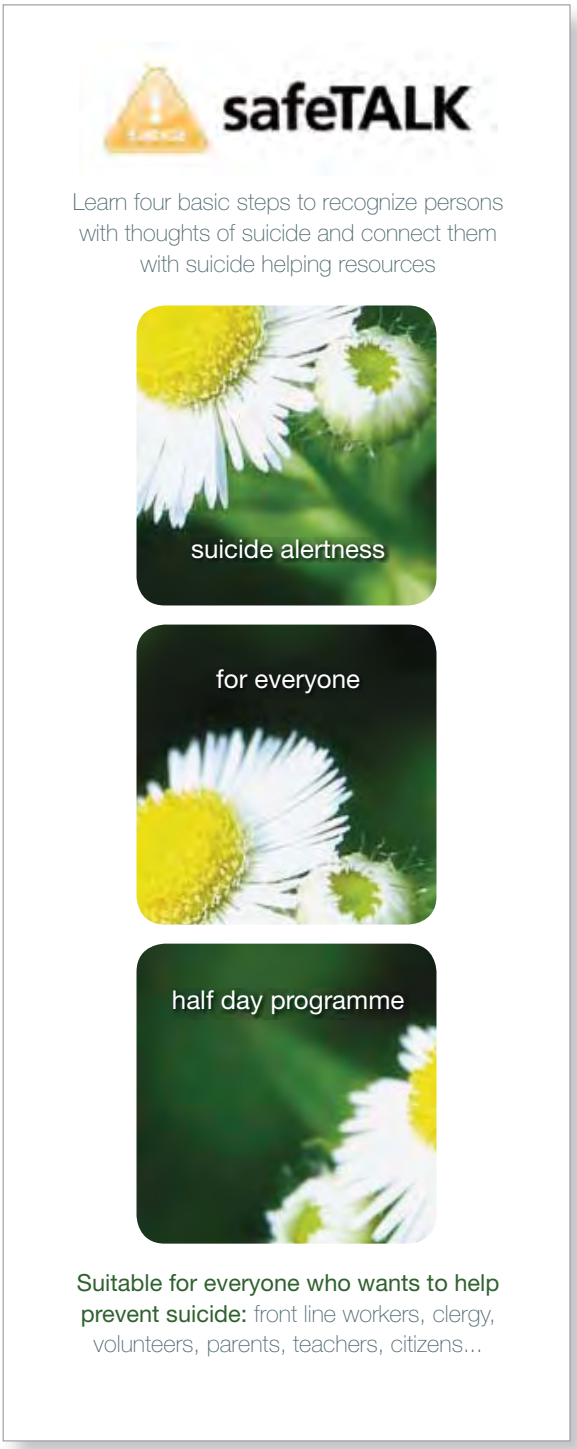
Implementing Measures to Reduce Suicide Rates

An additional €1m was allocated in 2011 to implement measures to reduce suicide rates in Ireland. Twenty five distinct programmes were allocated funding, focusing on skills based training, standardisation of helpline services, improving the primary care response to suicidal behaviour and increasing the capacity of HSE services to respond to clients who self harm. In addition, initiatives also focused on groups who may be at increased risk of suicidal behaviour because of the economic downturn.

The HSE also worked in partnership with other agencies on the SEE Change campaign which focused on targeting specific occupations, workplace and sporting organisations. Ten additional SAFE TALK trainers were trained and existing ASIST Trainers were up-skilled in December. An all island evaluation of ASIST was completed and published and is available on www.nosp.ie

Learning and Development

- A **review of the NSUE** was completed in November and the HSE contributed to the review of the Irish Advocacy Network leading to the development of a three year strategic plan for the organisation.
- The role and contribution of the **Practice, Education, Research Expert by Experience Project** which the HSE funds in partnership with Dublin City University (DCU), was independently evaluated in 2011 and this project has been extended for another three years.
- Nine teams representing nine services from around the country commenced the **DCU Co-operative Learning Leadership Programme** in October to facilitate increased service users' participation in planning and delivering better mental health services.
- The **National Mental Health Services Collaborative on Individual Care Planning** in partnership with the Mental Health Commission, St Patrick's University Hospital and St. John of God Hospital was completed and evaluated and a symposium on the experience is planned in early 2012.
- A third cohort of PCT representatives completed the **Team Based Approaches to Mental Health in Primary Care Accredited Programme**. The programme was reviewed in July and will be amended prior to further programmes being rolled out in 2012.



Valuing Our Staff

Maria Migone

Consultant Child and Adolescent Psychiatrist
Child and Adolescent Mental Health Service (CAMHS), Clondalkin, Dublin

I am a Consultant Child and Adolescent Psychiatrist and have been working in the Clondalkin area of Dublin for the last year and half. My team work directly with children and adolescents providing treatment and care for those with the most severe and complex problems and with other services engaged with children and young people experiencing mental health problems.

My work is very varied. What I find most rewarding is knowing that I can make a difference to both the children presenting with problems and to their families. Good outcomes are most likely when the child or adolescent and their family or carer has access to timely, well co-ordinated advice, assessment and treatment.

Referrals to our services come from many sources including emergency departments, GPs, crèches, schools either primary or post-primary, Social Workers, or Public Health Nurses. We undertake our assessments and treatments in many locations, the primary decision being on maximising efficiency and the best outcome for the child. This may at times include home visits, visiting a school to observe a child amongst their peers or providing treatment in the school.

We are receiving a growing number of referrals for children who are self-harming, referrals from schools about children with suspected ADHD or Autistic Spectrum are increasing, as are referrals for children or young adults with suicidal tendencies. Many of these are coming through either the school system or through GP services.

Some great initiatives have taken place during the year. A lovely new building is opening shortly which will serve a number of teams from our service and will have links to Trinity College, Dublin and in time it is hoped will also house a Day Hospital for young people who have acute mental health difficulties. We hope this will prevent admissions to inpatient facilities and reduce the inpatient length of stay for young people.

Small local initiatives have taken place. For example, in collaboration with the National Educational Psychological Service, we organised an information day for schools on ADHD. Funding has been received to extend the Jigsaw model to the Clondalkin area. This is an innovative approach for organising services and supports to enhance the mental health and well-being of young people. It promotes systems of care that are more accessible, youth-friendly, integrated and engaging for young people. A working group that involves our CAMHS team has been set up to progress this very positive initiative.

Training was organised for my team this year on basic Cognitive Behavioural Therapy for teenagers in conjunction with Dr Gary O'Reilly from University College, Dublin who provided this training free of charge. Staff are now also trained to undertake risk assessment of young people presenting with suicidal thoughts and to complete a risk management and risk prevention plan. This is based on the STORM model of training in use in Manchester University. We are rolling this training out to all staff in our service.

While we are doing well to ensure that all urgent referrals are seen quickly and routine appointments are managed within 3 months at present, my predominant concern is maintaining a fast response to referrals. Demand for our service is increasing. For our team to work effectively, a range of disciplines, skills and perspectives are required, so that children and adolescents are offered a care and treatment package geared to their individual needs. Our team is very small and it is increasingly difficult for us to provide the level of service we have been providing with a reducing pool of staff and the replacement of posts is crucial for us. With our current resources, we are currently prioritising referrals of younger age groups.

A Vision for Change
ADVANCING MENTAL HEALTH IN IRELAND

Supporting People with Disabilities

Introduction

The HSE works in partnership with other stakeholders to ensure that Ireland becomes a society where 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 well-being.

In 2011 we took further steps towards achieving this vision. We are moving from congregated to community provision and from segregation to inclusion, but the pace of change needs to quicken if we are to ensure that our services meet the needs of our citizens.

While we are working to bring about the changes required, we are still providing supports under the existing model. Services are delivered by both the HSE and our non-statutory partners. Approximately 80% of all services in 2011 were delivered by the non-statutory sector, funded through section 38 and 39 of the *Health Act 2004*. The disability budget for 2011 was €1,554m. A total of €399m was allocated under section 38 of the *Health Act 2004* and a further €735m under section 39 to non-statutory agencies, with the remainder supporting HSE directly provided services. The funding allocated to the non-statutory sector is covered by either Service or Grant Aid Agreements.

Additional funding of €10m was provided to the HSE in 2011 to address demographic pressures in the provision of day, residential, respite, personal assistance and home support services.

Changing the Way Services are Delivered

During 2011, significant progress was made in laying the foundations for radical change. The emerging DoH policy direction (*Value for Money and Policy Review*), coupled with recommendations from HSE national working groups on key service areas, emphasised the need for a new model of service to further the independence of people with disabilities in a manner which is efficient and cost-effective. It envisages the existing level of funding being redirected to support a person centred approach where the funding will follow the individual. It also envisages mainstream access to housing, employment, and education.

In 2011

- **1.68m hours of personal assistance home support hours were provided.**
- **Almost 3,000 people benefited from rehabilitative training and over 18,000 benefited from other forms of day activity.**
- **81 agencies provided adult day services in 817 locations, with 90% provided by the non-statutory sector.**
- **Around 3,600 people remain living in congregated settings.**
- **Over 155,000 bed-nights of respite care were provided to over 6,000 individuals.**
- **3,043 assessment reports were completed in respect of children under five, a 24% increase on 2010.**
- **Of these, 23% were completed within regulatory timelines.**

Implementing the Policies

This process is not the sole responsibility of the HSE, but rather a collaborative responsibility shared between the person, their families and carers, a multiplicity of agencies, Government and society as a whole. This represents a significant challenge for the many stakeholders. To facilitate this change programme and to reflect the collaborative nature of the responsibility, new structures were created in 2011:

- We established a National Consultative Forum (NCF), four Regional Consultative Fora and embarked on the establishment of Local Consultative Fora. These structures comprise representatives of all stakeholders and provide a focus for the implementation of the raft of policy initiatives detailed above. These structures enable the development and monitoring of robust implementation plans.

- The NCF launched a work stream to put in place a framework for the participation in the overall process of those who use our services at all levels.

In addition, during 2011 the following took place:

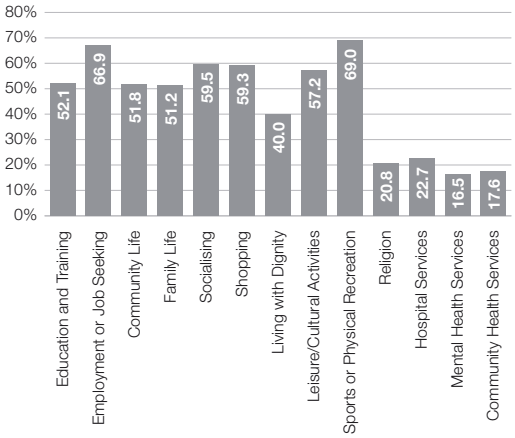
- A **Central Remedial Clinic** facility was opened on the grounds of Waterford Regional Hospital to enhance services for children with disabilities in counties Carlow, Kilkenny, South Tipperary, Waterford and Wexford, with up to 600 children availing of the services provided in 2011.

Zach Winters, using the services of the new Central Remedial Clinic facility in Waterford, pictured with his Occupational Therapist, Muireann Nolan, Dr. Frank Dolphin, Chairman of HSE Board and Mr. Hamilton Goulding, CRC Chairman.

- The HSE works closely with Genio, the non-statutory agency established to support social innovation. In particular, Genio has distributed funding, channelled from both state and philanthropic sources, to **help people to move out of congregated settings** and live independently chosen lives in the community. During the year Genio funded projects to help approximately 60 people move in the coming year. Our service providing partners in the non-statutory sector have been intimately involved in innovative developments in this regard for some years. For example, Cheshire Ireland, which provides a range of accommodation and support services for 285 people with neurological conditions and physical disabilities in Ireland, helped 12 people who used to live in its residential facilities in Ballina and Herbert Street, Dublin to move into their own homes in the community during 2011, thus allowing those facilities to be closed down. Cheshire Ireland envisages this trend continuing. Through the consolidation of other services in the region, HSE DML has succeeded in moving 12 people out of congregated settings with a further 4 to move in the near future. This has been achieved within existing resources.
- The National Physical and Sensory Disability Database (NPSDD) allows us to measure the extent of **participation restriction** that people experience. Figure 26 illustrates that sports and physical recreation (69%) and employment and job seeking (67%) were the greatest areas of restriction experienced by those surveyed. As people move from congregated settings, this will allow us to tailor and target services to improve people's level of participation in society. For example, this tool has already shown us that having a Personal Assistant significantly improves a person's level of participation.

The Policy Base: Policy Initiatives Progressed to Inform Radical Change	
Programme to progress disability services for children and young people	• National, regional and most local implementation groups established and resource mapping commenced.
The review of autism services	• Report finalised.
Progressing the move away from congregated residential settings	• National implementation group established and outline implementation plan agreed.
Development of more choice in respite services	• Report on host family alternative to respite care developed and finalised.
Progressing the move towards more appropriate day services	• Report finalised.
Development of a neuro-rehabilitation strategy in conjunction with DoH	• Strategy finalised and approved by the DoH. Clinical Lead appointed.

Figure 26: People with Disabilities % Participation Restriction 2010



Data source: Annual Report of the National Physical and Sensory Disability Database Committee 2010

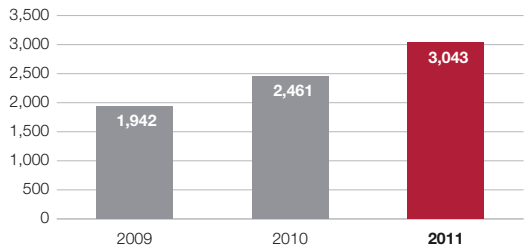
Part 2 of the Disability Act 2005

Part 2 of the *Disability Act 2005*, implemented in relation to children under five years of age in 2007, provides for the assessment of eligible children, the production of an assessment report and a service statement outlining the services that will be provided to meet the needs identified. The Act also established a dedicated redress system.

Compliance with statutory timelines for the provision of assessments in 2011 continued to pose significant challenges. Only 23% were completed within the timelines as provided for in the regulations. This reflected a number of difficulties including the prioritisation of intervention over assessment, the complexity of some assessments, pressure to produce assessments that comply with the Department of Education and Skills resource allocation model, the effects of the recruitment moratorium, and the non-filling of maternity and sick leave vacancies.

Despite these difficulties, there was a significant increase in activity during the year. In total 3,043 assessment reports were completed in 2011, exceeding the target by 30%. This was a 24% increase on 2010 figures.

Figure 27: Assessment Reports Completed 2009-2011



Data source: Disability Act Activity – Quarterly Reports 2011 (Disability Information Unit)

Progressing Disability Services for Children and Young People

The HSE established a national programme, Progressing Disability Services for Children and Young People to change the way services are provided for children and young people with disabilities. This is based on the recommendations of the *Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5-18 Years* produced by representatives of the professions and management involved in delivering multidisciplinary services to children.

Disability services for children have a long history in Ireland and many organisations provide excellent support and interventions for children and their families. However, as they have developed independently and were often established to serve one specific group of children only, there is a wide variation in the services available in different parts of the country and for different categories of disability. The aims of this programme are to ensure one clear pathway to services for all children according to need, resources used to the greatest benefit for all children and families and health and education working together to support children to achieve their potential.

While significant progress has been made, it has been uneven and slower than originally anticipated. This reflects the differences between areas in respect of resources available, the extent to which services had been developed and in the existing arrangements between service providers. In addition, the moratorium on recruitment has impeded progress.

National Disability Databases

Did you know…?

National Intellectual Disability Database (2010)

Of those registered in 2010:

- **26,484 people on the database – 57% male and 43% female.**
- **Just over 35% are between 0-19 years old.**
- **65% live at home with family.**
- **31% were in receipt of a full-time residential service.**
- **67% attended services on a day basis.**
- **84% availed of multidisciplinary support services, such as speech and language therapy.**
- **The largest proportion live in the HSE South (28%).**

National Physical and Sensory Database (2010)

Of those registered in 2010:

- **25,191 people on the database – 53% male and 47% female.**
- **70% are over 18 years old.**
- **The majority of the people live with family (85%).**
- **Only 3% live in full time residential services.**
- **54% were in receipt of day services.**
- **41% have a diagnosis of a nervous system disability.**
- **The largest proportion live in HSE DML (31%).**

Data source: HRB Statistics Series 13 and Series 14 (published 2011)

Valuing Our Staff

Rosemary Dillon

Senior Occupational Therapist working with people with acquired head injury Sligo, Leitrim and West Cavan

I have been working as a senior occupational therapist with people with acquired head injury since 2007 having worked previously as a community occupational therapist. My role currently is working with the Community Brain Injury Service in the Sligo, Leitrim and West Cavan area. This is a unique partnership between Physical and Sensory Disability Services in the HSE and Acquired Brain Injury (ABI) Ireland, a voluntary organisation founded to support individuals following an acquired brain injury.

I believe this partnership approach to service provision has achieved so much more than might have been achieved, by either the statutory or voluntary sector working independently of one another. It provides scope for creative and flexible approaches to enhancing the quality of clients' lives. For example, I can access community activities and resources, work with rehabilitation assistants in ABI Ireland who can follow through on recommended programmes and give feedback on progress of clients, link with home support workers in the HSE, personal assistants through the Irish Wheelchair Association or the Centre for Independent Living. There are very strong linkages in place with generic HSE services and voluntary organisations and this is vital to ensure we empower and enable people live as independently as possible.

Once a person has a brain injury, support is provided to both the client and family. A rehabilitation pathway is determined depending on the clients' needs. This varies for all individuals and can include returning home with ongoing monitoring, assessment and support, admission to the Brain Injury Transitional Living Unit for a period of community rehabilitation, admission to the National Rehabilitation Hospital for intensive rehabilitation or admission to community hospitals or nursing homes for slow stream rehabilitation or long-term care.

I find it so rewarding to be involved in a service which provides a diverse and innovative range of specialist rehabilitation services to people with an acquired brain injury, helping them regain independence and re-learn everyday life skills often lost to them as a result of their injury. What is very rewarding is the difference I and the team of people I work with, make to people's quality of every day living. This encompasses all aspects of daily living. It may be working with employers to help a client get back to work, assisting a client return to driving, or enabling a client engage in leisure activities or activities within their community.

What gives me great pride is the fact that services have improved so much over the last number of years for people with acquired brain injury. In 2010 I received the Anne Beckett Award for my work in developing practical interventions to empower and benefit people with ABI and to involve them in the planning of their own rehabilitation programmes and strategies to manage their difficulties. I take pride in the fact that this award raised awareness of ABI and gave a profile to the further developments which are required in service provision.

However, while great progress has been made overall, it is disappointing that some services have had to be curtailed and others not developed at all due to financial constraints. Acquired brain injury tends to be a silent disability as cognitive difficulties are not always recognised. The level of intervention and support which is required to ensure a client can maximise their ability to undertake everyday tasks is significant and is only achieved through consistency and repetition. While the challenges are significant, the rewards are great.

Protecting our Children and Young People

Introduction

The HSE has a statutory duty under the *Child Care Act 1991*, for the care and protection of children and their families. In its *Programme for Government 2011*, the Government has set out fundamental reform for the provision of children and family services in Ireland. As part of this reform, a new Child and Family Support Agency (CFSA) will be established, the core of which will be the existing HSE children and family services. The establishment of the new agency is part of a wider change agenda, aimed at strengthening the organisational capacity, processes and systems necessary to deliver safe, effective, consistent and reliable child protection services.

Reforming Children and Family Services

A number of significant changes in respect of children and family services in Ireland occurred in 2011. Key milestones included the appointment of a Minister for Children and Youth Affairs and the establishment of a new Department of Children and Youth Affairs. In January, Ireland's first National Director for Children and Family Services was appointed to assume full accountability for services. The reform programme contains a number of critical elements including:

- Establishing a new Child and Family Support Agency (CFSA).
- Transitioning of existing HSE and Family Support Agency services into the new agency.
- Continuing implementation of the HSE Child and Family Change Programme incorporating seven strands of activity: quality and risk, resource allocation, policies, procedures and practice, workforce, service development, culture, and governance and partnership arrangements.
- Considering the further rationalisation of services under the new agency.
- Developing appropriate legislative proposals to give effect to the reform changes proposed.

In 2011

- **As of December 2011, there were 6,160 children in care.**
- **7% were in residential care, and of these, 11% were under the age of 12 years.**
- **Over 90% were cared for by foster carers, 29% of which were relatives of the children.**
- **There were 3,769 foster carers.**
- **93% of children in care had an allocated social worker (target 100%).**
- **90% of children in care had a care plan (target 100%).**
- **7,271 referrals for child abuse were made.**
- **There were 4,802 notified Early Years Services, 60% of which received an inspection (target 100%) with 29 prosecutions taken on foot of an inspection.**

We are committed to putting the interests of children first, supporting the role of parents, carers and families in the development of their children, enhancing individuals' capacity to make informed decisions about their health and social well-being, contributing to protecting children and young people, working to address inequalities in the health and well-being of all children and young people, and supporting educational achievement.

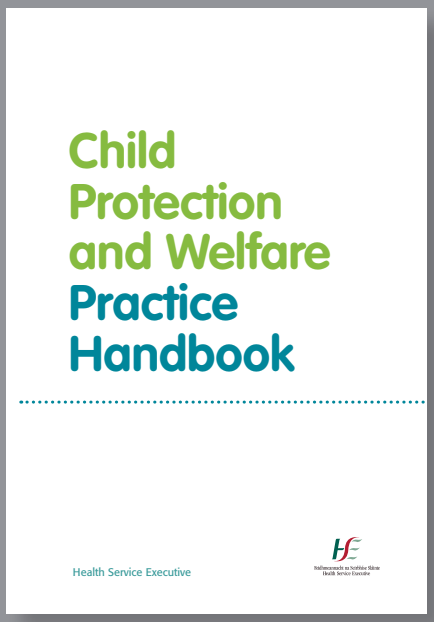
In 2011, the HSE and agencies delivering services on our behalf under Section 38 and 39 of the Health Act 2004, delivered a range of services in co-operation and in partnership with children and their families.

Protection and Welfare of Children

In July, the Minister for Children and Youth Affairs launched the *Children First National Guidance for the Protection and Welfare of Children 2011* to promote the protection of children from abuse and neglect. It outlines what organisations need to do to keep children safe, and what different bodies, and the general public should do if they are concerned about a child's safety and welfare. It sets out specific protocols for HSE social workers, Gardaí and other front line staff in dealing with suspected abuse and neglect. The scope of the guidance extends beyond the reporting to statutory bodies. It emphasises the importance of multidisciplinary, inter-agency working in the management of concerns about children's safety and welfare. Key to this is the sharing of information between agencies and disciplines in the best interests of children and the need for full co-operation to ensure better outcomes.

At the launch in July were (l-r) Derek Byrne Assistant Commissioner, An Garda Síochána, Jim Breslin, Secretary General, Department of Children and Youth Affairs, Gordon Jeyes, National Director, Children and Family Services HSE and Frances Fitzgerald TD, Minister for Children and Youth Affairs.

Protecting Children



The *HSE's Child Protection and Welfare Handbook* was launched in September, based on the protocols in the *Children First National Guidance 2011* and is the collective wisdom and best practice of experts and front line staff. It supports the vital work of social workers and other relevant practitioners in dealing with child protection and welfare cases ensuring a nationwide consistency of approach, setting out the key issues in the different stages of action from referral through assessment to intervention.

In addition, building on the partnership focus between Children and Family Services and An Garda Síochána, an updated joint training programme for HSE social workers and Gardaí on *Children First 2011* and the *Child Protection and Welfare Practice Handbook*, commenced in September and will continue until June 2012.

Supporting the national Children's First Unit, regional managers and 17 area managers were appointed in quarter four to co-ordinate a consistent implementation of Children First. A copy of *Children First* and supporting material is available at www.hse.ie/go/childrenfirst

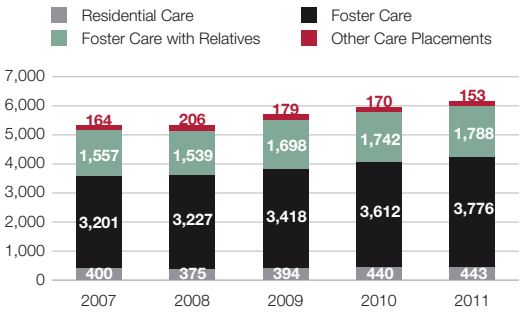
Children in Care

At the end of December 2011, there were 6,160 children in care with over 90% (5,586) of these children in foster care placements. There are many types of foster care (short term, long term, emergency, respite, high support and relative foster care) and residential care (mainstream, high support, special care) provision but all care provision is designed to meet the assessed needs of the individual child coming into care.

Each child should have an individual care plan in order to identify the placement that best meets their needs, in addition to an allocated worker. During 2011, 93% of children in residential care and foster care had an allocated social worker and 90% of children in care had an up-to-date care plan. Among children in care between six and 16 years of age, 98% were in full time education.

Figure 28 shows that there has been a steady increase in the number of children coming into care over the last number of years. Overall, there has been a 16% increase in the number of children in care since 2007 and this increased demand for services is mirrored internationally. The increased demand, combined with a decrease in budget allocation, has had a significant impact on services. In 2012 our priority will be to ensure that services are reconfigured so that we can meet the needs of children requiring care and protection, within the allocated financial resources.

Figure 28: No. of Children in Care 2007-2011



Data source: HSE Performance Reports

Other areas of progress during the year included:

- A **portfolio management approach** for all children and family projects was initiated to support a strategic review of services on an ongoing basis.
- The appointment of regional directors and area managers for children and family services has led to a direct line of **professional accountability** from national director to regional directors to area managers in each of the 17 HSE Areas.
- An **audit and validation** of all HSE staff working in children and family services took place in December in preparation for the transition to the new CFSA.
- A wide ranging **workforce development programme** was established.
- Standard procedures for referral/assessment were implemented in all 32 HSE Health Offices/17 HSE Areas.
- An **additional 60 social workers** were allocated posts as part of the Ryan Report Implementation Plan. At the end of December, three of the 60 additional social workers were filled locally, one of which was a transfer. A further 12 new staff were in post, seven have had a contract issued and 38 have accepted posts awaiting final clearance.
- A **National Aftercare Policy 2011** was developed with an implementation group tasked with developing an implementation plan for early 2012.
- The **Capital Development Plan** continued with a design team looking at options for a building suitable to the needs of young people requiring special care.
- An intra-agency **Youth Homelessness Forum** was established and an audit of Section 5 of the *Child Care Act 1991* was completed.
- In response to additional funding allocated in the HSE National Service Plan 2011, a total of 7,700 **counselling sessions** were given to over 317 individuals with a history of institutional abuse.
- Two **out-of-hours social work services** commenced, on a pilot basis, in Donegal and Cork in April and September respectively. The evaluation of these two sites will be completed in early 2012.
- Stage 1 of a restricted tender process was completed in the procurement of a **national children and families IT system**.
- **HSE Family Support Action Plan 2011-2013** was finalised in 2011. The key work areas will be funded for two year by Atlantic Philanthropies, including development of a comprehensive family support commissioning strategy, a supporting parents strategy, family support networks/hubs and a framework for participation of children and young people in relation to service planning, design, development, delivery and evaluation.

Online Child Protection Resource

During the year the HSE entered into a contract with Childlink, the company that manages the North South Child Protection Hub, to allow HSE staff and HSE funded agencies to access a North/South online resource to support staff in their work and to enhance their professional development.

www.nscph.com

Listen to Our Voices

The Department of Children and Youth Affairs (DCYA), in partnership with the HSE, a Youth Advisory Group and a number of organisations that work with children and young people living in care, conducted a consultation process with children living in the care of the State. The project was called ***Listen to our voices! Hearing children and young people living in the care of the State***.

The objectives of the consultation process were to seek the views of children and young people in the care of the State, in detention and in residential services for children with a disability on the issues that matter to them, to explore existing mechanisms for children and young people to express their views and to make recommendations on future structures to be established for children and young people's voices to be heard. A report on the findings was launched in July.

Minister for Children and Youth Affairs, Frances Fitzgerald TD, with young people at the launch of Listen to our voices!

Enhancing the Provision of Palliative Care

Introduction

Palliative care is an approach that improves the quality of life of patients and their families, facing the problems associated with life-limiting illness. This is achieved through the prevention and relief of suffering by means of early identification, high quality assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.

During the year, we continued to develop services in both the specialist and generalist palliative care services to support us in providing care in the place of the patient's need and choice. A significant proportion of specialist services are delivered in partnership with the voluntary sector.

In 2011:

- Agreement was reached between University College Dublin/Trinity College Dublin and Our Lady's Hospice to appoint the first ever Irish **palliative medicine professor**, who will take up post in 2012.

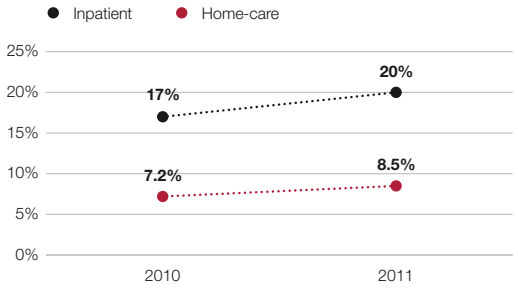
Minister of State, Kathleen Lynch TD; Mo Flynn, CEO, Our Lady's Hospice, Harold's Cross; and Paddie Blaney, Director, AIIHPC at the launch of the All Ireland Institute of Hospice and Palliative Care.

In 2011

- **Ireland had eight dedicated specialist palliative care inpatient units.**
- **An average of 350 people were treated on an inpatient basis each month with 91% admitted within 7 days of referral.**
- **There were 38 acute hospital specialist palliative care teams.**
- **All HSE Areas had access to a Community Specialist Palliative Care team.**
- **Each month, approximately 3,000 people availed of this service with 79% being seen within 7 days.**
- **67% of people in Ireland would prefer to die at home.**
- **Approximately 1,400 children were living with a life-limiting condition.**

- The launch of the **All Ireland Institute of Hospice and Palliative Care (AIIHPC)** occurred in October with events in Dublin and Belfast attended by Ministers of State from both sides of the border. AIIHPC represents a major opportunity to create an integrated, all island approach to palliative and end-of-life care. The institute works in the three interlinked areas of education, research, and policy and practice, with the ultimate aim of securing the best palliative care experience for our populations. Further information can be found on their website www.aiihpc.org
- The first full year of data for the **palliative care minimum data set** was collated, which will report comprehensive service activity levels in 2012. It was noted that there was an increased percentage of non-malignant cases across all elements of specialist palliative care services with the percentage of non-cancer cases receiving inpatient care increasing from 7.2% in 2010 to 8.5% in 2011, and those receiving home care increasing from 17% to 20%.

Figure 29: Proportion of non-cancer cases cared for in inpatient and home-care settings 2010-2011



Data source: HSE Performance Reports

- The **National Palliative Medicines Information service**, the first of its kind in Europe, had a successful first year of operation.
- *Primary Palliative Care in Ireland: Identifying Improvements in Primary Care to Support the Care of Those in Their Last Year of Life* was launched in November, recommending a series of measures to be adopted to enhance the ability of GPs and primary care teams to deliver **quality care** to people dying in the community.

In addition:

- Thirteen sites received project funding under the Dignity and Design process to **improve care at end-of-life services**.
- **Referral criteria** and assessment of need for specialist services were developed and piloted in Our Lady's Hospice, Dublin.
- A **Bed Review Working Group** was established to scope and review intermediate palliative care support beds and make recommendations.
- Ireland's first health promoting palliative care demonstration project took place in North West Limerick. The **"Compassionate Communities"** project has just completed the first year of the pilot phase. Through the project, Milford Care Centre is working actively with the community in a number of different ways to engage people in issues around death, dying, loss and care.
- Ireland secured the bid to host the third **International Public Health and Palliative Care Conference** in April in Limerick, through a joint venture between Milford Care Centre and the University of Limerick.

New initiative to aid grieving families launched at Wexford General Hospital

A symbol for display in particular parts of the hospital to alert other patients, visitors and staff that a patient has just died, was launched at Wexford General Hospital in February.

The staff at the hospital were very aware of the need to identify a discreet way of informing people that a death has taken place and that grieving family were nearby in order to prompt an atmosphere of quiet, respect and sensitivity in the immediate area. The 'End-of-Life Care' symbol, available through the Hospice Friendly Hospitals initiative, is a three-stranded white spiral against a purple background.

As well as the symbol being displayed as required at room/ward level, framed versions of the spiral symbol, accompanied by an explanation of its meaning, are displayed in the hospital foyer and corridors so as to inform patients, staff and the public of its purpose.

Photographed at the Awards Ceremony at Drapers Hall in London are: Jason Harries, Managing Director CHKS, with Sean O'Healy, Mari Gallagher and Claire Hahessy of Galway Hospice.

Galway Hospice

Galway Hospice was awarded the CHKS International Quality Improvement Award for 2011. CHKS Quality Awards celebrate the dedication of healthcare providers across the UK and Europe in providing world class healthcare, and reward outstanding achievements in patient care and the patient experience, as well as staff welfare, safety and morale. One award is made each year. Galway Hospice had previously received CHKS accreditation and ISO 9001:2008 Certification in 2010, the first hospice in Ireland to achieve dual world class standards across all of its services.

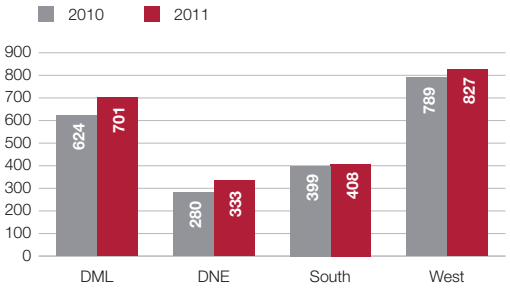
Sligo Summer School on End-of-Life Care

Twenty six participants from acute, residential and community settings attended a summer school on end-of-life care, in July in Sligo. The focus of the school was to develop an understanding of aspects of practice development within the context of person centred care at end-of-life.

The theme of the inaugural Introductory Practice Development Summer School was 'Fostering a Culture of Effectiveness in End-of-Life Care'

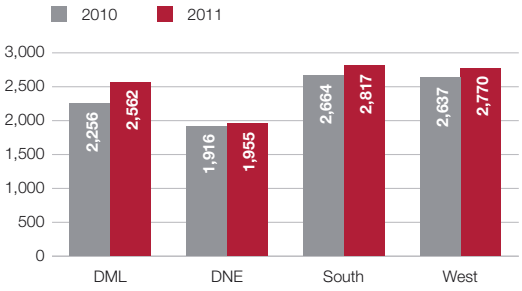
The programme, the first of its kind in the Irish health service was jointly supported in partnership with the HSE and the Network of Hospice Friendly Hospitals. The school was developed in conjunction with the International Practice Development Collaborative.

Figure 30: Total no. of patients (new plus existing) in receipt of specialist inpatient palliative care 2010-2011



Data source: HSE Performance Reports

Figure 31: Total no. of patients (new plus existing) in receipt of specialist palliative home care 2010-2011



Data source: HSE Performance Reports

Palliative Care Services for Children

The appointment of Ireland's first Consultant in Paediatric Palliative Care to give clinical leadership and direction for the further development of children's hospice/palliative care services was made in 2011, based in Our Lady's Children's Hospital, Crumlin, Dublin and funded by the Irish Hospice Foundation (IHF). Children and their families will be further supported through the development of a network of eight Children's Outreach Nurses (two per region). The nurses will provide advice and support to other health professionals involved in the care of very sick children at home. The first of these nurses has been in post in the Children's University Hospital, Temple Street, Dublin since 2009, with the second appointed to Our Lady of Lourdes Hospital, Drogheda during the year. The remaining nurses will be in post by mid 2012.

Capital Developments

- The opening of a new **St. Patrick's Hospital/ Marymount Hospice in Cork**, and the transfer of all patients and staff from its original base in Wellington Road, to the new facility at Curraheen, Cork was a momentous occasion in September. Services delivered include a 24 bed specialist inpatient unit with capacity to increase to 44 beds – these will become fully operational as resources are made available. It also accommodates a day centre, outpatients, education centre, community based specialist teams, and associated facilities to meet the needs identified in the regional needs assessment. The development also accommodates 63 care of the older person beds.

New building for St. Patrick's Hospital/Marymount Hospice, Curraheen, Cork.

New facility at St. Francis Hospice, Blanchardstown, Dublin.

- **St. Francis Hospice** opened a second hospice facility in Blanchardstown, Dublin. The Community Palliative Care Team (West) continues to provide its services within the community from St. Francis Hospice, Blanchardstown. Hospice day care and outpatient services are also being provided for patients on two days a week. The facilities within the new hospice include an inpatient unit, comprising 24 single patient rooms and some family overnight accommodation. The opening of the inpatient beds will be progressed in 2012.

Valuing Our Staff

Feargal Twomey

Consultant in
Palliative Medicine
Milford Hospice and
Mid-Western Regional
Hospital, Limerick

I returned to Ireland in 2010 to work as part of the multidisciplinary team at Milford Care Centre, Limerick having previously worked as a Consultant in Palliative Medicine in Manchester, England. In my role I also provide advisory and consultative support to the Mid-Western Regional Hospital (MWRH), Limerick, as part of the Specialist Palliative Care team there.

The specialist palliative care service based at Milford Care Centre represents the model of service delivery envisaged in the 2001 Report of the National Advisory Committee on Palliative Care. We provide specialist services in our hospice inpatient unit, day care and outpatients and in the patient's home via our hospice at home (Homecare) team in Counties Clare, Limerick and North Tipperary. There is full multidisciplinary input from medical and nursing staff, physiotherapists, occupational therapists, pastoral care, social worker and others in each care setting.

Our work in the acute hospitals includes encouraging earlier referrals to our service in order to facilitate specialist intervention and support as early as possible in a patient's illness. The growing number of referrals of patients with non malignant disease (24% last year) at the MWRH represents our success in this area to date. We continue to build on our working relationships across the hospital including in paediatrics, intensive care and the Emergency Department. Our key message is that palliative care can work in parallel with acute care to help patients with progressive and incurable illness to live as well as they can until they die.

Part of our role is to also help inform and change perceptions that people in the wider community have of palliative care, hospice care, death and dying and to raise awareness of what we do at Milford. For example people may not realise that many (55% in the last six months) of the patients admitted to our hospice inpatient unit are discharged to home. In addition, our innovative Compassionate Communities project is working with individuals and groups in the community of North West Limerick to enhance the social, emotional and practical support available for those living with the experience of death, dying, loss and care.

A very welcome development at Milford has been the appointment of a third Consultant in Palliative Medicine in August 2011, providing support to St. John's Hospital, Limerick. We are also continuing to strengthen our educational and research links with the University of Limerick (UL) and now, for the first time, we have graduate entry medical students coming through the hospice on clinical placements. One example of this collaboration in the research arena is the evaluation of the hospice at home service delivered by Milford Care Centre, launched in April 2012. The Centre will also host the 3rd International Public Health and Palliative Care Conference in April 2013.

I am the current Clinical Lead for Palliative Care for the HSE West, under the auspices of the Clinical Strategies and Programmes Directorate. This role involves working regionally to re-energise a collaborative approach to both the consolidation of current services and the strategic development of future services across the West in line with the national vision.

Like many other areas in the health services, Ireland's financial difficulty has impacted on palliative care. In Milford's case, two years of successive cuts to our budget have led to a reduction in number of our inpatient beds. Though this was a challenging step for us to take we recognise the opportunity it presents for us to again review all aspects of the services we provide.

Tackling Social Exclusion

Introduction

Poverty and social exclusion have a direct impact on the health and well-being of the population. Our aim is to improve access to mainstream and targeted health services, address inequalities in health and enhance the participation and involvement of socially excluded groups and communities in the planning, design, delivery, monitoring and evaluation of health services. In partnership with other agencies to address these issues, the HSE continued its work during the year to help socially excluded, vulnerable and at risk people to access and utilise the health services they required.

This included addressing the health impacts of addiction and/or substance misuse, HIV/AIDS, focusing on adult homelessness, lesbian, gay, bisexual and transgender (LGBT) health issues, and supporting Travellers, Roma and other ethnic minorities.

Supporting People with Addiction and Substance Misuse

The Pharmacy Needle Exchange Programme, a partnership initiative between the Elton John Aids Foundation, Irish Pharmacy Union and the HSE became operational during October. Targeting areas outside of Dublin, the programme will be run over a three year period with
65 pharmacies trained and recruited to provide needle exchange each year. At the end of the year, 24 pharmacies were operational.

Work also commenced on the development of *A Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use in the Emergency Department and Acute Care Settings for Nurses and Midwives*. The framework supports safe, quality and effective care for service users and promotes the effective management of problem alcohol use in acute, primary and community care settings. As part of this:

- An online alcohol self-assessment tool and video-based brief intervention was developed. The aim of the online intervention is to identify at risk individuals among the general population (www.drugs.ie).

In 2011

- **10,711 clients were in receipt of methadone maintenance treatment.**
- **100% of people under 18 years commenced treatment for substance misuse within two weeks following assessment.**
- **85% of people admitted to residential homeless services have a medical card.**

In addition, the National Drug Treatment Reporting System (NDTRS), reporting a year in arrears, showed:

- **52% rise in people entering drug treatment (2005 v 2010).**
- **Most common problem drugs were opiates (57%), cannabis (25%) and cocaine (9%).**
- **42% increase in numbers treated for alcohol problems (2005 v 2010).**

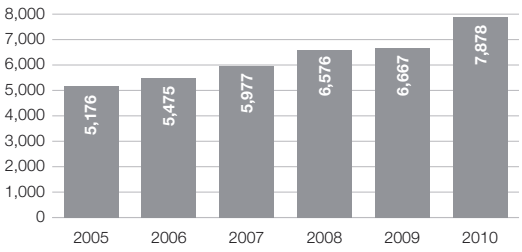
- A feasibility test for screening/brief interventions in four hospital EDs was completed in July. The results showed good co-operation from the public, with only 6% declining to be screened. The tool detected 36% requiring brief advice, 9% required referral to specialist services and 49% required no further intervention.
- An alcohol publications section has been developed at www.hse.ie/go/alcohol to collate existing HSE alcohol reports and include resources from the project and relevant alcohol related evidence as it becomes available.
- In November, the second National Drugs Conference of Ireland took place. The theme of the conference, 'Drug Interventions: What Works?', focused on delegates learning from each other by exchanging ideas, sharing knowledge and best practice as well as showcasing evidence based projects that have worked both here in Ireland and internationally.

Substance Misuse

Did you know…?

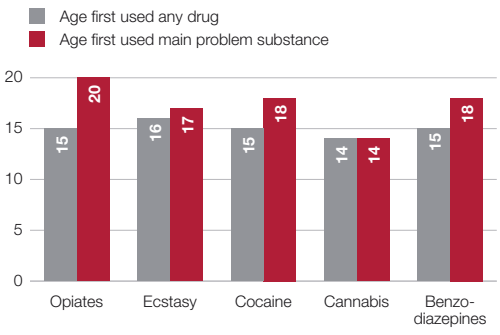
- **In 2010, 9.3% of cases receiving treatment for problem drug use were under 18 years of age, and 5.9% were still at school.**
- **72.5% of cases were male, a figure which showed a decrease of slightly more than 2% since 2005.**
- **48.5% of cases were living with their parents or other family members, while 3.9% were homeless.**
- **Early school leavers, in 2010, accounted for 18.6% of cases in treatment.**
- **The number of cases receiving treatment who reported being in employment dropped to 9.1% in 2010, against 22% in 2005.**

Figure 32: No. of problem drug use cases entering treatment 2005-2010



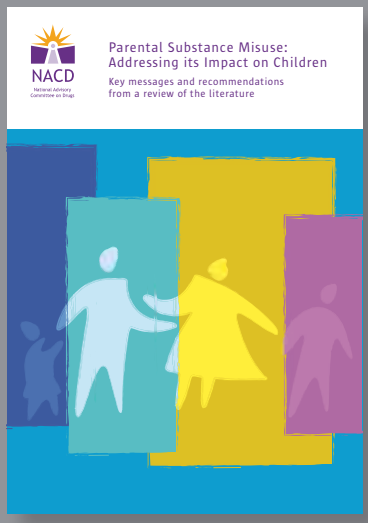
Data source: National Drug Treatment Reporting System

Figure 33: Median age at first use of any drug v first use of main problem substance – 2010



Data source: National Drug Treatment Reporting System

Parental Substance Misuse: Addressing its Impact on Children



In October, a new report Parental Substance Misuse: Addressing its Impact on Children was presented at a seminar jointly hosted by the National Advisory Committee on Drugs (NACD), the HSE and Alcohol Action Ireland. Children of substance misusers are more likely to experience problems with mental health, social skills, academic achievement and substance use. The report reviewed all major international research on the impact of parental substance misuse on children and identified what steps can be taken in Ireland to reduce its impact. The report also highlighted the consequences of substance misuse during pregnancy which can have harmful effects on the baby.

It identified that there is a need for more integrated working between addiction services, children's services and medical professionals to help reduce the negative impact of parental drug and alcohol misuse on children and the wider family.

Other areas of work included:

- A **HSE National Traveller Health Advisory Forum**, comprising HSE and Traveller representation, was established
- In September, the *Birth Cohort Follow Up Report of the All Ireland Traveller Health Study* was published. The report presented the one year follow-up of **Traveller infants** born on the island of Ireland between October 2008 and October 2009. This research investigated health-related issues of maternal and infant health status and the health services utilisation experience of 508 Traveller families and their infants, completed with the co-operation of Traveller mothers themselves, public health nurses and other healthcare staff.

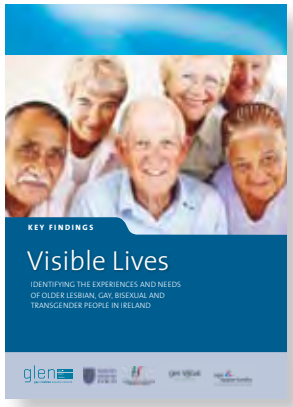
HSE National Intercultural Health Strategy 2007-2012

The National Intercultural Health Strategy provides a comprehensive framework within which the unique health and care needs of people from diverse minority ethnic communities may be addressed. A number of resources, including the Emergency Multilingual Aid and Intercultural Guide, have been developed under the aegis of the strategy, aimed at supporting staff in delivering culturally competent services.

Lost in Translation? is a resource produced in 2011, to support staff in planning, managing and assuring quality translations of health related material into other languages in a cost effective manner that is also in accordance with good practice. As Irish society has become increasingly diverse, new measures are required to enable the health system to respond appropriately to the needs of service users from all groups, including those who come from a range of ethnic, cultural and language backgrounds.

Provision of multilingual resources is a proven means of assisting service users from diverse backgrounds to access and navigate health services more effectively and appropriately. Such information assists those who may not be functionally literate, may have hearing or sight impairments, may not be competent in the English language, or who may need information presented in "plain English" with a number of pictorial aids. A database has also been developed of health related translated information.

- **Roma** are among the most disadvantaged, vulnerable communities in Europe. Efforts were commenced via the Government High Level Group on Travellers to develop a National Roma Integration Strategy within the framework of the European Union Framework for National Roma Integration Strategies. In recognition of the need to address the health needs of the Roma community in Ireland, a **Roma Outreach Worker** has been funded. A series of thematic seminars were held in collaboration with Pavee Point and HSE children and family services
- The development and implementation of **screening programmes** targeting vulnerable groups due to commence in 2011, was delayed and will commence in early 2012.
- The HSE was represented on a number of cross departmental groups to address the **health impacts of exclusion**, including the National AIDS Strategy Committee, Drugs Advisory Group, Local and Regional Drug Task Forces, Homeless Regional Consultative Forums/Regional Management Groups, Inter-departmental Group on Refugee Resettlement, etc.
- The HSE supported the **National HIV Prevention and Sexual Health Awareness Programme** for men who have sex with men (MSM), launched by the Gay Mens Health Service, in association with Dublin City Council and the HSE.
- **The Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010** held implications for delivery of health services to same sex couples and their families. Aspects of entitlements to services, informed consent and parenting were particularly relevant. During 2011, consultation took place with GLEN (Gay and Lesbian Equality Network) to explore these and guide staff to advise, support and effect actions effectively, sensitively and appropriately.
- In partnership and close collaboration with all local authorities and voluntary agencies, we continued our work to **support the homeless**, implementing models such as Pathway to Home in the greater Dublin region.
- A draft strategy and action plan was developed to support **LGBT communities** to access and use health services. The consultation phase on this will conclude in quarter two, 2012. Also, in partnership with GLEN, Trinity College Dublin and Age and Opportunity a number of research projects were undertaken on LGBT people including *Visible Lives, Identifying the experiences and needs of Older Lesbian, Gay, Bisexual and Transgender people in Ireland and LGBT Minds*, exploring the experiences of LGBT people in mainstream health services.



Traveller Health

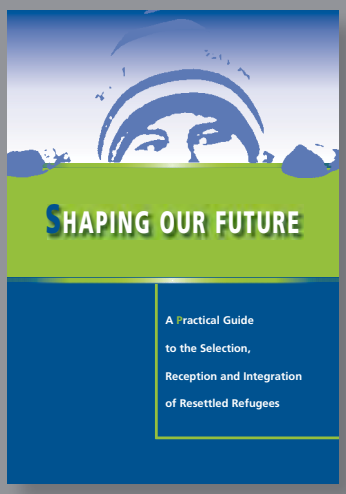
Did you know…?

- **Traveller parents are younger in comparison to the general Irish population (difference of 7.1 years for fathers and 5.7 years for mothers).**
- **Traveller mothers have a shorter birth gap between pregnancies, higher parity and stillbirth rates compared to the general population.**
- **On average, 5% of Traveller mothers have had at least one stillbirth compared to the 1.6% average of the general population.**
- **The breastfeeding rate for Travellers is still very low. Just over 2% of Traveller mothers initiated breastfeeding compared to around 50% in the general population.**
- **Average birth weight of Traveller infants was comparable to the general population.**
- **Community-based health services, PHNs and GP services are the main services used by Traveller mothers and their infants in the first year of life.**
- **While Traveller infant mortality rates have decreased, they still have a higher infant mortality rate than the general population (12.0 per 1,000 live Traveller births in 2008/2009 and 14.1 in 2007/2008 compared to 3.9 and 3.2 per 1000 live births in the general population for the same periods).**

At the launch of the MSM campaign with the Lord Mayor of Dublin, Andrew Montague and Minister of State Roisin Shortall, TD.

Photo: Jason Clarke Photography.

Refugee Resettlement Programme



The Refugee Resettlement programme began in 1998, with 40 persons resettled in 2000. In 2005, the quota was increased to 200 persons per year, to be introduced on a phased basis. Up to the end of 2011, 994 refugees arrived in Ireland under the programme from 27 different countries of origin and 38 different countries of refuge. The refugees are resettled in 18 different Irish towns, in 15 different counties. The numbers accepted for resettlement in recent years have been reduced due to the current economic crisis, from 192 arrivals in 2009 to 20 in 2010 and 45 in 2011. It is expected that approximately 50 persons will be admitted in 2012 which will include five serious medical cases.

Every effort is made to ensure that the resettlement places are allocated where they will have the greatest impact. In 2011, 24 places were offered to refugees in Libya who had been displaced once again due to conflict there, ten places assisted the Government of Malta where the numbers of asylum seekers had increased dramatically in recent years, and two medical cases were also admitted during the year.

When accepting persons for resettlement under an international programme, there is the expectation that the needs, especially medical and educational needs, will be addressed within a specific period post arrival. The HSE works very closely with the Resettlement Unit in the Department of Justice and Equality to ensure that these commitments are met from a health perspective.

Collaborative interagency working, and the response from community and voluntary sectors, has been crucial in ensuring the success of this programme, facilitating a smooth arrival, access to services, and integration of this vulnerable cohort of people.

Valuing Our Staff

Thomas O'Brien

Addiction Services Manager
HSE Dublin North East,
Ballymun

One of the main highlights for our services in 2011 was the Dublin North City Addiction Service team working with the HSE Organisational Development and Design Department to create a strategic three-year work plan for the service.

We wanted to refocus our attentions on the National Drugs Strategy and the important leading role that we, as a service, have to play in delivering on its recommendations. The senior managers in consultation with staff worked together to formulate needs based plans in light of the forthcoming merger of alcohol misuse into the strategy, along with other recommendations contained within the substance misuse policy. While the concept of organisational change can be daunting, so far we have had a positive experience. The new plan offered ideas on new ways of working, which continue to have a positive impact on how the addiction service operates. The plan set out guidelines on the needs of the addiction service for the future, particularly the need for a more integrated approach between us and primary care services. As the prevalence and nature of drug and alcohol use increases, I must commend the staff for their willingness to adapt to the challenges this will bring in the future.

I am particularly glad to see that despite the necessary budgetary restrictions which were implemented over the past number of years, the multidisciplinary teams within the addiction service have worked tirelessly to ensure that the quality of client care remains a central focus of the service.

Many staff have left the service without being replaced and this has meant that many difficult adjustments have had to be made to ensure clients struggling with an addiction are looked after in the same professional manner as before. It is good to see that staff remain committed to teamwork, and continue to share a vision for the future for this ever growing problematic, yet vulnerable, patient group. Management, staff and union officials worked together to reach agreement on opening hours, sessional hours, cost containment initiatives and internal reconfiguration. It is important to me to acknowledge the effort and support offered in what were, at times, difficult negotiations. While there was initial concern at the prospect of loss of earnings, staff showed integrity and professionalism in coming to an agreed way forward.

Another positive development was that while there has always been input from service users, it was acknowledged that there was a need for more. Apart from maintaining a quality service despite funding restrictions, and an acknowledgement that the addiction services require a new structure, we have also increased service user involvement on our clinical governance committee and our strategic committee. This involvement acknowledges the necessity of having informed input on how to make the service even better. We are confident that in the coming years further major improvements will be forthcoming.

There has been much willingness for staff to work together in a more 'synergised' manner within our own service, and also through a shared approach with other statutory, voluntary and community organisations. We have seen a number of changes in our management structure bringing about reform in the service to address emerging needs. This involved the creation of a number of sub-committees for issues such as cost containment, primary care integration, clinical audit, etc. Other advice groups have come together to share knowledge and experience about how best to deliver on issues of importance. Most of the initiatives undertaken at the time were genuinely a cause for concern, yet matters were progressed with sensitivity leading to a more self critical addiction service re-engaging with a client centred approach. Our service is better because we recognise a need for broader addiction issues to be addressed within a framework of client-led care planning. Our service has seen the need for a radical shift in emphasis and yet despite the potential challenges envisioned, we have embraced the concept of change.

Delivering Services in Our Regions

Dublin Mid-Leinster

Introduction

The HSE Dublin Mid-Leinster (DML) region manages the delivery of a range of health and personal social services to the people of Dublin city, south of the River Liffey, south County Dublin, Dun Laoghaire/Rathdown and all of counties Kildare, Wicklow, Laois, Offaly, Longford and Westmeath. The primary aim is to deliver quality health services to the highest standards possible to the people of the region while remaining within voted budget and in the context of reducing staff numbers.

The focus in 2011 was on a number of key areas to ensure that services were delivered in a seamless, efficient and cost effective way, facilitating easy access for clients and addressing areas of greatest need. Some of these included:

- Developing stronger clinical networks between hospitals within the region
- Progressing implementation of national Clinical Programmes in the region's acute hospitals
- Ensuring service priorities in all care groups were monitored for progress against targets
- Continuing the preparation of the three paediatric hospitals in Dublin for migration to the new National Paediatric Hospital.

The programme of reconfiguration and reorganisation continued to be the focus throughout the year to ensure its responsiveness to demographic changes, clinical advancements and the increasing demand for services including those of the elderly population.

Some significant developments in 2011 included:

- Opening a six bed Acute Medical Assessment Unit in the newly opened Midland Regional Hospital, Tullamore, as part of the national acute medicine programme
- Opening a new Paediatric Intensive Care Unit at Our Lady's Children's Hospital, Crumlin
- Commencing a capital project at St. Mary's Care Centre, Mullingar for a 90 bed community hospital, expected to be completed in early 2012
- Strengthening access to primary care services. There are 140 Primary Care Teams (PCTs) now in place in DML.
- Opening of Clonskeagh Community Nursing Unit (CNU) which is registered for 94 beds

Regional highlights during 2011 included:

Cancer

- Official opening of a new National Surgical Centre for Pancreatic Cancer at St. Vincent's University Hospital

Disability

- Resettling 12 people from a congregated setting through the consolidation of other services, with a further four to move in the near future

Primary Care

- Setting up an initiative for stroke survivors by the PCT in Tallaght with the Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH)
- Expansion of MIDOC out of hours GP services to Tullamore and Edenderry in Co. Offaly, Moate, Co. Longford and Glasson, Co. Westmeath

Palliative Care

- Further development of End-of-Life care initiative at Naas General Hospital

Children and Families

- Continued roll out of the Triple P (Positive Parenting Programme) in Longford and Westmeath

Promoting and Protecting Health

- Free health screening and information service to all visitors at the National Ploughing Championships, Kildare

Quality and Safety

- Embedding the Nursing Instrument for Quality initiative in AMNCH

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH...

Modernising healthcare facilities

The Midland Regional Hospital, Tullamore was opened in March. Built at a cost of €150m, the hospital has 247 beds in operation and a 21 bed day hospital and is the regional centre for orthopaedics and ENT. It also provides specialised services such as oncology/haematology, coronary care and renal dialysis. The hospital has four major operating theatres along with two day theatres, an endoscopy suite and a minor procedures room. The full range of clinical support services are available on site including physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and dietetics, pastoral care, oncology pharmacy and general pharmacy. Complementing the above services the hospital has a state of the art radiology department including MRI, incorporating PACS technology, along with a fully accredited blood transfusion, haematology and histology laboratory. It is envisaged that microbiology and biochemistry will receive full accreditation status by the end of 2012. Other important services include a vascular laboratory and cardiology unit with a visiting angiography service.

L-R: Orlaith O'Brien, Director of Nursing; Dr. Gerard Crotty, Clinical Director; James Conway, HSE Assistant National Director; the then Taoiseach Brian Cowen; Miriam Horan, Midland Regional Hospital, Tullamore; Jason Henshaw, Midland Regional Hospital, Tullamore and Gerry O'Dwyer, Regional Director of Operations, DML.

Enhancing patient care and recovery

The official opening of the **new Paediatric ICU at Our Lady's Children's Hospital, Crumlin** took place in June. The project, at a cost of €9.8m, provides a vastly improved environment for patients and their families. Children and adolescents from all counties of Ireland began receiving care in the new Unit from March. The quality of care that patients receive in the unit matches the best available internationally.

Patient Amy O'Gorman and her parents Tom and Jacinta at the official opening of the new Paediatric Intensive Care Unit in Our Lady's Children's Hospital in Crumlin.

Undertaking innovative projects

A grant of €271,000 was awarded from the GENIO Trust to the **PROTECT (Personalised Recovery Orientated Treatment, Education and Cognitive Therapy) Project**, a partnership initiative involving existing health, training and social care providers in Wicklow, which aims to improve engagement with individuals diagnosed with psychosis and the early intervention services (DETECT). The GENIO Trust aims to harness innovation and best practice within services for individuals with disability or mental health difficulties. The objective of the project is to ensure that those identified in need of early intervention by DETECT in Wicklow are able to access all of the services they need or choose. A set of targeted interventions including cognitive therapy, occupational therapy and family and carer education will be delivered in conjunction with DETECT and their own community mental health team.

L-R: Dr Justin Brophy from Newcastle Hospital, Angela Lane, Ciaran Cobbe, Eimear Connaughton, Bridget Harney, Dr Brian Fitzmaurice, Mark Meakin from PROTECT and Martin Rogan, HSE Assistant National Director for Mental Health at the launch of PROTECT.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

The HSE EVE Plantmarket Training Centre featured a garden design focussing on **Mental Health Recovery at Bloom**, Ireland's largest gardening event. The garden focussed on the message that there is hope and recovery for those who experience mental illness. It was designed and built by the students of EVE Plantmarket and charts man's journey to recovery from mental health difficulties. The garden was a positive example of the work being undertaken in the implementation of the national mental health policy Vision for Change. The garden achieved a bronze medal in the engaging space section and came second, by one vote, in the People's Choice Awards.

L-R: Martin Rogan, Assistant National Director, Mental Health; Brent Pope; John Sweeny, HSE Eve Plantmarket and Margaret Webb, General Manager, Eve Plantmarket.

Integrated working and provision of person centred care

A new PCT, serving more than 5,000 people was set up in Rathdrum, Co. Wicklow. A comprehensive range of health and social services, with the support of local GPs, is now available for Rathdrum and the surrounding areas of Aughrim, Ballinacash, Ballinacor, Ballinderry, Knockrath and Tropperstown. The range of integrated services available includes community nursing, physiotherapy, occupational therapy, home help, social work for all age groups, dietetics, speech and language therapy, psychology services, adult mental health and dental services. The PCT will be further enhanced when the new Primary Care Centre is established.

L-R: Marion Meany, Local Health Manager; Fionnuala O'Mahoney, Primary Care; Dr. Philip Sheeran-Purcell, GP; Elizabeth Doyle, TDO/MSOP and Dr. Rick Aboud, GP Unit.

Dublin North East

Introduction

The HSE Dublin North East (DNE) region covers Louth, Meath, Cavan and Monaghan, Dublin city and county, north of the River Liffey and is responsible for the direct and indirect provision of public health and personal social services to a population of 1,019,658. Against the backdrop of reduced budgets and staffing resources, the ongoing challenge for the region is not only to maintain access, quality and safety of services but to continue to improve them. Staff continued to meet these challenges with dedication and respect for the dignity of service users.

In 2011, DNE prioritised the acceleration of the HSE's reform programme to reconfigure core services in line with strategy, deliver an appropriate balance between hospital and community services, focus on best care models in childcare, disability, mental health and older people services, and progress the implementation of the national clinical change programmes.

Significant developments for the region included:

- Opening an Endoscopy Department at Connolly Hospital, Blanchardstown to provide rapid access endoscopy referral for patients presenting to the Emergency Department (ED)
- Three new operating theatre suites opening at Cappagh Hospital, specifically designed for orthopaedic surgery
- A Stroke Rehabilitation Unit at Louth County Hospital, Dundalk whereby a structured comprehensive rehabilitation programme is developed by staff in conjunction with the patient and their family/carers
- Strengthening services at the Mater Misericordiae University Hospital (the Mater) with the opening of the Maurice Neligan Congenital Heart Clinic at the Young Adult Congenital Unit
- Implementing the Mater's Nurse-led Synge Interim Care Unit in Fairview Community Unit
- Progressing services for older people with the opening of new Community Nursing Units (CNUs) at St. Joseph's, Raheny and Beaufort House in Navan
- Building started on a new acute psychiatric unit at Beaumont Hospital, due for completion in 2013. This will replace services historically provided in St. Ita's Hospital, Portrane
- Enhancing the Rotunda Hospital's community midwifery services with the provision of DOMINO (home birth) care to the women of Ballymun, along with Finglas and Cabra. The hospital's Early Transfer Home Programme was expanded to facilitate the increase in births. In addition, midwifery-led clinics in Swords and Blanchardstown were reconfigured

Regional highlights during 2011 included:

Acute and Pre-Hospital Care

- Beaumont Hospital's Richmond Neurosurgical Intensive Care Unit was ranked fourth and the hospital's general Intensive Care Unit (ICU) ranked ninth in an international ICU nutrition survey

Cancer

- Louth County Hospital and Cavan General Hospital selected as candidate sites to deliver colon cancer screening

Palliative Care

- Opening of a new day service at St. Francis Hospice on the grounds of Connolly Hospital, Blanchardstown

Mental Health

- Mental Health Services for Older People Unit, North Dublin temporarily relocated to a new CNU in St. Vincent's, Fairview

Disability

- Formal opening of Knockamann Kafé which provides skill development opportunities for clients
- Launch of a new web-based resource by Beaumont Hospital to help teachers of children with mild acquired brain injury
- Opening of Hillside, a new centre for children and their families in Cavan

Promoting and Protecting Health

- Be Active After School Activity Programme launched which won a Crystal Clear Health Literacy Award
- Opening of a sexual health clinic in Monaghan Hospital funded by CAWT, the cross border health services partnership
- Piloting an alcohol misuse prevention project called 'Take Care' by the Health Promotion Department

Social Inclusion

- Social inclusion programme (CAWT) established in the Cavan/Monaghan area offering a range of free health improvement programmes for older women

Primary Care

- Community Response Team, Louth accepting referrals as an admission avoidance measure from Our Lady of Lourdes Hospital

Children and Families

- The first independent study into the use of the Marte Meo method in Ireland was launched. It is used to support parents of children with communication and developmental difficulties

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

Enhanced and appropriate access to hospital services

A new eight bay **Medical Assessment Unit (MAU)** opened in Our Lady of Lourdes Hospital, Drogheda in May. This enhanced service now provides appropriate access for all patients presenting to hospital with medical complaints. This in turn has reduced pressure on the hospital's ED, reduced waiting times and inappropriate admissions to inpatient beds.

Staff check the equipment in the new MAU.

In July a new dedicated **Paediatric Assessment Unit (PAU)** opened in Cavan General Hospital. The unit treats all acutely ill children up to 15 years for urgent illnesses such as high temperatures, chest conditions, infections, abdominal pain, vomiting and diarrhoea. The PAU is staffed at all times by two nurses who have specialised training and paediatric experience. Medical support is provided by the on-call paediatric consultant, registrar and senior house officer as well as by the on-call surgical team.

L-R: Dr Alan Finan Consultant Paediatrician and Clinical Lead for Women and Children's Services, Cavan and Monaghan Hospital Group; Siobhan Flanagan CNM II PAU; Dr. Mohammad Waqar Khan, Paediatric Registrar; Martina Halton, Staff Nurse PAU; Zeny Dolor and Vince Dolor (mother and patient).

Responding to health needs

We know through research that 26% of children in Ireland are overweight and 7% are obese. In response to this the HSE, together with the Border Counties Child Care Network (BCCN) and other statutory and voluntary bodies, have developed the **Up4it**! project which has been made possible through EU funding secured by CAWT. Up4it! is now available for free to families in the Cavan-Monaghan region and is aimed at families who have children aged between eight and eleven years who are overweight according to their body mass index and have no medical cause for being overweight or obese.

L-R: Claire McGinley, Project Manager, CAWT Obesity Project; Denise McCormilla, CEO, Border Counties Childcare Network; Irene Cunningham, Dietician, HSE and Gerry Roddy, Health Promotion Manager, HSE DNE.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH...

Raising awareness and standards

Enhancing services to older people, a group of 25 health care staff from community, residential and acute services across the DNE region completed the **first Enhancing and Enabling Well-Being for the Person with Dementia** three day programme. The new programme was developed by the nursing and midwifery services as part of a National Dementia Training Project and has been disseminated for national roll out. Developing a patient centred approach to the care of people with dementia is central to improving their quality of life. Fundamental to delivery of this care is the provision of education and training programmes that are accessible to all health care practitioners caring for people with dementia.

L-R: Margaret McMenamin, Community Mental Health Nurse; Elizabeth Reilly, Specialist Co-ordinator and Tim O'Sullivan, Community Mental Health Nurse.

Development of client skills

The new **Knockamann Kafé** located in the Day Resource Centre of the Knockamann development, St. Joseph's Intellectual Disability Service in Protrane, Co. Dublin was officially opened in November. The Knockamann development is a customised residential development, comprising ten bungalows, each with six individual bedrooms and a comprehensive Day Resource Centre. Knockamann Kafe is an integral part of the Day Resource Programme and provides opportunities for clients to develop skills such as customer services, handling money, time keeping, food preparation and the opportunity to work towards recognised accredited qualifications.

L-R: Staff members and clients: Ann McKenna, Damien Cullen, Siobhan Farrell, Linda Kavanagh, Teresa Lennon and Gerry Clail pictured with the then President Mary McAleese.

South

Introduction

The range of service reorganisation and cost reduction initiatives implemented during the year enabled the HSE South to deliver services within the financial and staff resources available to it in 2011. More importantly all areas successfully implemented a challenging programme of change, including new models of care, while delivering high-quality and safe services to the public. This was a significant achievement given the challenging service demands faced by staff which clearly demonstrates our staff's energy and commitment to the delivery of quality health services to our service users.

During 2011, a number of significant changes took place:

- Re-organisation of acute hospital and community services in Cork city, transferring:
  - medical rehabilitation services for older people from South Infirmary Victoria University Hospital (SIVUH) to St Finbarr's Hospital, Cork
  - cardiology services from SIVUH to the Cardiac Renal Centre, Cork University Hospital (CUH)
  - elective orthopaedic and trauma rehabilitation services, elective pain and elective plastics from St. Mary's Orthopaedic Hospital (SMOH) to SIVUH. Three new operating theatres were built to accommodate the service at SIVUH
- Night time closure of the Emergency Department (ED) at SIVUH in line with restructuring of emergency services city wide.
- Development on SMOH site to create St. Mary's Health Campus incorporating plans for:
  - an Urgent Care Centre to treat patients with minor injuries from Cork city and surrounding areas
  - a new Primary Care Centre
  - reorganisation of accommodation, Grove House (for people with intellectual disabilities)
- Increased long stay bed capacity for older people such as the opening of purpose built Community Nursing Units (CNUs) at Heather House (grounds of SMOH), Farranlea Road and Ballincollig
- New community mental health teams and centralisation of acute inpatient units in line with recommendations in Vision for Change in Waterford/ Wexford, Carlow/Kilkenny and South Tipperary
- Transferring of acute mental health admissions from St. Senan's Hospital, Enniscorthy to purpose built unit in Waterford Regional Hospital
- Three Home Based Treatment Teams and two new Acute Day Services (Day Hospitals) became operational in South Tipperary, Carlow and Kilkenny enabling service users to receive treatment in their own homes and communities
- HSE South is working with the National Service Users Executive to develop a comprehensive framework for service user involvement in mental health services
- Increased surgical day procedures in Kerry General Hospital (KGH) through the national casemix adjustment mechanism
- Increased outreach services in Kerry by consultant surgeons and geriatricians, supporting community hospitals and primary care teams
- Delivering on targets set by the Special Delivery Unit (SDU), DoH for scheduled and unscheduled care through increased integrated and flexible working between community and hospital services

Regional highlights during 2011 included:

Acute/Pre-hospital and Maternity

- Opening of day procedures unit and pre-operation assessment unit, KGH
- Opening of new acute medical unit and a new haemophilia centre, CUH
- CUMH, lead hospital in Europe using robotic surgical system for gynaecological surgery
- Opening of new CT scanner, Wexford General Hospital
- Major capital development including:

  Construction of new:
  - Community Hospital, Kenmare, Co. Kerry
  - ED in KGH
  - ED extension including neonatal unit, Waterford Regional Hospital

  Approval for new:
  - ED, concourse and maternity theatre/ delivery suites, Wexford General Hospital
  - ED, medical assessment unit, day services unit and hospital concourse, St. Luke's Hospital Kilkenny

Older People

- Redevelopment of St. John's Community Hospital, Enniscorthy, Co. Wexford
- Opening of new Community Nursing Units (CNUs) at Heather House, Farranlea Road and Ballincollig

Disability

- Official opening of Central Remedial Clinic facility, Waterford

Mental Health

- Opening of purpose built day hospital in Gorey, Co. Wexford
- Opening of Tús Nua, rehabilitation unit on the grounds of St. John's Hospital, Enniscorthy
- Self harm reduction programme for persons diagnosed with borderline personality disorder successfully completed in Cork
- Child and adolescent mental health service transferred from St. Stephen's Hospital, Glanmire, Co. Cork to new child and adolescent inpatient unit, Bessboro, Cork city

Children and Families

- Newborn hearing screening programme commenced for all newborns in Cork, Wexford and Waterford

Primary Care

- Primary Care Centres in Mahon, Cork city; Gorey, Co. Wexford; Waterford (Waterford Health Park), Kilkenny city (Ayrfield) and Carlow (Shamrock Plaza)
- Healthcare award received by Primary Care Team, Kinsale, Co. Cork
- New podiatry service in Cork, Kerry, Wexford and Waterford resulting in enhanced diabetes service

Cancer

- Opening of a new rapid access prostate clinic in Waterford Regional Hospital

Palliative Care

- Transfer of St. Patrick's Hospital/Marymount Hospice, Cork to a new hospital at Curraheen, Cork

Social Inclusion

- Refurbishment of community mental health and addiction treatment centre in Waterford
- Opening of new Methadone Clinics in Cork

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

Capital investment

€20m was invested in **Wexford General Hospital** to incorporate a new ED, maternity theatre, delivery suites and concourse. Upon completion the ED will have increased by 13 treatment spaces leading to improved admission times for patients. The capacity in the delivery suites will increase from two, two bed delivery rooms to five single bed delivery rooms. The dedicated maternity theatre will free up demand on existing theatres within the hospital enabling the hospital to increase day case activity and reduce waiting times for patients.

L-R: Pat Healy, Regional Director of Operations, HSE South; Dr. Colm Quigley, Clinical Director, WGH; Minister Brendan Howlin TD and Lily Byrnes, General Manager, WGH.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

At **St. Luke's Hospital, Kilkenny**, €15m was earmarked for capital developments to include a new ED, an acute medical assessment unit (AMAU), day services unit and hospital concourse. The ED will include a waiting area, triage area, three-bay resuscitation area and a separate paediatric resuscitation bay with each having their own x-ray facilities. It will also include a major treatment and examination area, a separate paediatric treatment area, a minor treatment area and a bereaved relative's room. The AMAU will consist of two four-bay assessment areas, two isolation rooms, a treatment room and support accommodation. The day services unit will include accommodation for a range of endoscopic procedures, including colonoscopy.

L-R: Pat Shortall (Deputy General Manager), St. Luke's; Anna Marie Lanigan (Area Manager, HSE Carlow-Kilkenny/South Tipperary); Pat Healy (Regional Director of Operations); Helen Butler (Director of Nursing, St. Luke's); Dr. Garry Courtney (Clinical Director, St. Luke's); Minister for Environment and Local Government Phil Hogan TD; James Murphy, O'Mahony Pike Architects; Ciarán Ruane (Estates Officer) and Tim Keogh (Project Manager).

Leading the way in medical advances

Cork University Maternity Hospital (CUMH) was designated the **first European Robotic Gynaecological Epicentre** becoming the only hospital in Europe to perform both cancer and non-cancer procedures using sophisticated robotics. The da Vinci Surgical System, is a sophisticated robotic platform which consists of a surgeon's console and a patient-side cart with four interactive robotic arms controlled from the console. It is designed to enable surgeons to perform delicate and complex surgery using a minimally invasive approach. In July, CUMH saw one of the first women in Europe undergo the state of the art procedure using the da Vinci Surgical System which assisted her in having a successful pregnancy.

L-R: Dr. Barry O'Reilly, Consultant Obstetrician/ Gynaecologist, CUMH with Patrick and Anne O'Mahony following the birth of baby Lucy.

Promoting health in the community

An **outdoor exercise area** was set up in Bandon Community Hospital which was made possible through funds raised by the various older people's groups from the surrounding areas and a grant from the HSE lottery funding. This initiative not only enhances the fitness levels of older people but also complements the ethos of positive ageing to remain in good physical and mental health.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH...

Working in partnership

A number of **social inclusion projects** continued during the year through the Health Action Zone in the RAPID areas in Cork City highlighting the partnership of statutory and voluntary organisations, City of Cork VEC, Cork City Council and An Garda Síochána. New initiatives included the development of an evaluation tool kit for the Fundamental Movement Skills Programme. Students from University College Cork studying sports and physical education run this programme with pre-school, primary and post primary students in their schools. In addition, increased teaching hours were accessed through the City of Cork VEC for the Food Focus Initiative where a local community garden has been developed to enable the community to access fresh, affordable vegetables. Another key development included enabling local women to participate in peer-to-peer training on BreastCheck and CervicalCheck in conjunction with the National Cancer Screening Programme. A number of women participated in survey training, which they then carried out in their local community. All of these initiatives contribute to long term health improvements in the community.

Visit by Cathal Magee, the HSE's Chief Executive Officer, and Pat Healy, Regional Director of Operations, HSE South, to the social inclusion projects in the RAPID areas in Cork City.

Putting patients at the centre of service re-organisation

Ayrfield Primary Care Centre at Ayrfield Medical Park opened in Kilkenny. The state of the art centre provides the infrastructure which enables greater collaboration between GPs and HSE services. It includes GPs and practice nurses working as part of a PCT with a range of HSE health professionals including public health nurses, physiotherapists, speech and language therapists, community mental heath nurses, occupational therapists, dieticians and administration. The centre can provide hospital based services at a local level, such as minor surgery and exercise stress tests for diagnosis of heart disease as well as facilities for infusions and intravenous treatments. There will be access on site to private services such as psychology, chiropody, audiology, massage therapy and yoga/pilates. There will also be access to dedicated consultant clinics in plastic surgery, ear nose and throat, psychiatry, urology, ophthalmology and gynaecology. A pharmacy and dental practice are also available.

Supporting service users

A new self-harm reduction programme named the **Endeavour Programme** was completed by 12 service users from North Lee adult mental health services in Cork who had been diagnosed with borderline personality disorder (BPD). Throughout the programme, clients learned how to cope with the difficulties associated with BPD through intensive individual therapy and by learning alternative healthy coping skills and behaviour. The Endeavour Programme is an evidence based treatment using dialectical behaviour therapy (DBT), a treatment developed by an American based clinical psychologist. The treatment assists clients to let go of self-destructive behaviour and improve their quality of life and that of their families.

L-R: Dr. Nataraj Gojanur, Consultant Psychiatrist; Barbara Shorten, Art Therapist; Dr. Mary Kells, A/Senior Clinical Psychologist; Daniel Flynn, Senior Clinical Psychologist and Programme Leader; Sinead Boyce (Greaney), Clinical Nurse Specialist; James O' Mahoney, Advanced Nurse Practitioner (Psychotherapy), all from North Lee Adult Mental Health Services and Gretta Crowley, Operations Manager, HSE South.

West

Introduction

The HSE West Regional Service Plan 2011 sets out the type and volume of service to be delivered through direct service provision or through a wide range of agencies funded by the HSE. Despite the reduction in resources the region's commitment, as always, was to deliver a safe and quality service to all its patients and clients, improve access to ensure a patient centred focus and deliver efficient and effective use of resources giving best value for money.

Despite the significant challenges in 2011, the HSE West delivered on the HSE National Service Plan targets while also achieving significant efficiency savings and overall cost reductions. This is a reflection of the dedication and commitment of individual staff members and teams throughout the region.

Acute hospitals continued to focus on changes in the way services needed to be delivered in order to ensure patients received the most appropriate care, in an appropriate setting and in a timely and safe manner. Some specific improvements were achieved in access to outpatient services, reduction in average length of stay and increased number of day case treatments.

Significant developments during the year included:

- Opening of new Urgent Care Centre at Roscommon County Hospital
- Opening of Enhanced Recovery Unit in Letterkenny General Hospital (LGH)
- Opening of a Pre-operative Assessment Clinic in Mid-Western Regional Hospital (MWRH), Limerick
- A new Acute Mental Health Unit commenced services in Letterkenny
- A new Community Nursing Unit (CNU) developed in Loughrea, Co. Galway furthering the HSE's overall strategic plan for older people services
- Opening of new Primary Care Centres in Ballina, Co. Mayo and City East, Co. Galway

Regional highlights during 2011 included:

Acute/Pre-hospital and Maternity

- Launch of a new rheumatology telemedicine outpatient clinic between Roscommon County Hospital and Merlin Park University Hospital
- Ground breaking technology in use at cardiology department, University Hospital, Galway
- Opening of an MRI unit in Mayo General Hospital as well as a new purpose built occupational therapy department
- New endoscopy suite became operational in Ennis General Hospital. In addition, a teleradiology reporting service was introduced
- Nurses from MWRH and the Regional Orthopaedic Hospital, Croom, Co. Limerick completed a medical ionising radiation (x-ray) prescribing programme
- An integrated PACS/RIS (picture archiving and communication system/radiology information system) was commissioned in LGH
- A clinical academy was initiated at LGH to provide undergraduate medical education in conjunction with National University of Ireland, Galway

Mental Health

- Opening of a new regional Child and Adolescent Mental Health Services (CAMHS) unit in Galway
- Development of two mental health teams in Sligo/Leitrim
- Introduction of three therapists specialising in eating disorders as part of cross border CAWT initiative

Primary Care

- A community heart failure management programme commenced in Galway
- Development and delivery of a generic chronic disease self management programme in Donegal

Disability

- Early intervention programme for babies and toddlers set up in Sligo/Leitrim in collaboration with Helium, a children's arts and health company, on a unique arts initiative called infant imaginings

Promoting and protecting Health

- An innovative nutrition and cookery course was developed for male family carers in Galway.
- Completion of a pilot 12-week physical activity and lifestyle awareness programme for 9 to 12 year old overweight and obese children in Galway
- A public health screening day at Roscommon County Hospital attended by more than 200 people

Cancer

- Community nurse education programme in oncology undertaken by community nurses, Co. Galway
- Rapid access lung clinics were introduced in MWRH, Limerick and Galway University Hospital
- Opening of a new rapid access prostate clinic in MWRH

Palliative Care

- End-of-Life care further progressed in Sligo, LGH and MWRH

Children and Families

- In line with strategic direction for the services, reorganisation of governance structures commenced with area and regional manager posts progressed

Social Inclusion

- Additional capacity created for addiction services in Limerick city

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

Improved processes for delivering patient care

Letterkenny General Hospital officially opened its **Enhanced Recovery Unit** in November. This new surgical unit enables the early admission of patients on the morning of surgery and facilitates accelerated recovery and discharge from hospital. The development of this unit was made possible through the reallocation of resources within the hospital and the support from CAWT as part of the European Union's INTERREG IVA funded cross border urology project.

L-R; Sean Murphy, General Manager, (LGH); Professor Frank Keane, Professor of Surgery, RCSI; Dr. Anne Flood, Director of Nursing and Midwifery; Dr. Paul O'Connor, Clinical Director; Ms. Siobhan Kelly, Clinical Nurse Manager, ERU; Patrick Gildea (patient); Mary Wood, Administration; Marina Cassidy, Staff Nurse and Amanda McCoy, Staff Nurse.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

The **Early Pregnancy Assessment Unit (Snowdrop Unit)** opened in the Mid-Western Regional Maternity Hospital, Limerick in December. This is a specialised unit, dedicated to providing care to women in early pregnancy. The Unit's function is to make an early diagnosis of pregnancy loss (miscarriage or ectopic pregnancy) followed by timely, effective treatment in a caring and supportive environment. The overall aim of the unit is to improve the patient's journey at such an anxious and distressing time.

A **Pre-operative Assessment Clinic** was established in the Mid-Western Regional Hospital, Limerick. This consultant led multidisciplinary clinic has expanded to include patients for elective colorectal and orthopaedic surgery who require anaesthetic review prior to surgery. Assessing patients in advance of surgery presents a valuable opportunity to provide information and education along with carrying out essential investigations. The clinic allows the hospital to make maximum use of available resources minimising late cancellations and increasing efficiency of operating theatre time. It provides an opportunity for patients to participate in planning their own care and also allows for earlier discharge and reduced length of stay in hospital.

Use of ground-breaking technology

The Cardiology Department in University Hospital Galway has become the first department in Ireland to use **ground-breaking cardiology technology**, which will significantly improve the detection of cholesterol build up and narrowing within coronary arteries. This new technology, Opital Coherence Tomorgraphy, will ensure better long term results for patients who undergo coronary artery stenting.

L-R: Rosemary Walsh, Clinical Nurse Manager, Coronary Care; Nick Synnott, Cardiac Technician; Dr. Dermot Phelan, Specialist Registrar, Cardiology Department; Sue Hennessy, Project Manager, Cardiology Department; Dr. Faisal Sharif, Consultant Cardiologist; Alison Hanley, Staff Nurse.

Education and training

Eight nurses from the Mid-Western Regional Hospital Limerick and Regional Orthopaedic Hospital, Croom, Co. Limerick completed the **Medical Ionising Radiation (x-ray) Prescribing by Nurses programme** which now enables them to prescribe x-rays independently. The local implementation group plays a vital role in overseeing and facilitating this development for patients within a multidisciplinary collaborative framework. This expanded practice for nurses is a significant initiative which allows nurses to provide a more responsive, effective and efficient service, thereby meeting the needs of patients in a person centred manner.

HIGHLIGHTING SERVICE IMPROVEMENT THROUGH…

Capital advancement

Residents and clients of St. Brendan's CNU and St. Martin's Day Services in Loughrea moved into **the new CNU**, located alongside the former building in Loughrea. The new 100 bed CNU is a purpose built facility which provides residents with both single and double ensuite bedrooms. The former St. Brendan's building will be developed to meet the primary care needs of the community in Loughrea with a number of primary care services having already relocated there.

Staff pictured during the move to the new St. Brendan's Community Nursing Unit in Loughrea.

Facilitating independent living

In December, the new purpose built **Occupational Therapy (OT) department at Mayo General Hospital** was officially opened. The relocation of the new OT department greatly enhances the service and care to service users by providing treatments and assessments such as postural, splinting, cooking and meal preparation with a comprehensive rehabilitation centre in the heart of the hospital.

The Occupational Therapy team at Mayo General Hospital, from L-R; Sarah Ronayne, Occupational Therapist, Gracia Gomez-Kelly, OT Manager and Sinead Duddy, Senior Occupational Therapist.

Supporting Operational Services

Supporting Operational Services

Introduction

The HSE is the largest organisation in the State with the largest Government allocated budget and a workforce of over 104,000 people. Support services play a vital role in the efficient running of the organisation. Many innovative initiatives and developments took place during 2011, some of which are highlighted in this section.

Improving Quality and Delivering Safe Services

Designing and delivering services, to ensure high quality safe services for all our patients and clients, is our primary concern. We are committed to the multi-agency approach being taken under the auspices of the *Patient Safety First* initiative, to ensure the provision of high-quality care to all patients.

During 2011, we continued to focus on the development and implementation of safe quality healthcare. Critical to making this happen was the establishment of a new Quality and Patient Safety Directorate in January.

A culture of continuous quality improvement through effective governance structures, clinical effectiveness, outcome measurements, and evaluation is at the centre of our approach to improving services. Central to this is a strong system of clinical governance and our *Integrated Risk Management Policy*.

We have well advanced controls and systems for managing risk within the HSE, we also have a comprehensive approach to managing complaints, and a rolling programme of healthcare audit. All of these processes give rise to important learning which leads to changes in healthcare practice that better guarantee the safety and quality of care for patients.

Areas of progress in 2011 included:

- Implementing the national clinical programmes, including introducing standard clinical care pathways
- Submitting to the Minister for Health a revised HSE Code of Governance, approved by the HSE Board in July.
- Implementing an Audit Recommendation Tracking System to promote a culture of accountability and continuous quality improvement. Of the audits commenced in 2011, 94% were completed by year end.
- Working with the DoH and the Health Information and Quality Authority (HIQA) in preparation for the launch of the *National Standards for Safer Better Healthcare*.
- Developing a Quality Management System to facilitate reporting on incidents, risk management and self assessments against standards.
- Developing quality improvement plans to address areas of concern highlighted in reporting processes.
- Consulting on a guidance document, *The five step approach to clinical audit* for publication in 2012.
- Establishing implementation groups to oversee recommendations from both internal and HIQA reports such as in regard to Mallow and Ennis Hospitals.
- Implementing a *National Maternity Healthcare Record* in all HSE funded maternity hospitals/units.
- Publishing the *HSE Standards and Recommended Practices for Healthcare Records Management V3.0*. Work also commenced on the roll out of the Healthcare Records Programme to non-acute services.
- Delivering a number of training workshops in regard to serious incident management investigation to key staff and service users. In May, 72 senior managers and clinicians received training in conducting look back reviews.
- Progressing work in relation to a new standardised Medication and Prescription and Administration Record.

Dr Diarmuid Hegarty, NoWDOC Medical Director with Angela Tysall, HSE Service Manager for the NoWDOC Service.

Quality Assurance Accreditation Award for NoWDOC

At the end of January, the Royal College of General Practitioners (RCGP) Northern Ireland presented the NoWDOC (GP out-of-hours) service with a Quality Assurance Accreditation Award. NoWDOC is one of the nine publicly funded GP Co-operatives and provides urgent out-of-hours GP care to patients in the North West (Donegal, South Leitrim and North Roscommon). NoWDOC is the first GP co-operative to achieve this quality accreditation and it was the first international accreditation for the RCGP.

NoWDOC became aware of the programme to accredit out-of-hours service providers in Northern Ireland through its involvement in cross-border out-of-hours GP services. Patients were accessing GP out-of-hours care on both sides of the border with the service in Northern Ireland having strict quality standards in place. In order to develop the NoWDOC service and other cross border services, it was necessary to demonstrate that the standards in the Republic are recognised as equivalent and acceptable to those in Northern Ireland. Work was undertaken by the NoWDOC service with the RCGP to adapt their accreditation programme for suitability to the Republic of Ireland setting.

Human Resources

Human resources are one of the core building blocks of an efficient and effective health system – a system that is based on significant personal interaction at many levels. Our staff work directly at the front line, and behind the scenes providing essential support services, to ensure we deliver a fully functioning, high quality health care system.

Meeting the Challenge of Change

The Public Service Agreement (PSA) 2010-2014, also known as the Croke Park Agreement, has been steadily working towards delivering substantial savings and efficiencies in the public sector. Within the health sector, this has focused predominantly on reducing staff numbers, better use of staff resources, improved processes and redeploying staff to protect and, where possible, enhance service delivery within priority areas. The PSA is recognised as an essential enabler for the health sector to allow it to deliver services in an appropriate and sustainable manner.

In its first annual review, the Implementation Body tasked with measuring progress concluded that, in its first year, the agreement had exceeded the targeted savings for the public service pay bill in 2011 and that those parties to the agreement made solid and measurable progress in meeting their commitments.

The main health sector achievements of the PSA to date have been:

- The continued delivery of services as planned within reduced resources. Across the sector as a whole, staff at all levels have generally shown levels of flexibility and co-operation which have minimised disruption to services and facilitated ongoing implementation of service changes.
- Co-operation with the work of the national clinical programmes and the priorities of the Special Delivery Unit, DoH.
- The HSE more than meeting its annual staff reduction targets.
- Internal redeployment of at least 750 staff within the health service (September data), as well as short-term redeployment/mobility, to achieve best deployment of available resources and improved organisation of services.
- Agreement on revised terms for the provision of hospital laboratory services outside normal hours. This agreement provides for increased availability and access to diagnostics. It also supports improved service delivery for patients, a more cost-effective response to peaks/surges in demand and improved productivity by allowing equipment to be used more over a longer working day. It projected significant savings, estimated at €5m-€7m for 2011. A similar agreement has been reached in the radiography services and will be implemented in 2012.

- The bringing of all HSE procurement activity into a single national procurement operating model.
- One of the first major cross-sectoral redeployment initiatives under PSA, the transfer of the Community Welfare Service from the HSE to the Department of Social Protection, was completed on 1st October 2011 with the transfer of 1,020 staff. This will also mean a better, more integrated service to clients and savings for the Exchequer.

Medical Education, Staff Training and Professional Development

In times of downsizing, it is difficult to maintain a positive approach to learning and staff development. However, it is in these difficult times that now, more than ever, maintaining a continuous learning environment for professional development is essential to ensure that staff have the necessary skills and competencies to work in such a challenging environment.

In 2011:

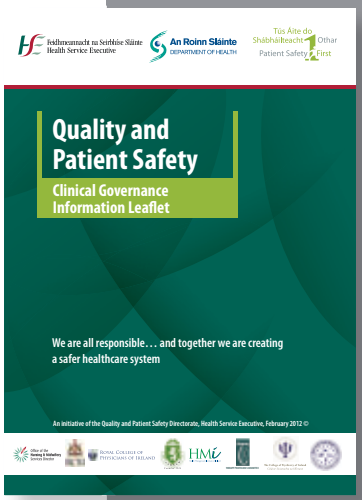
- www.HSELanD.ie, the HSE's learning and development website was awarded the top award in the education category of the National eGovernment Awards. It was also shortlisted and runner up in two other award ceremonies.
- Health and social care professionals were supported in maintaining and developing standards of clinical practice, practice education, research, validation of qualifications and development of an online community of practice. A report was published on the review of the practice education system. Many positive benefits were highlighted in the review. However, challenges in securing sufficient placements for students in many areas are increasing in the context of ongoing service pressures. A survey of the research activity, skills and training needs in Ireland was also published.
- To offset the impact of staff reductions, the HSE introduced a Succession Management initiative to identify, assess and develop high performing managers in the system with a view to providing potential successors for senior roles. An initial pilot in HSE DNE saw participating managers, as part of their development, implementing a range of key projects identified within the service integration agenda.

www.HSELanD.ie

Did you know…?

www.HSELanD.ie learning resources include:

- **360 competency assessment tool to allow an employee to identify their strengths and areas for development**
- **Personal Development Plan Workbook to help employees set career goals and plan their learning objectives**
- **55 e-learning programmes which cover a wide range of skills for example computer skills, personal effectiveness and clinical skills**
- **Online learning resources such as reports, publications, e-videos, online libraries, leadership and management resources, and organisational development resources**
- **Collaborative learning hubs to reflect specific content areas and facilitate knowledge sharing between geographically spread multidisciplinary groups.**



Clinical Governance

Clinical governance is about people receiving the right care, at the right time, from the right person in a safe, honest, open and caring environment. In 2011, the HSE appointed a national lead to develop clinical governance in the organisation and also established an international reference panel.

A clinical governance checklist was developed and issued in September. The document provides a guide for clinical governance development, across the continuum of care, in each of the national clinical programmes, based on the relevant national standards and legislation. The completion of the checklist assisted clinical leads in ensuring that clinical governance arrangements are incorporated in the model of care/pathway documents as they are developed.

A communications strategy was also initiated to inform the wider health care community of the vision, benefits and guiding principles – 'We are all responsible…and together we are creating a safer healthcare system'. In early 2012, Clinical Governance Development: Assurance Check for Health Service Providers will be launched.

Finance and Procurement

Single National Procurement Operating Model

All staff engaged in procurement activity across the HSE now report into HSE Procurement. This development was facilitated under the PSA. The implementation of this model in 2011 was a key enabler in achieving cost reductions, increasing efficiency and streamlining and standardising the procurement process.

Legal Services

The delivery of legal services to the HSE under a new contracting model commenced in March ensuring that expenditure on legal services is done in a controlled and managed fashion and realises value for money. This model involves in excess of 30 law firms approved to deliver services through four geographical panels. The law firms on these panels were used to advise and represent the HSE in key legal areas such as child care, environmental health, mental health and disability. A single law firm acted as the service manager for the contract. Since implementing the new model there has been:

- 23% reduction in contract costs
- 5% reduction in contracted legal hours
- 19% reduction in the average hourly rate

Strengthening Governance Arrangements with the Non-Statutory Sector

National standard governance documentation was introduced in 2009 to formalise the funding arrangements with the non-statutory sector. Compliance, and its associated governance requirements, has increased and, by the end of the year, practically all the funding was covered by the standard documentation. A planned review was completed, with the documentation updated accordingly. In addition, national standardised documentation for use by the commercial (*for profit*) agencies was developed and will be implemented next year. This will ensure a consistent approach for all agencies operating in the health service environment.

Project work commenced on the further development of appropriate management arrangements, improved operating procedures and standardisation of related practices, for finalisation early next year.

2011 Capital Plan

The HSE's gross capital allocation in 2011 was €377.25m, compared to the 2010 gross capital allocation of €436.79m. The 2011 gross allocation included €15m for subhead C4 (building and equipping mental health and other health facilities (funded from the disposal of surplus assets). The corresponding amount for 2010 was €50m. The HSE applied €6.8m sale proceeds to capital projects in 2011. This compares with €3.59m sale proceeds applied to capital projects in 2010.

The HSE recorded capital income in the sum of €351.07m in 2011. This included €335.05m of exchequer funding, of which €15.70m was in respect of ICT projects. The total capital expenditure in 2011 was just under €318m. This included capital grants to voluntary agencies of €132.08m.

The HSE estate comprises of 2,655 properties. A wide variety of capital projects progressed in 2011 including:

- New emergency departments (EDs) at Kerry General Hospital (under construction), Waterford Regional Hospital (under construction), Wexford General Hospital (at tender stage) and St Luke's Kilkenny (at tender stage).
- A €25m ward block development at St Vincent's University Hospital (Phase 2) including the construction of a Cystic Fibrosis Unit (due to open by the middle of next year).
- A €35m Critical Care Block at the Mid-Western Regional Hospital, Limerick is under construction.
- Construction commenced on the building of a new €9.9m ED and Neonatal Intensive and Special Care Baby Unit at Waterford Regional Hospital.
- Building work is well underway on the Mater Campus Hospital Development, a project that involves the rebuilding of key parts of Dublin's Mater Misericordiae University Hospital.
- In addition to investment in the ambulance replacement programme, building works commenced on three new ambulance stations in Thurles and Nenagh, Co Tipperary and Tuam, Co Galway.

The Primary Care Strategy continued to be rolled out with 40 Primary Care Centres procured by lease agreement. In addition:

- Waterford Health Park primary care centre, was officially opened (this was shortlisted in the World Architecture Awards in 2010).

Waterford Health Park primary care centre.

- A new €1.7m primary care centre opened in Glenties, Co. Donegal providing a single storey purpose built premises to facilitate all primary care services including community service clinics.
- The new health centre at Inchicore, Dublin cleverly incorporates the 18th Century former barracks and school building into a 21st Century state of the art healthcare facility and was one of the first projects to be completed at part of the wider St. Michael's Estate regeneration plan in partnership with Dublin City Council.

Inchicore primary care centre.

Sales from mental health assets raised €6.45m and were reinvested into mental health services. A total of €35m was spent on the Mental Health Investment Programme in 2011.

- The new HSE Child and Adolescent Inpatient Unit in Cork was named the Best Health Building in the 2011 Irish Architecture Awards while the Child and Adolescent Mental Health Unit at Merlin Park Hospital, Galway was also shortlisted in the Best Health and Leisure Category.

Child and Adolescent Psychiatric Unit, Bessboro, Cork.

- A new Child and Adolescent facility at Cherry Orchard Hospital, Ballyfermot, is nearing completion. This amalgamates a number of existing satellite departments within a new building and is central to the HSE's *Vision for Change* mental health programme.
- A new Acute Mental Health Unit was completed in Letterkenny, Co Donegal.

Developing Information and Communication Technology

The HSE issued ICT capital payments in the sum of €15.70m for the year ended 31st December, 2011. In total, 204 projects were undertaken during the year, 52 of which were completed and 152 will continue into 2012.

Some initiatives which took place during the year included:

National Patient Administration System (PAS)

The HSE National Patient Administration System went live in the Mercy and South Infirmary Victoria University Hospitals in Cork. In 2011, funding and approval was secured for the further deployment of the system at all three Dublin maternity hospitals as well as Children's University Hospital, Temple Street and Our Lady's Children's Hospital, Crumlin.

Clinical Systems

- The National Endoscopy Clinical Information System was deployed in five hospitals with further deployments planned in 2012 in support of the National Colorectal Screening Programme.
- A new system for tracking and tracing Reusable Invasive Medical Devices (RIMDs) was deployed in eight hospitals.
- The implementation of an ICT system for the histopathology Quality Assurance (QA) Programme commenced in several hospitals. Similar projects to support the radiology and endoscopy QA Programmes were also initiated.
- The National Kidney Disease Clinical Patient Management System was deployed in five sites.
- There was significant progress in the implementation of the Intensive Care Unit (ICU) Clinical Information Systems at Our Lady's Children's Hospital, Crumlin and in Sligo General Hospital. The implementation of the ICU system at Cork University Hospital commenced.
- Facilities to enable GPs to provide electronic referrals to hospitals for patients requiring access to cancer services was expanded and work also commenced to enable electronic referrals for access to other services.
- Funding was secured for a new ED Clinical Information System, which is likely to be procured in 2012.

Contracts were concluded for a number of other new systems:

- National Environmental Health Information System
- Civil Registration Online Appointment Bookings
- Counselling Service

Procurements were commenced for a number of major new systems:

- National Child Care Information System
- Ambulance Service Computer-Aided Dispatch

Corporate Systems

- A Corporate Information Facility (CIF), a data warehousing solution to provide corporate decision makers with the ability to interpret significant volumes of corporate and operational data, went live during the year. The system provides a very efficient and effective method for extracting, cleaning and hosting data centrally. It also enables in house development of key reports for corporate decision makers in a very timely and responsive manner, using standard toolsets. Using the system, key reports and data extracts were developed for payroll accounting, Corporate Planning and Corporate Performance and the Special Delivery Unit in the DoH.

NIMIS
The National Integrated Medical Imaging System

The HSE NIMIS (National Imaging Medical Information System) project is investing in providing state of the art electronic radiology systems for 33 Irish hospitals. NIMIS will make Ireland's radiological services filmless and enable secure and rapid movement of patient image data throughout the health service. This new imaging system allows doctors to electronically view their patient's diagnostic images, such as X-Rays and CT Scans, quickly and easily. The rapid access and availability of patient's records to health professionals is a significant step for patient safety. NIMIS will be installed in 33 hospitals within a three year period, which started in 2010.

Significant progress was made in 2011 with the first site, Sligo General Hospital, going live in June. This was followed by Beaumont Hospital in August, the Mater in September, Waterford in October and all the North East hospitals in November and December. The system is now live in ten hospitals with approximately 3,000 studies processed on the system daily. There are approximately 750,000 studies stored on the system to date. The NIMIS Project is currently on schedule and on budget for full implementation in 2013.

- A National Capital Income and Payments System was implemented, providing a solution to streamline the management and processing of payments for all capitally funded projects.
- A national Non-Consultant Hospital Doctor (NCHD) Post Management System was introduced within the public health service in Ireland. The system is one of the first IT systems in Ireland which enables the integration and sharing of relevant information between employers, the relevant regulatory agency and the relevant educational providers in a real-time manner.

Improving our Communications

In 2011 we continued to develop a proactive, open and highly professional communications culture within the organisation. This work is designed to meet the needs of the many and varied stakeholders of the HSE, including the public and those who use services, staff, the media and the political system.

A comprehensive communications resource planning process was introduced from January, following a detailed planning period in the previous year.

This process brings together all the HSE functions engaging in communications projects, to standardise and integrate all communications activities of the organisation. It is designed to ensure strategic focus and purpose, increase economies of scale, prevent duplication and waste of valuable resources and allow integration of messages with service provision. During 2011, over 84 projects were delivered following this high quality project management approach, ranging from large scale health education campaigns, to staff engagement programmes, to smaller discrete public relations and online promotional projects.

A high volume of media queries were also managed throughout the year, providing a responsive service in relation to emerging issues, and contributing high quality public relations services to all HSE communications campaigns.

Some selected highlights during 2011 included:

- QUIT, a new campaign aimed at curtailing tobacco use in Ireland, seeing strong results in its first year with significant increases in demand for support services.
- Your Mental Health awareness campaign, resonated strongly with its target audience and encouraged people to communicate and seek support for mental health concerns.
- Antibiotics are wasted on Colds and Flu – an integrated campaign aimed at reducing inappropriate use of antibiotics.
- New Children First child protection guidelines – new guidelines for all childcare and general HSE staff via publication, event and online hub.
- Digital Communications – an organisation wide digital strategy was outlined for the HSE, aiming to develop a single authoritative online health information resource and an online database of conditions and treatments for public and professional access.
- Developing and updating the information available on the HSE website and on HSEnet. www.hse.ie received over 3.88m visits in 2011, a 26% increase on 2011.
- Managing the HSE's Health and Wellness Centre at the 2011 National Ploughing Championships.
- HSE DNE Communications supported local managers in the management of change/service reconfiguration projects, e.g. Mental Health North Dublin and Louth Meath Transformation.
- HSE South Communications provided a comprehensive and supportive response to the publication of the *Report by Commission of Investigation into Catholic Diocese of Cloyne 2011*, ensuring people affected were aware of the counselling and support services available to them.
- Continuing to develop and improve *Health Matters*, producing four quarterly issues with a readership of almost 100,000 people. A digital edition of the magazine was also developed and is available on the www.hse.ie.
- Supporting the development and production of a range of commercial television series on health topics, for example *The Nurse*, which focused on the work of public health nurses in various settings nationwide, and *Don't Tell the Bride*, which featured the HSE's registrars for civil marriages.

Planning and Measuring Performance

The development of strong planning and performance management functions within organisations is essential to leading and driving integrated planning and performance systems, processes and activities which support integrated service delivery. Ensuring effective governance and accountability within the health services is a key component of this.

During 2011:

- A proposed third *Corporate Plan* for the HSE for the period 2011-2014 was submitted to the Minister for Health on 9th September, on the understanding that it would need to be amended in light of clarity on the role of the HSE under the Government's Health Reform Programme.
- The *National Service Plan (NSP) 2012* was submitted to the Minister for Health on 23rd December (subsequently approved on 13th January, 2012).
- The *HSE Annual Report 2010* was published.
- The performance report against the *HSE Corporate Plan 2008-2011* was published.
- Twelve monthly performance reports and supplementary reports were published.
- Twelve HealthStat Forums, chaired by the HSE CEO, were held during the year. The HealthStat performance dashboards for individual hospitals and local health offices, together with performance results and comparative bar charts on selected metrics, were also published monthly.
- Metadata was compiled for all performance indicators included in NSP2011 and made available on the HSE website.
- A reconfiguration of the performance reporting business process, including an increase in data collection and new presentation of performance information, was undertaken in 2011 to meet the emerging needs of the Minister for Health under the *Programme for Government*.

All NSPs, Annual Reports, HealthStat and Performance Reports are available on www.hse.ie

Valuing Our Staff

Neil O'Hare

NIMIS Project Lead
and Chief Physicist
St. James's Hospital, Dublin

NIMIS
The National Integrated Medical Imaging System

My background is as a medical physicist. Since 2007, I have been seconded on a part-time basis, as Project Lead to the NIMIS project while also working as Chief Physicist in St. James's Hospital. Prior to this I have been involved in a number of similar projects in St. James's and other hospitals.

Launched in 2010, NIMIS is the National Imaging Medical Information System project which is making Ireland's radiological services filmless enabling secure and rapid movement of patient image data through the health service. Where NIMIS is live in hospitals, it provides real patient benefit and efficiencies in the way people work. It greatly assists communications with hospitals, particularly between radiologists, doctors, nurses and patients. For patients it means fewer repeat x-rays or scans, faster turn around for reports, rapid transfer of images between clinicians and also those located in other hospitals.

During 2011 we went live in Sligo General Hospital, Beaumont Hospital, the Mater, Waterford and all the North East hospitals. We are now live in ten hospitals and hope to have full implementation in 33 hospitals by 2013.

Seeing what has been achieved is very rewarding. In 2008 when we made our business case, we knew the benefits would be enormous and with both the Project Team and Project Board at the time, we pushed out the boundaries to make it happen. A lot of research was undertaken in terms of best practice in other jurisdictions. We are doing it somewhat differently here though. As it is a single national project, data sharing issues which many other jurisdictions are still battling with have been resolved, and we have started to expand into other areas of imaging, including such areas as cardiology, obstetrics, and vascular imaging. We have also expanded the system to include the capture and reporting of electrocardiograph (ECG) traces where applicable.

What has worked well is that hospitals were involved from the beginning to ensure the system matched their requirements and to harmonise it with their other clinical systems. Ensuring we met procurement regulations was vital. At the time we shortlisted vendors, we invited hospitals into their presentations. This allowed an assessment from a user's point of view and gave great buy-in for the end product.

We do continue to meet challenges as we roll-out. Hospitals are struggling with releasing staff in a very tight financial environment. It has been a learning curve for us and each time we go live in a hospital, there is learning for us for the next one! We have set deadlines for hospitals and where, for whatever reasons, these have not been met, we have moved onto others with the intention of reverting to those hospitals when issues have been resolved. This has been a slightly 'aggressive' approach but one which has worked in terms of achieving success.

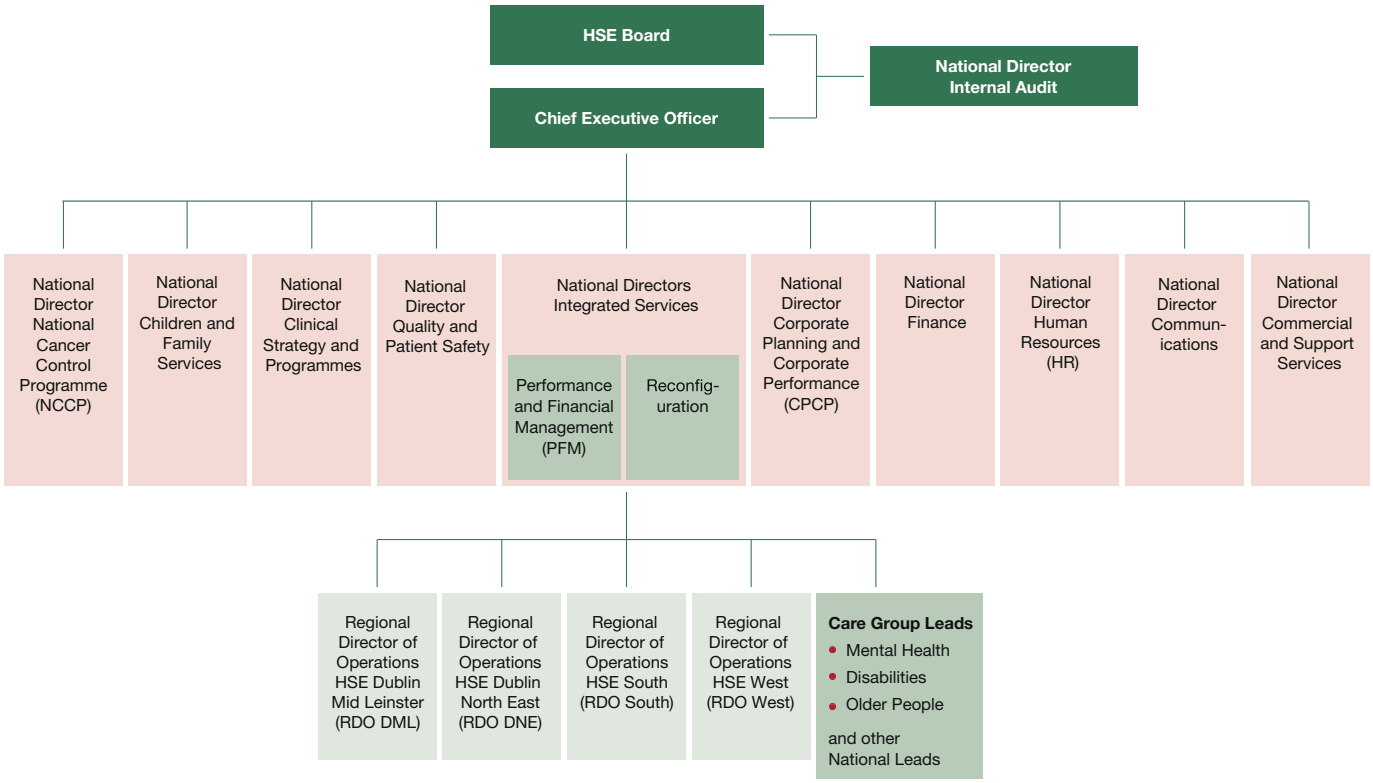
I take great pride in the very positive feedback which myself and the team get from the clinical community who are delighted with the efficiencies NIMIS is bringing to their work. Our objectives were very clear from the start and people are encouraged by the fact that what we said we would do, we are doing. I have a great team which is half the battle! It includes radiography, IT and clerical experts. We also get expert advice from a radiologist and a procurement expert which has proven vital.

Finally, a huge "thank you" to both my NIMIS team and the Medical Physics and Bioengineering Department in St. James who have enabled me undertake this role.

Appendices

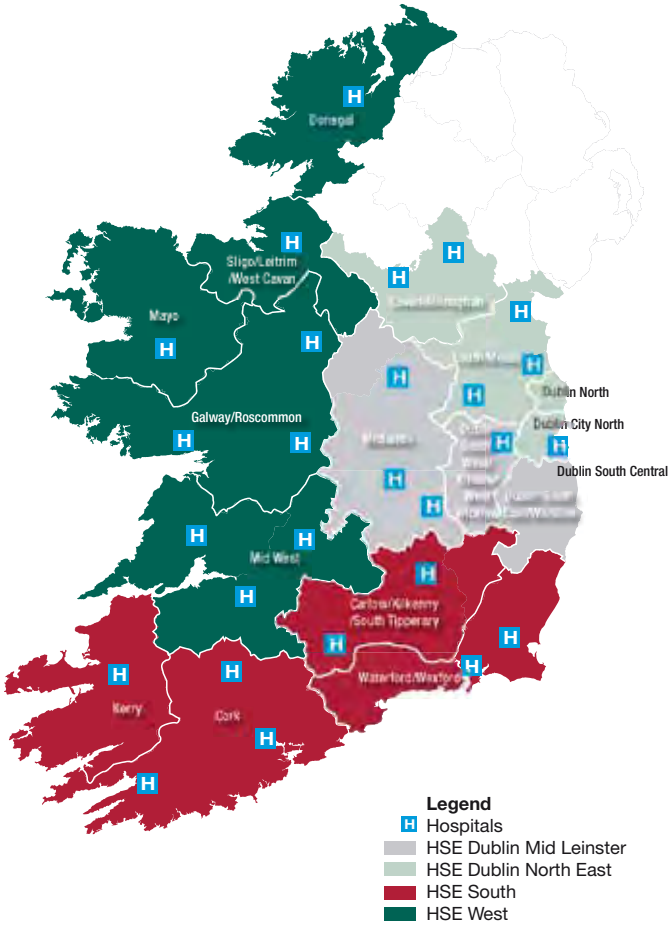
Appendix 1 **Organisational Structure**

As at 31st December, 2011



Appendix 2 **Maps and Contact Details**

HSE Area Management Structures



HSE WEST

Regional Director of Operations:
John Hennessey
HSE West, Merlin Park, Galway
Tel: 091-775404
Email: rdo.west@hse.ie

HSE Areas

HSE Donegal

Area Manager: John Hayes
Iona Office Block, Upper Main St.,
Ballyshannon, Co. Donegal
Tel: 071-9834000

HSE Sligo/Leitrim/West Cavan

Area Manager: Damien McCallion
St. John's Hospital Campus
Ballytivan, Sligo
Tel: 071-9148816

HSE Mayo

Area Manager: Frank Murphy
St. Mary's Headquarters, Westport Rd.
Castlebar, Co. Mayo
Tel: 094-9049065

HSE Galway/Roscommon

Area Manager: Catherine Cunningham
1st Floor, HR Building
Merlin Park, Galway
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HSE Mid-West

Area Manager: Bernard Gloster
31/33 Catherine Street, Limerick
Tel: 061-483556

HSE South

Regional Director of Operations:
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Model Business Park
Model Farm Road, Cork
Tel: 021-4928500
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HSE Areas

HSE Kerry

Area Manager: Michael Fitzgerald
Rathass, Tralee, Co. Kerry
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HSE Cork

Area Manager: Ger Reaney
Model Business Park
Model Farm Road, Cork
Tel: 021-4928540/028-40404

HSE Waterford/Wexford

Area Manager: Richie Dooley
Lacken, Dublin Road, Kilkenny
Tel: 056-7784150

HSE Carlow/Kilkenny/South Tipperary

Area Manager: Anna Marie Lanigan
Lacken, Dublin Road, Kilkenny
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HSE Dublin North East

Regional Director of Operations:
Stephen Mulvany
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Swords, Co. Dublin
Tel: 01-8908759
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HSE Areas

HSE Cavan/Monaghan

Area Manager: Leo Kinsella
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Co. Monaghan
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HSE Louth/Meath

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Ardee Business Park
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HSE Dublin North

Area Manager: Anne-Marie Hoey
Swords Business Campus, Balheary
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HSE Dublin City North

Area Manager: Anne O'Connor
Ballymun Healthcare Facility
Ballymun Road, Dublin 9
Tel: 01-8467341

HSE Dublin Mid-Leinster

Regional Director of Operations:
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Naas, Co. Kildare
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HSE Areas

HSE Dublin South East/Wicklow

Area Manager: Martina Queally
Vergemount Hall, Clonskeagh
Dublin 6
Tel: 01-2680506

HSE Dublin South Central

Area Manager: Gerry O'Neill
Cherry Orchard Hospital,
Ballyfermot, Dublin 10
Tel: 01-6206330

HSE Dublin South West/Kildare

Area Manager: David Walsh
Oak House, Millennium Park
Naas, Co. Kildare
Tel: 045-880419

HSE Midlands

Area Manager: Joseph Ruane
Health Centre, Longford Road,
Mullingar, Co. Westmeath
Tel: 044-9395111

Contact Details for Acute Hospitals

HSE Dublin Mid-Leinster

Adelaide and Meath Hospital Inc.
National Children's Hospital (Tallaght Hospital),
Tallaght, Dublin
Tel: 01 4142000

Children's University Hospital, Temple Street, Dublin
Tel: 01 8784200

Coombe Women's Hospital, Dublin
Tel: 01 4085200

Midland Regional Hospital, Mullingar
Tel: 044 9340221

Midland Regional Hospital, Portlaoise
Tel: 057 8621364

Midland Regional Hospital, Tullamore
Tel: 057 9321501

Naas General Hospital
Tel: 045 897221

National Maternity Hospital, Dublin
Tel: 01 6373100

Our Lady's Children's Hospital, Crumlin
Tel: 01 4096100

Royal Victoria Eye and Ear Hospital, Dublin
Tel: 01 6644600

St. Colmcille's Hospital, Loughlinstown, Co. Dublin
Tel: 01 2825800

St. James's Hospital, Dublin Tel: 01 4103000

St. Luke's Hospital, Rathgar, Dublin Tel: 01 4065000

St. Michael's Hospital, Dun Laoghaire, Co. Dublin
Tel: 01 2806901

St. Vincent's University Hospital, Elm Park, Dublin
Tel: 01 2774000

HSE South

Bantry General Hospital, Co. Cork Tel: 027 50133

Cork University Hospital Tel: 021 4546400

Cork University Maternity Hospital Tel: 021 4920500

Mallow General Hospital, Co. Cork Tel: 022 21251

Kerry General Hospital Tel: 066 718 4000

Lourdes Orthopaedic Hospital, Kilcreene,
Co. Kilkenny Tel: 056 7785000

Mercy University Hospital, Cork Tel: 021 4271971

St. Luke's General Hospital, Kilkenny
Tel: 056 7751133

South Infirmary Victoria University Hospital, Cork
Tel: 021 4926100

South Tipperary General Hospital, Clonmel
Tel: 052 6177000

Waterford Regional Hospital Tel: 051 848000

Wexford General Hospital Tel: 053 9153000

HSE Dublin North East

Beaumont Hospital, Dublin Tel: 01 8093000

Cappagh National Orthopaedic Hospital,
Finglas, Dublin
Tel: 01 8140400

Cavan General Hospital Tel: 049 4376000

Connolly Hospital, Blanchardstown, Dublin
Tel: 01 6465000

Louth County Hospital, Dundalk Tel: 042 9334701

Mater Misericordiae University Hospital, Dublin
Tel: 01 8032000

Monaghan Hospital Tel: 047 38800

Our Lady's Hospital, Navan Tel: 046 907 8500

Our Lady of Lourdes Hospital, Drogheda
Tel: 041 9837601

Rotunda Hospital, Dublin Tel: 01 8730700

HSE West

Ennis General Hospital, Co. Clare Tel: 065 6863100

Galway University Hospitals: University Hospital
Galway Tel: 091 524222; Merlin Park University
Hospital Tel: 091 751131

Letterkenny General Hospital, Co. Donegal
Tel: 074 9125888

Mayo General Hospital Tel: 094 9021733

Mid-Western Regional Hospital, Dooradoyle,
Limerick
Tel: 061 301111

Mid-Western Regional Maternity Hospital, Limerick
Tel: 061 327455

Mid-Western Regional Orthopaedic Hospital,
Croom, Co. Limerick Tel: 061 397276

Nenagh General Hospital, Co. Tipperary
Tel: 067 31491

Portiuncula Hospital, Ballinasloe, Co. Galway
Tel: 090 9648200

Roscommon County Hospital Tel: 090 6626200

St. John's Hospital, Limerick Tel: 061 462222

Sligo General Hospital Tel: 071 9171111

Appendix 3 **Capital Projects in 2011**

Acute Hospital and Pre-Hospital Care Capital Projects

PROJECT STAGE – PLANNING	PROJECT STAGE – CONTINUATION OF CONSTRUCTION IN 2011	PROJECT STAGE – CONSTRUCTION COMPLETED IN 2011
Dublin Mid-Leinster	**Dublin Mid-Leinster**	**Dublin Mid-Leinster**
• Dublin Maternity Hospitals – relocation projects • St. James's Hospital, Dublin: - Haematology/hepatology project - Centre of excellence for successful ageing project	• St. Vincent's University Hospital, Dublin – new clinical building (phase 2) including wards, cystic fibrosis unit and dermatology unit. • National Maternity Hospital – emergency theatres and associated accommodation	• AMNCH Dublin – laboratory upgrade • Children's University Hospital, Temple St., Dublin – theatre upgrade • Our Lady's Children's Hospital, Crumlin – paediatric intensive care project
Dublin North East	**Dublin North East**	**Dublin North East**
• Our Lady of Lourdes Hospital, Drogheda, Co. Louth: - Construction of ward block (50 replacement beds – single rooms), plus new theatre department (x4 theatres); - Construction of ward block (50 replacement beds – single rooms), plus new theatre department (x4 theatres); - Medical education centre • Rotunda Hospital, Dublin – maternity reconfiguration • Connolly Hospital, Dublin – MRI installation	• Mater Misericordiae University Hospital Dublin: - Mater Adult Hospital – redevelopment including emergency department (ED) and 12 observation beds; outpatients department (OPD); intensive care unit (ICU)/high dependency unit (HDU) (36 beds); 12 new theatres; radiology; central sterile services department (CSSD) and 120 replacement beds	• Beaumont Hospital, Dublin – neurosurgery upgrade • Cappagh National Orthopaedic Hospital, Dublin – 3 modular theatres upgrade • Our Lady of Lourdes Hospital, Drogheda, Co. Louth - Intensive care unit upgrade - Installation of a modular mortuary - New medical assessment unit • Cavan General Hospital – renal unit, refurbishment/upgrade • Connolly Hospital, Dublin – surgical block and endoscopy suite refurbishment • Mater Misericordiae University Hospital Dublin – mortuary upgrade and water distribution system upgrade
South	**South**	**South**
• Southern acute hospital reconfiguration project • Wexford General Hospital – new ED • St. Luke's Hospital, Kilkenny – new ED • Mallow General Hospital, Co. Cork – day procedures unit and endoscopy suite	• Kerry General Hospital, Tralee – new ED • Waterford Regional Hospital – ED extension including neonatal unit. • St. Mary's Orthopaedic Hospital, Cork – Upgrade of existing ward to facilitate relocation of Mercy University Hospital OPD • Cork University Hospital - MRI over PET CT - New medical assessment unit • Cork University Maternity Hospital – upgrade of existing recovery area to create an emergency obstetrics theatre	• Cork University Hospital - Development control plan - New cardiac renal unit - Installation of PET CT - New haemophilia/haematology day unit

PROJECT STAGE – PLANNING	PROJECT STAGE – CONTINUATION OF CONSTRUCTION IN 2011	PROJECT STAGE – CONSTRUCTION COMPLETED IN 2011
West	West	West
• University Hospital, Galway – new clinical block (initial phase – 50 bed) • Mid-Western Regional Hospital (MWRH), Limerick – outpatient block • Sligo General Hospital – medical education centre • Letterkenny General Hospital, Co. Donegal – medical education centre • Sligo General Hospital – ward block, enabling works	• Letterkenny General Hospital, Co. Donegal – new medical block, including ED, 19 bays; acute assessment unit, 11 bays plus 3 x 24 bed wards • Mayo General Hospital, Castlebar – replacement of radiology equipment in ED • Sligo General Hospital – replacement of radiology equipment • Mid-Western Regional Hospital, Limerick – new critical care block to provide 12 ICUs, 14 HDUs and 16 Critical Care Units • New Ambulance Stations - Thurles, Co. Tipperary - Nenagh, Co. Tipperary - Tuam, Co. Galway	• Ennis General Hospital – endoscopy facilities and equipment; lifts and associated works • Mayo General Hospital – new oncology day unit • University Hospital Galway – ventilation systems upgrade (5th floor) • University Hospital Galway – neo natal upgrade • Ennis General Hospital – ward block • Our Lady's Hospital, Manorhamilton, Co. Leitrim – ambulance station upgrade
Other	Other	Other
• AMNCH – Paediatric ambulatory and urgent care centre (as part of National Paediatric Hospital project) • National Forensic Mental Health Services (reconfiguration) – 80 replacement and 40 additional beds • National plan for radiation oncology • National central stores project • National secure units for children, various locations • NIMIS project – MWRH (Limerick), Mid-Western Regional Orthopaedic Hospital, (Croom, Co. Limerick), Ennis, Nenagh and Mayo General Hospitals, South Infirmary Victoria University Hospital (Cork), Connolly Hospital, Blanchardstown (Dublin) and Kerry General Hospital	• National Ambulance Control and Call Centre – ambulance service college • NIMIS, St. Luke's Hospital (Rathgar), Our Lady's Children's Hospital (Crumlin) and Naas General Hospital (Co. Kildare). • Fire safety risk assessments – approximately 180 assessments across a range of HSE premises • St. Joseph's Hospital, Stranorlar, Letterkenny, Co. Donegal – refurbishment as an administrative headquarters	• National Integrated Medical Imaging System project (NIMIS) – Sligo General Hospital, Beaumont Hospital and Mater Misericordiae University Hospital (Dublin), Waterford Regional Hospital, Our Lady of Lourdes Hospital (Drogheda), Our Lady's Hospital (Navan), Louth County Hospital, Cavan/Monaghan General Hospital • Maintenance contracts for fire alarm and emergency lighting systems in DML, DNE and the West

Non-Acute Capital Projects

Older Persons	Older Persons	Older Persons
• St. James's Hospital – centre of excellence for ageing • Borrisokane Co. Tipperary – new day hospital/day care centre on existing site Galway – New 24 bed alzheimer's residential unit	• St. Mary's Hospital, Mullingar, Co. Westmeath – 100 bed community hospital to accommodate 50 replacement beds from existing unit for older people • Kenmare, Co. Kerry – community hospital replacement • Keel, Achill Island, Mayo – day care centre	• Cookstown Way, Tallaght – day care centre • Cashel, Co. Tipperary – 65 bed CNU • Loughrea, Co. Galway – 100 bed CNU • Dungloe Hospital, Donegal – extension

PROJECT STAGE – PLANNING	PROJECT STAGE – CONTINUATION OF CONSTRUCTION IN 2011	PROJECT STAGE – CONSTRUCTION COMPLETED IN 2011
Mental Health	Mental Health	Mental Health
• Armagh Road, Crumlin, Dublin – 17 bed mental health day hospital and hostel • St. Fintan's Hospital, Portlaoise – refurbishment to provide accommodation for child and adolescent mental health service • Abbeyleix, Co. Laois – Equipping of residential accommodation • Our Lady of Lourdes Hospital, Drogheda, Co. Louth – new acute mental health unit • Ard Na Greine, North Circular Road, Dublin – refurbishment/upgrade • St. Brigid's Hospital, Ardee – replacement hostels/long stay accommodation • St. Ita's Hospital, Portrane – rehabilitation units • Killarney, Co. Kerry – combined challenging behaviour and mental health residential unit to facilitate re-location of remaining residents of St. Finan's Hospital • Cork University Hospital – acute mental health unit • Ballinasloe, Co. Galway – community mental health unit • Carrick on Shannon Project, Co. Leitrim – accommodation to allow for development of community based mental health services • University Hospital Galway – new acute mental health unit • Cherry Orchard Hospital, Ballyfermot, Dublin – 22 bed child and adolescent inpatient unit	• St. Mary's Hospital, Mullingar, Co. Westmeath – 100 bed community hospital to accommodate 50 replacement beds for mental health • St. Loman's Hospital, Mullingar, Co. Westmeath – replacement of St. Edna's ward to provide 20 bed special behavioural unit and up to 24 replacement beds • Grosvenor Road, Dublin – upgrade of hostel • Ballyfermot, Dublin – primary care including accommodation for mental health services • St. Vincent's, Fairview, Dublin – six additional beds in adolescent unit (phase 2) • Grangegorman, Dublin – replacement accommodation for all services on existing site including accommodation for residents and a day hospital • Beaumont Hospital, Dublin – 44 bed psychiatric unit • St. Ita's Hospital, Portrane – continuing care unit • Clonmel, Co. Tipperary – day hospital/ community mental health team headquarters • Wexford – 50 bed CNU to accommodate residents of St. Senan's Hospital • St. John's Hospital, Enniscorthy, Co. Wexford – 13 place high support mental health hostel (Mill View) to re-house residents from St. Senan's Hospital • Clare – refurbishment of Gort Glas Day Centre • Waterford Regional Hospital – upgrade of acute mental health unit • Kerry General Hospital, Tralee – high observation unit • Limerick – refurbishment of acute mental health unit • Grove House, Cellbridge, Co. Kildare – refurbishment/upgrade • Cherry Orchard Hospital, Ballyfermot, Dublin – child and adolescent day unit	• St. Mary's Flat/Lyons Villa, Chapelizod, Dublin – replacement of 15 beds • Ballyfermot Hostel, Cherry Orchard, Dublin – new 17 bed low support hostel • St. Loman's Hostel, Clondalkin Road, Dublin – new 17 bed low support hostel • Blanchardstown – high support hostel • St. Bridget's Hospital, Ardee, Co. Louth – continuing care refurbishment • Cavan General Hospital – interim acute psychiatric unit • Ballinasloe, Co. Galway – 50 bed CNU • Letterkenny, Co. Donegal – adult acute mental health unit • Clonmel, Co. Tipperary – 40 bed residential unit and high support hostel to accommodate residents of St. Luke's Hospital

PROJECT STAGE – PLANNING	PROJECT STAGE – CONTINUATION OF CONSTRUCTION IN 2011	PROJECT STAGE – CONSTRUCTION COMPLETED IN 2011
Disability	Disability	Disability
• Headway, 1-3 Manor Street, Dublin – acquired brain injury day unit • Tower View, Mullingar, Co. Westmeath – extension and refurbishment • Shalimar House, Navan, Co. Meath – upgrade • Redevelopment of National Rehabilitation Hospital, Dun Laoghaire	• National Rehabilitation Hospital, Dun Laoghaire, Co. Dublin – fire safety works • Oakridge Day Unit, Daughters of Charity, Blanchardstown, Co. Dublin – early intervention and assessment unit • Catholic Institute for Deaf People (CIDP), Navan Road – a village for the deaf, includes residential accommodation with education, cultural and sporting facilities • St. John's Hospital, Enniscorthy, Co. Wexford – 2 x 7 bed high support hostel (Havenview House) to re-house residents from St. Senan's Hospital • Angle Disability Day Care Centre, Dungloe, Donegal – refurbishment/ upgrade • Coralstown House, Co. Westmeath – refurbishment • Billistown, Co. Westmeath – refurbishment • Crookedwood, Co. Westmeath – refurbishment • St. Peter's Intellectual Disability Services, Castlepollard, Co. Westmeath – upgrade of residential units	• St. Raphael's Residential Unit, Youghal, Co. Cork – 30 bed residential unit to accommodate transfer of clients from original building • Angle Disability Day Care Centre, Dungloe, Donegal – minor upgrade of existing learning disability day centre
	Primary Care	Primary Care
	• Primary Care Centres: Glenties (Co. Donegal), Inchicore, Ballyfermot, Churchtown, Terenure, Donnybook and Mulhuddart (Dublin); Kilbeggan (Co. Westmeath), Longford, Newbridge (Co. Kildare), Kingscourt (Co. Cavan), Cavan, Kenmare (Co. Kerry), Schull (Co. Cork), Monksland and Castlerea (Co. Roscommon), Athenry (Co. Galway) and St. Mary's, Abbey (Co. Limerick)	• Primary Care Centres: Chamber House (Tallaght), Mountmellick and Portarlington, (Co. Laois), Naas (Co. Kildare), Macroom (Co. Cork), Mahon (Cork), Kilkenny City, Callan (Kilkenny), Carlow, Tramore (Co. Waterford), Roscommon, Ballina (Co. Mayo), City East (Co. Galway)
	Children and Families	Children and Families
	• Coovagh House, Limerick – Refurbishment	• Castlefield Child Residential Unit, Dublin – refurbishment • Ballydowd high support units – upgrade
		Palliative Care
		• Marymount Hospice, Cork – 24 replacement and 20 additional beds
		Social Inclusion
		• Corporate House, Limerick – drug and alcohol centre

Appendix 4 **Performance Against Key National Service Plan Targets 2011**

	KEY PERFORMANCE MEASURE	Actual 2010	Target 2011	Actual 2011
Primary Care	No. PCTs implementing structured integrated diabetes care	34	57	58
	No. PCTs continuing to implement structured asthma prevention and care	New 2011	16	16
	No. PCTs holding Clinical Team Meetings	348	518	425
	% newborn babies visited by PHN within 48 hours of hospital discharge	84%	95%	84%
	% children receiving child health development screening on time before reaching 10 months of age	58%	90%	82%
Acute Care	Inpatient discharges	588,432	574,400	588,623
	Day case discharges	734,967	755,100	804,274
	% patients admitted to hospital within 6 hours of ED registration	Not comparable	100%	47%
	% patients discharged from hospital within 6 hours of ED registration	Not comparable	100%	77%
	Inpatient elective procedures: adults waiting < 6 months	75%	100%	72%
	Day case elective procedures: adults waiting < 6 months	88%	100%	81%
	Inpatient elective procedures: children waiting < 3 months	46%	100%	41%
	Day case elective procedures: children waiting < 3 months	52%	100%	50%
	Breast cancer: % cases compliant with HIQA standard of 2 weeks (urgent referrals)	95%	95%	99%
	Acute medicine programme	New 2011	12 sites	12 sites
	No. defined stroke units in place	New 2011	9 sites	6 sites
	Structured heart failure treatment	New 2011	12 hospitals	7 hospitals
Children and Families	% children in care who have a written care plan (Child Care Regulations 1995)	90%	100%	90%
	% children in care who have an allocated social worker at the end of the reporting period	93%	100%	93%
Mental Health	No. of CAMHS teams	55	60	61
Disability	% of disability assessments completed within the timeframes (as per regulations)	21%	100%	23%
Older People	Total no. home help hours provided for all care groups	11,680,516	11,980,000	11,092,436
Palliative Care	Palliative care inpatient bed provided within 7 days	New 2011	92%	94%
Food Safety	High risk premises inspected	New 2011	23,441	21,010

Note: Information in table has been rounded

Appendix 5 **Annual Energy Efficiency Report**

Introduction

This appendix outlines the HSE's position on its energy use and actions taken to reduce consumption, in response to legislation (S.I. 542 of 2009) which requires public sector organisations to report annually.

Overview of Energy Usage in 2011

The HSE is the largest energy user in the country and as such, recognises its obligation to be at the forefront in introducing energy reducing initiatives. Whilst energy intensive equipment is partially responsible for yearly energy increases, it is the baseline use of light, heat and cooling that accounts for approximately 70% of energy use and it is here that savings must be made.

In 2011, the HSE consumed 1.33 TWh of energy:

- 572 GWh of electricity
- 745 GWh of fossil fuels
- 8.2 GWh of renewable fuels.

This reflects over 2500 MPRNs and up to 1000 GPRNs along with the various sites that have fossil and renewable energy. In this regard the figures contain a level of estimation. However, we are working with the Sustainable Energy Authority of Ireland (SEAI) in order to achieve full visibility by 2013.

Actions Undertaken in 2011

The HSE continues its close working relationship, both with the Department of Communications, Energy and Natural Resources and with the SEAI. In 2010 we were one of the first organisations to join the SEAI Partnership Programme. As part of the SEAI Energy Mapping we have obtained several licenses for an energy management software package which is now available to hospitals. This Energy Management Software package will assist Technical Services Departments in project managing their energy projects and will be very beneficial to sites seeking ISO 50001 accreditation.

In 2011 the HSE undertook a range of initiatives to improve our energy performance including:

- Our Lady of Lourdes, Drogheda Hospital Energy Efficient Upgrade.

  This energy project will reduce energy consumption for Our Lady of Lourdes Hospital campus by introducing controls to the current heating system for the main hospital campus and decentralising the heating system by removing Steam/low pressure hot water (LPHW) heat exchangers and replacing with local LPHW boilers, thus improving efficiency and eliminating steam distribution losses. We also replaced the existing lighting installation with energy efficient T5 fluorescent light fittings. The primary energy equivalent of 13,117 GWh will be saved by 2016.

- Retrofitting of energy efficient lamps and adaptors in Cork University Hospital.

  Energy savings coupled with a fast payback were achieved by replacing 112 T8 lamps with T5 lamps and adapters in the Central Sterile Services Department (CSSD)/Hospital Sterile Supply Unit (HSSU) area and Ward 1A. In the CSSD/HSSU area the savings are 12,720 kWh and in Ward 1A they are 25,439kWh. Retrofitting of the 10 remaining wards outside 1A will give an estimated energy saving of the order of 254,390kWh.

Actions Planned for 2012

In 2011, results were obtained from the monitoring equipment which had been used to monitor the energy efficiency of Kinsale Community Hospital, Co. Cork for the previous 12 months. The potential savings are major, estimated at over 35% and of the order of 261,182kWh. This project was run in cooperation with Bord Gáis Networks.

The HSE has developed and is in the process of rolling out its long term, strategic programme for energy reduction by improving energy efficiency. The programme will pivot around the Energy Management Concession concept, which will deliver guaranteed energy savings through energy efficiencies year on year. This programme is based on the fundamental principle of driving energy efficiency by deploying energy management experts utilising cutting edge technology who will be contractually committed to delivering guaranteed energy savings.

A pilot programme was initiated in 2011. The first project consisted of sites from HSE South split into two lots, Lot 1 covering sites in the Cork and Kerry region and Lot 2 with sites in Kilkenny, Carlow, Wexford, South Tipperary and Waterford. We have now broadened the programme to include St. James's Hospital, Dublin as the first major site. This programme will deliver savings in 2013 and judging from the estimated savings at the Kinsale Community Hospital above, we believe the potential for savings nationally from this programme to be substantial.

Financial Statements 2011

Financial Statements

Operating and Financial Review

This operating and financial review outlines the key financial results for 2011, along with the principal drivers of the HSE's performance, both past and future.

Overview

The HSE delivered a balanced Vote in 2011. 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 gross Vote outturn of €13.687 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 2011 was €15.781m, (2010: €18.977m excluding savings of €150m arising from the lower than expected uptake of the exit schemes in 2010), or less than 0.1% (2010: 0.17%) of the total net Vote of the HSE.

A Supplementary Estimate of €148m was voted by Government to the HSE at the end of 2011 which included €58m due to the HSE relating to the 2010 exit scheme and a transfer of €40m from the Vote of the Department of Health. €100m of this additional funding was applied directly to the Primary Care Reimbursement Service (PCRS) in respect of primary care and medical card schemes.

The HSE reported a surplus in the revenue income and expenditure account of €98.426m for 2011 (2010: €123.924m). A substantial element of this surplus is technical in nature and is attributable to the differences between the differing bases of accounting under accruals and Vote 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 2011 amounted to €345.424m (2010: €369.217), of which €204.311m was expended on HSE capital projects and €132.755m on capital grants to service providers. This is offset by an Adjustment to Liability to the Exchequer of €19.388m which relates to balance on capital proceeds of disposal account indirectly remitted by way of a reduced technical adjustment on the establishment of the HSE in 2005, netted against historical capital expenditure deficits in 2011. Accordingly, a surplus of €27.746m for 2011 (2010: deficit €1.149m) was reported in the capital income and expenditure account. A list of these service providers and the respective capital grant amounts is detailed in Appendix 2 to the Annual Financial Statements.

Table 16: Key Financial Information 2011 – Vote Accounting

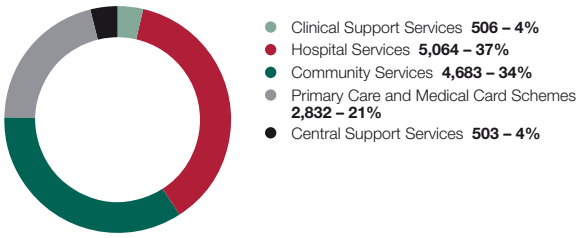
	Estimate €'000	2011 Vote Outturn €'000	Under/(Over) €'000
Gross Revenue Expenditure	13,564,696	13,469,876	94,820
Gross Capital Expenditure	377,791	432,954	(55,163)
Total Gross Vote Expenditure	**13,942,487**	**13,902,830**	**39,657**
Receipts Collected by HSE	1,079,942	1,016,724	63,218
Other Receipts (Revenue)	401,564	441,323	(39,759)
Other Receipts (Capital)	541	124	417
Total Appropriations in Aid	**1,482,047**	**1,458,171**	**23,876**
Net Total Expenditure	**12,460,440**	**12,444,659**	**15,781**

Table 17: Key Financial Information 2011-2010 – Accruals Basis

	2011 €'000	2010 €'000	Change €'000
Income	13,686,620	14,201,193	(514,573)
Net Operating Surplus	98,426	123,924	(25,498)
Revenue Expenditure			
Pay and Pensions	5,051,788	5,144,801	(93,013)
Non-Pay (HSE only)	5,086,702	5,285,387	(198,685)
Grants to Outside Agencies	3,449,704	3,647,081	(197,377)
Capital Expenditure	317,678	370,366	(52,688)
Capital Commitments	797,080	907,316	(110,236)
Net Surplus on Vote to be Surrendered to the Exchequer	15,781	168,977	(153,196)

The main areas of expenditure in 2011 are set out in Figure 34. As can be seen, €5.064bn (37%) was spent on our hospital services, €4.683bn (34%) on community services, €2.832bn (21%) on primary care and medical card schemes and the remainder (8%) on either central or support services. Just under €318m was spent on maintaining and developing the capital infrastructure of the health system.

Figure 34: Breakdown of Total Expenditure by Service (€m and %) 2011



Data source: HSE Corporate Finance

Key Financial Performance Messages

- The HSE delivered a balanced Vote in 2011 with a small surplus to be returned to the Exchequer.
- The results for 2011 show a total expenditure of €12.516 billion against a full year budget of €12.499 billion. The overall deficit for the health system on an accruals basis at the end of December is €17.2m, after taking account of the Supplementary Estimate revision of €148m.
- Hospital services to the end of 2011 reported a deficit against budget of €125.3m. Within community services to the end of 2011 there is a surplus against budget of €21.1m. The PCRS finished the year with a deficit of €14.4m or 0.6% of its allocation following the application of the supplementary estimate.
- 2011 was another very challenging year financially for the HSE with a total opening budget reduction of €962m (6.7%) and a net reduction of €683m (4.8%) as a result of €279m of additional planned expenditure. Activity levels above Service Plan were delivered in most areas.
- The delivery of such a strong in-year cost management performance against very challenging economic conditions is a significant achievement worthy of note. Whilst each region contributed to the overall balanced Vote reflecting proactive management of expenditure throughout 2011, the South is particularly commended for achieving a breakeven position for the year. Similarly, NSP 2011 set very significant expenditure reduction targets for the PCRS which were mainly achieved in the year with an overall reduction in expenditure of €360m in 2011. The underlying challenges in hospitals and childcare require to be addressed early in 2012 in the context of NSP 2012. The hospitals facing the largest challenge based upon the outturn for 2011 include Tallaght, Limerick, Galway and Portiuncula, Letterkenny and Drogheda. While €40m has been provided to Childcare there is still a significant financial challenge to be faced in 2012.
- The HSE is now taking immediate action to review the plans of these hospitals to achieve a balanced budget in the context of the NSP 2012 and the recently issued budgets. It is recognised that there is a real challenge in maintaining services while meeting the financial targets for 2012 in these hospitals.

Key Service Messages

- Inpatient discharges at the end of December was 2.5% (+14,223) more than expected levels of activity but only marginally ahead of 2010 levels (+191). The total number of inpatient discharges to the end of December was 588,623 of which 66.7% (392,894) were emergency cases.
- The number of day cases for 2011 stood at 804,274, 6.5% (+49,174) ahead of targeted activity and 9.4% (+69,307) more than 2010.

- At the end of December inpatients and day cases combined exceeded 1.39 million which is 5.2% (+69,498) more than December 2010.
- Demand for elective procedures increased as the number of people listed for procedures grew on average by 22% from June to December 2011, compared to the previous year. The end of December 2011 figure was 18% higher (+9,786) than the same period in 2010.
- 11,688 people were waiting more than 6 months (NSP 2011 target) at the end of Dec 2011 compared to 7,402 at the end of December 2010, a 47% increase.
- In recognition of the increased demand and pressure on supply in 2011, a primary target list (PTL) was created in August to ensure that, in the first instance, nobody waited more than 12 months for a planned procedure by the end of the year.
- This was achieved in 39 out of 40 hospitals, 372 people were waiting over 12 months at December 31 (in the Galway hospitals GUH and Merlin Park) compared to 1,083 at the same period in 2010.
- There were 1.168 million emergency presentations during 2011, a decrease of -2.6% on expected levels of activity and -1.1% below 2010 levels.
- Emergency admissions for 2011 amounted to 372,462, exceeding 2010 levels by 0.8% (+2,969).
- The number of contacts with GP Out of Hours Services for 2011 was 949,703 and remains 5.6% (+50,514) more than 2010. The number of contacts recorded for December (89,925) was 13.6% higher than the actual monthly average number of contacts for the year (79,142).
- The Medical Card Processing Office at PCRS has processed 953,873 Medical Card applications and reviews and issued 708,832 Medical Cards on foot of these applications since the centralisation process began. Applications are currently being processed at a rate of approximately 20,000 per week. Following the first six months of the operation of the centralised medical card system, the HSE has established a project to review and further develop the processes and customer service elements of the centralised medical card system and to recommend and implement improvements to existing processes as required.
- At the end of December there were 425 Primary Care Teams in operation which is 87% of the revised HSE target of 489. The 425 Primary Care Teams are at various stages of maturity and development. They provide services to a population of over 3.4 million with 3,117 staff members and over 1,592 GPs participating. The governance and management model of Primary Care Teams is currently being reviewed to take account of the models of care proposed under the Programme for Government.
- At the end of December there were 22,327 people supported under the Nursing Homes Support Scheme. Additionally, there were 583 persons whose application was determined to final stage but who were still on the national placement awaiting placement approval. In 2011 there was an additional net increase of 629 people provided for under the scheme.
- During 2011 12,798 referrals were received by the 53 Community Child and Adolescent Mental Health Teams. This represents a 10.8% (+1,248) increase over the number of referrals received in 2010 (11,550).

Primary Care Reimbursement Service (PCRS)

Expenditure in PCRS amounted to €2,517m, a saving of €360m on the start of the year's forecasted expenditure of €2,877m. A number of cost management initiatives were set out in the NSP 2011. These initiatives generated reductions totalling €243 million. These included:

- Changes to pharmaceutical pricing and reimbursement regimes
- Changes to GP fees
- Introduction of a prescription charge which delivered demonstrable cost savings.

Other initiatives improved the efficiency and effectiveness of operations and influenced contractor/client behaviour which impacted positively on the resulting demand for services and the financial outturn by year end.

The delivery of such a strong cost management performance in the context of challenging economic conditions as reflected in the increased Live Register numbers and the commensurate impact these factors have on demand for schemes, is a significant achievement. Table 18 provides a breakdown of the savings achieved by initiative during the year.

Table 18: Breakdown of PCRS savings achieved in 2011

Initiative	Saving 2011
Full year effect of 2010 schemes	**€29m**
Efficiencies and control including probity and fees	**€51m**
Full year 2010 savings – Prescription charges	**€27m**
Drug price reductions	**€131m**
Efficiencies in high tech drugs	**€4m**
Total	**€243m**

Data source: PCRS Statistical Analysis
Note: Information in this table has been rounded

Strengthening Governance Arrangements with the Non-Statutory Sector

The HSE provided funding of €3.45bn to non-statutory agencies to deliver health and personal social services. In total 2,878 agencies were funded, with 3,879 separate funding arrangements in place.

- Acute Voluntary Hospitals €1.76bn (51%)
- Non Acute Agencies €1.69bn (49%)

The level of funding provided by the HSE to individual agencies varied from €100 to €329m, with nine agencies accounting for over 50% of the funding and 91 agencies accounting for over 90% of the funding.

Continued Cost Management in 2011

Over the last number of years the HSE has been actively engaged in a programme to reduce the cost base, ensuring that the resources are used to provide real value for money (VFM). A cost reduction target for the four year period 2007-2010 was set at €500m. At the end of 2010, a cumulative total of €684m savings had been achieved. Considerable input from services and management was required to manage financial resources in the most efficient and effective way possible during 2011 while maximising the level of service. Rigorous attention ensured that significant savings achieved in previous years were maintained, with an additional €202.8m reduction target for 2011.

Cost reductions of €178.4m were delivered against this target. The range of reductions agreed for 2011, reflect the outcome of a process where the HSE focused on maximising the financial impact of nationally led programmes and processes to ensure the least impact on levels of service in meeting financial breakeven requirements.

In addition to savings in pay, these reductions also included the management and delivery of procurement and logistics, estates, and education and training activities, as well as a national approach to managing discretionary expenditure under a number of headings such as maintenance, furniture and vehicles. The delivery of non-pay savings required not only significant engagement and negotiation with the HSE's supplier base in seeking to reduce prices and control volumes of stock of supplies and services, but also considerable attention by services and managers to maximise the efficient use of non-pay resources while responding to an increased demand for services. These further economies were challenging not only because of the requirement to maintain VFM from previous years and to continue to manage cost growth, but also, and very significantly, in the context of managing areas of increasing spend, increasing service activity, and delivering on broader service reconfiguration and improvement priorities. There is also evidence of significant efficiencies achieved through the management of non-pay cost growth and the resulting cost avoidance. Services are being delivered more efficiently by not growing costs and between 2008 and 2011 this saving amounted to €1.2bn. For example, if medical and surgical cost growth had not been managed between 2010 and 2011, the projected opening cost for 2012 would be nearly €22m or 5% higher. Equally, catering would be €3m or 3.8% higher or office, rents and rates costs would be €13m or 7% higher.

State Indemnity and the Clinical Indemnity Scheme

On 1 January 2010 the management of HSE non-clinical personal injury and third party property damage claims was delegated to the State Claims Agency (SCA) under the National Treasury Management Agency (State Authority) Order 2009. Negligent acts or omissions of servants and/or agents of the HSE that result in personal injury or third party property damage which were previously conventionally insured under liability insurance policies are now covered under State indemnity.

The Clinical Indemnity Scheme (CIS) was established in 2002 to rationalise pre-existing medical indemnity arrangements by transferring to the State responsibility for managing clinical negligence claims and associated risks. Under the scheme, which is managed by the SCA, the State assumes full responsibility for the indemnification and management of all clinical negligence claims, including those which are birth-related. The State Indemnity and CIS schemes are funded on a pay-as-you-go basis. Payments in respect of State Indemnity and CIS claims in 2011 were €81.204m (2010: €79.283m). At 31 December 2011, the estimated liability incurred to that date under the Clinical Indemnity Scheme and State indemnity was €866m. In accordance with the directions of the Minister for Health, no provision has been made for this liability in the financial statements.

Business Environment and Implications for 2012

The budget provision for 2012 represents a major challenge to the HSE and comes at a time of significant reform of the public health system. The total quantifiable cost reduction target of €750m for 2012 follows two unprecedented years in the history of the health service in which the HSE had total budget reductions of €1.75bn. Staff levels have reduced by over 8,700 since the peak employment levels in 2007.

In the last two years, the reductions in health expenditure have been achieved largely through a combination of price reductions such as public service pension levy and pay cuts, procurement efficiencies, successive drug price reductions and cuts in fees for GPs and community pharmacists as well as changes in demand-led schemes, increases in charges and reductions in numbers employed. In 2012, the savings measures largely relate to reductions in numbers employed but there are also other reductions in pay costs and service efficiencies. As a result of the scale

of the cost reductions required and the accumulated reductions in frontline staff, the bulk of the reductions that the HSE is required to deliver in 2012 will impact increasingly directly on frontline services. This is mainly because of the anticipated reduction in the numbers of staff who will have exited the services by the end of February 2012 at the end of the "grace period". A review of the 2012 National Service Plan will be needed once the full impact of staff leaving is known.

Priorities for 2012 are to:

- Deliver the maximum level of safe services possible for the reduced funding and employment levels, including addressing insofar as possible the unstructured nature of the downsizing. This involves prioritising some services over others to meet the most urgent needs resulting from demographic growth and Government and service priorities.
- Deliver the cost reductions needed to deliver a balanced Vote in 2012.
- Support the continued implementation of the reform programme including the HSE National Clinical Care Programmes.
- Implement key elements of the Programme for Government particularly in children and families, mental health, primary care and acute hospitals, and the recommendations of the Comprehensive Expenditure Report 2012-14.

The 2012 National Service Plan includes large cost reduction targets, the achievement of which is critical to delivering a balanced Vote. There is a risk that the services will struggle to meet the targets set. The timing of legislation is critical to the successful delivery of community drug schemes and income targets. The absence of a single national financial system and the HSE's dependence on multiple disparate/standalone or legacy systems renders data less reliable. This is problematic in an environment where the Vote is being broken into care groups and systems struggle to support this.

There may be additional adverse financial impact if the numbers leaving in 2012 exceed 3,000 WTEs, which would require additional lump payments to be made from service budgets. Management will actively monitor and assess all of these and other risks that emerge as 2012 proceeds and, depending on their impact, may need to adjust planned service levels during the year to ensure the HSE can operate within its Estimate.

Conclusion

The HSE delivered National Service Plan commitments within its funding provision in 2011 against very challenging resource constraints, both in financial and staffing terms. There is a fundamental challenge in terms of our ability to maximise services through fast tracking new, innovative and more efficient ways of using a reducing resource. While it will be impossible to avoid an impact on frontline service delivery in 2012, the imperative for accelerated health reform is equally clear. There is a clear and pressing need, as outlined in the HSE National Clinical Programmes, to move to models of care across all services/care groups which treat patients at the lowest level of complexity and provide services at the least possible unit cost. If the cost base within the health service is to be adjusted in line with the requirements of the Comprehensive Expenditure Report 2012-14, the focus must be on reconfiguration, reform, greater productivity and challenging traditional cost structures and models of service delivery. Staffing levels, skill mix and staff attendance patterns/rosters also need to be addressed within the context of the Public Service Agreement 2010-2014. However all of these efficiencies will not compensate for the loss of frontline healthcare delivery staff in such large numbers. The NSP 2012 will be implemented while the structural reform of the HSE and health services are being progressed as outlined in the Programme for Government and as recently announced by the Minister for Health. During 2011, the HSE worked with Government to begin to lay the foundations for this major health reform programme. The HSE is committed to continuing this work to modernise, streamline, and reorganise health services to ensure that patient centred, accessible, affordable, and sustainable services are available to the whole population.

Board Members' Report

Introduction

The HSE Board is the governing authority of the HSE, which is the State's largest organisation, and is accountable to the Minister for Health. The HSE had a revenue expenditure of €13.588bn in 2011, with more than 104,000 whole time equivalent staff delivering services throughout the country (approximately one third of whom work for related service delivery agencies).

The Board has responsibility for the performance of the functions of the HSE as prescribed under sections 7 and 12 of the Health Act 2004. This involves a wide range of significant functions and duties including responsibility for reviewing, approving and monitoring the progress of the HSE Corporate, Service and Capital Plans. The Board also approves significant expenditure as well as ensuring that financial controls and systems of risk management in place are robust and accountable. In addition, Board members provide a value-added input to HSE strategy, act as a catalyst for change and challenge, advise and support the Chief Executive Officer (CEO) and management.

Members

The Board consists of 11 members, the Chairman and 10 ordinary members who are all appointed by the Minister for Health, in accordance with Section 11 of the Health Act 2004.

The CEO of the HSE is also an ex officio member of the Board.

The Irish health services entered a new phase in April 2011 with plans set in train to see a significant change in the relationship between the HSE and the Minister for Health/DoH. The composition of the Board was changed to reflect this new relationship. The new Board consists of senior figures from the DoH and from the HSE, including clinicians.

The Board members, as of 31st December 2011, are listed on page 5.

Committees of the Board

The Health Act 2004 provides for the establishment by the Board of committees to provide assistance and advice to the Board in relation to the performance of its functions.

The Board determines the membership and terms of reference of each committee.

The Board currently has three standing committees: the Audit Committee, the Remuneration and Organisation Committee and the Risk Committee. The Special Delivery Unit (SDU) Committee was established in June 2011 to provide the appropriate leadership and oversight within the HSE to ensure the SDU's processes, to improve the effectiveness and quality of services for patients, are integrated with existing implementation plans of the organisation.

Audit Committee

The Audit Committee membership comprised Mr. Tom O'Higgins (Chairman), Mr. Paul Barron, Ms. Laverne McGuinness, Mr. Brian Gilroy and Ms. Mary Dooley following the change in Board membership in May 2011.

The Committee reports to the Board on all aspects of financial reporting and accounting policy, with particular emphasis on the effectiveness of the HSE's system of internal financial control. The National Director of Finance and the National Director of Internal Audit attend meetings of the Committee, while the CEO and other members of the Management Team attend when necessary.

The external auditors attend as required and have direct access to the Committee Chairman at all times. The Committee meets with the HSE's external auditors to plan and review results of the annual audit of the HSE's annual financial statements. The Committee receives quarterly 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.

Remuneration and Organisation Committee

The Remuneration and Organisation Committee membership comprised Dr. Frank Dolphin (Chairman), Mr. Cathal Magee and Mr. Michael Scanlan following the change in Board membership in May 2011. The Remuneration and Organisation Committee operates under agreed terms of reference and is responsible for making recommendations to the Board on remuneration and organisational matters in the HSE.

Risk Committee

The Risk Committee membership comprised Dr. Paula Kilbane (Chairman), Ms. Bairbre Nic Aongusa, Dr. Tony Holohan, Dr. Barry White, Dr. Philip Crowley, Ms. Margaret Murphy, Mr. Paul Harrison, Ms. Avilene Casey and Mr. Dermot Monaghan following the change in Board membership in May 2011.

The Risk Committee operates under agreed terms of reference and focuses principally on assisting the Board in fulfilling its duties by providing an independent and objective review of non-financial risks. The Committee also considered internal audit reports concerning the effectiveness of non-financial internal controls and HIQA reports including the implementation of HIQA recommendations.

To date the HSE risk management function has been established within the Quality and Patient Safety Directorate and is developing, as the HSE as an organisation, evolves towards maturity. Full liaison between the Audit and Risk Committees of the Board is essential to the proper functioning of these two inter-related Board committees. Liaison is facilitated by meetings of the two committees and ongoing engagement between the two Committee Chairs.

Other Committees

Special Delivery Unit (SDU) Committee

The Committee provides the appropriate leadership and oversight within the HSE to ensure the SDU's processes, to improve the effectiveness and quality of services for patients, are integrated with existing implementation plans of the organisation.

The SDU Committee membership comprised of Dr. Martin Connor (Chairman), Mr. Tony O'Brien, Dr. Siobhan O'Halloran, Dr. Barry White, Ms. Jane Carolan and Ms. Laverne McGuinness in 2011. The SDU Committee operates under agreed terms of reference as set out by the Board.

Support to the Committees

Support to the Board, and its committees, is provided by the Secretary to the Board, Mr. Dara Purcell. National Directors and other senior staff attend and report as required to the Board Committees.

Meetings of the Board and its Committees

In accordance with Schedule 2 of the Health Act 2004, the Board is required to hold no fewer than one meeting in each of 11 months of the year. In 2011 the Board met on 16 occasions, holding 11 monthly Board meetings and five additional meetings. The Audit Committee met on six occasions, the Remuneration and Organisation Committee met on three occasions and the Risk Committee met on six occasions. The SDU Committee met on three occasions.

The attendance at Board meetings and its Committees is recorded in tables 19 and 20.

Table 19: Attendance at Meetings of the Board

Scheduled HSE Board Meetings (11)		Additional HSE Board Meetings(5)	
F. Dolphin[4]	11/11	F. Dolphin[4]	5/5
N. Brennan[1]	4/4	C. Magee[4]	5/5
P. Farrell[1]	3/4		
J. Fitzgerald[1]	2/4		
N. Hunt[1]	4/4		
S. Langford[1]	4/4		
J. Lavelle[1]	4/4		
C. Magee[4]	11/11		
E. McCague[1]	4/4		
J. Mooney[1]	4/4		
A. Scott[1]	3/4		
D. Power[1]	4/4		
M. Scanlan[2]	6/7	M. Scanlan[2]	5/5
T. Holohan[2]	7/7	T. Holohan[2]	2/5
P. Barron[2]	7/7	P. Barron[2]	4/5
B. Nic Aongusa[2]	7/7	B. Nic Aongusa[2]	3/5
B. White[2]	6/7	B. White[2]	3/5
P. Crowley[2]	6/7	P. Crowley[2]	4/5
L. McGuinness[2]	7/7	L. McGuinness[2]	5/5
B. Gilroy[2]	7/7	B. Gilroy[2]	5/5
M. Connor[3]	2/6	M. Connor[3]	2/5

Number of meetings attended/number of meetings scheduled during members tenure
Note 1: Board Members 01/01/11 – 19/05/11
Note 2: Board Members 20/05/11 – 31/12/11
Note 3: M. Connor appointed to the Board on 06/06/11
Note 4: Board Members Jan-Dec 2011

Table 20: Attendance at Meetings of Board Committees

Audit Committee		Remuneration and Organisation Committee	
N. Brennan	3/3	F. Dolphin	1/1
S. Langford	3/3	P. Farrell	2/2
J. Mooney	3/3	J. Fitzgerald	2/2
P. Barron	3/3	N. Hunt	2/2
L. McGuinness	2/3	C. Magee	1/1
B. Gilroy	3/3	M. Scanlan	1/1

Risk Committee		SDU Committee	
S. Langford	2/3	B. White	2/3
J. Lavelle	2/3	L. McGuinness	2/3
E. McCague	1/3	M. Connor	3/3
J. Mooney	3/3		
A. Scott	3/3		
D. Power	2/3		
T. Holohan	3/3		
B. Nic Aongusa	3/3		
B. White	2/3		
P. Crowley	3/3		

Number of meetings attended/number of meetings scheduled during members tenure

HSE's Framework for Corporate and Financial Governance

The HSE's Framework for Corporate and Financial Governance was drafted to meet the requirements of the *Health Act 2004* and best practice requirements for public sector organisations in relation to corporate governance. Following approval by the Board, the receipt of Ministerial approval and discussion with the trade unions, the first governance suite of documents was published on the HSE's website in 2009.

Representatives of the various National Directorates assigned had specific responsibility for implementation of framework documents ensuring that the framework requirements are embedded in the organisation. Consistency with other policy developments within each directorate is also assured. Some documents specify responsibilities for more than one directorate in relation to implementation.

The Minister, when approving the framework, specified that there will be a requirement to conduct a full review of the framework within three years of publication. A review process was completed in the HSE in 2011, the progress of which is monitored at Audit Committee and overseen by a member of the Management Team with the assistance of a Quality and Risk Manager.

The *Framework for Corporate and Financial Governance* has been comprehensively reviewed to ensure that it is consistent with the revised *Code of Practice for the Governance of State Bodies* (published November 2009), emerging legislation, the National Standards for Safer Better Health Care and HSE organisational structural changes.

A number of changes have been made including the inclusion of a new Part III which outlines the HSE assurance framework. This describes the four levels of assurance within the HSE and, for the employee, explains the linkages between what is required of them, which is now clearly outlined in Part II of the framework, and the various methods used within the HSE to provide assurance of compliance. A webpage is developed which allows access to the framework and the supporting policies, procedures and guidelines. Each National Director ensures that their teams have full knowledge of the responsibilities now clearly outlined in Part II of the framework and that it is against this that all compliance is benchmarked. The updated HSE Code of Governance was presented to the Board at the July 2011 meeting and subsequent approval from the Minister for Health, in accordance with Section 35 of the *Health Act 2004* was obtained.

Statement of Board Members' Responsibilities in respect of the Annual Financial Statements

The members of the Board are responsible for preparing the annual financial statements in accordance with applicable law.

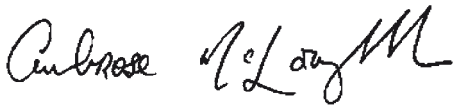
Section 36 of the Health Act 2004 requires the Health Service Executive to prepare the annual financial statements in such form as the Minister for Health may direct and in accordance with accounting standards specified by the Minister.

In preparing the annual financial statements, Board members 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 Board members 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 Board members 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



Dr Ambrose McLoughlin
Chairman

18 May 2012

Statement on Internal Financial Control

This Statement on Internal Financial Control represents the position in place in the year ended 31 December 2011.

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 Board of the HSE is the governing body with authority to perform the functions of the HSE. The Board may delegate some of its functions to the Chief Executive Officer (CEO). The Board may establish committees to provide assistance and advice to it in relation to the performance of its functions. The Board has established a number of Committees including an Audit Committee and a Risk Committee which comprise both Board members and external nominees.

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

The CEO's functions include implementation of Board policy, oversight and management of performance, management of effective control systems and reporting on performance, as required. The CEO is the Accounting Officer for the HSE. He must also supply the Board with such information (including financial information) relating to the performance of his functions as CEO as the Board may require.

The Board together with the CEO have 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 for the implementation and maintenance of internal controls over their respective functions. This embedding of the system of internal 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 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 Board make this statement in accordance with the Department of Finance Code of Practice for the Governance of State Bodies. In making this Statement on Internal Financial Control the Board has relied on the Statement made by the CEO as Accounting Officer in the 2011 Appropriation Account.

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 incurred by the HSE are stringent in terms of accountability and transparency in order to fulfil our responsibility for funding amounting to €13.68 billion from the Exchequer in 2011. These duties are set out in the Health Act 2004 and in the Public Financial Procedures of the Department of Finance.

Maintaining the system of internal financial controls is a continuous process and the system and its effectiveness are kept under continuous review. Development, maintenance and monitoring of this system of internal control involves additional challenges in the HSE, where devolved financial systems are multiple and fragmented and are not fit-for-purpose. The financial systems are not capable of providing the level of detailed analysis of Vote expenditure which is required by Government Accounting rules. The HSE relies on an interim reporting solution to support all national level financial reporting, including monthly management reports, the Annual Financial Statements and the Appropriation Account. This system imports data from 12,000 cost centres per month from HSE legacy systems and is manually manipulated 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, the ageing of the system and the loss of key finance staff. Incremental development of the system continued in 2011 to implement a single capital payment process and a cash projection model, using existing system licences. The solution is to invest in people and systems to meet the emerging needs of the health environment, building an integrated national ledger to support the emerging health structures and the development of a 'close to report' process that can deliver data within a week of month end. The HSE is in discussions with the Department of Health on these proposals with a view to collectively agreeing an approach to systems development in the short to medium term.

The 2011 National Service Plan was adopted by the Board in December 2010 and approved by the Minister for Health on 21 December 2010 within the statutory timeframe. During 2011 monitoring and evaluation of performance and budgets against service plan objectives was carried out.

Effective Internal Financial Control

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

- 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 Framework for Corporate and Financial Governance was comprehensively reviewed in 2011 to ensure that it is consistent with the revised Code of Practice for the Governance of State Bodies (published November 2009), emerging legislation, the draft HIQA National Standards for Safer Better Health Care and HSE organisational structure changes. A number of changes have been made to the original framework including the inclusion of a new part III which outlines the HSE Assurance Framework. This describes the four levels of assurance within the HSE and for the employee explains the linkages between what is required of them – now clearly outlined for them in part II of the Framework – and the various methods used within the HSE to provide assurance of compliance. A webpage was developed on www.hse.ie which allows access to the Framework and the supporting Policies, Procedures and Guidelines. Each National Director is undertaking to ensure that their teams have full knowledge of their responsibilities now clearly outlined in part II of the Framework and that it is against this that all compliance is benchmarked. The updated Code was presented to the Board at its July 2011 meeting and subsequent approval from the Minister for Health in accordance with Section 35 of the Health Act 2004 was obtained.
- 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 CEO.
- The HSE's National Financial Regulations form an integral part of the system of internal 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 Finance 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 a dynamic and continuous process, with new regulations and updates to existing regulations issued periodically in response to new or emerging requirements. While policies and regulations are nationally standardised, internal processes are largely systems-driven, and variations in process remain unavoidable until such time as the HSE has implemented a single organisation-wide financial system.
- The HSE recognises the importance of 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 Directorate 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. A new Quality and Patient Safety Directorate was established in January 2011 with a focus on the development and implementation of safe quality healthcare. An integrated approach to risk management is utilised, incorporating both clinical and non-clinical risk. 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 Board 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. In 2011 implementation groups were established to oversee recommendations from both internal and HIQA reports such as in regard to Mallow and Ennis Hospitals. The risk management processes in the HSE, while being developed, are still relatively immature. The full suite of HSE Risk Management policies, procedures and guidelines were revised and updated in 2011 and are published on www.hse.ie.
- A formal external review of the Risk Management Function in the HSE was commissioned by the Board of the HSE and conducted in 2011.The purpose of this review was to review the current risk management function in terms of its design, structure, annual cost, and stage of implementation, addressing the following:
- key HSE policies and standards, specifically:
  - the HSE Quality and Risk Standard,
  - the HSE Integrated Risk Management Policy, and,
  - the HSE Quality, Safety and Risk Management (QSRM) Framework
- the current stage of implementation of the QSRM Framework and likely trajectory
- the design of the Quality and Patient Safety Directorate, and,
- the annual cost of the above

The primary focus was to establish the current position in the HSE transition to a fully integrated and functioning risk management function and to:

- bring forward any blocks to progress
- identify resource/structural deficits
- identify actions to address these

Having summarised the assessment of the current state of implementation, the report also identified a wide range of recommendations to accelerate adoption of the quality safety and risk management agenda. Management have prepared plans for the implementation of these recommendations and progress against these plans was monitored by the Risk Committee during 2011.

- Under Section 29 of the Health Act 2004, the HSE is required to prepare a formal 3 year plan, known as the HSE's Corporate Plan. The plan provides the overarching framework within which the organisation will address its priority areas, or key activities, over the three years and gives guidance on where we will focus the efforts of staff and the targeting of resources. The second HSE Corporate Plan covered the years 2008-2011 and set out what the HSE planned to achieve during that timeframe. A draft third plan was submitted to the Minister for Health on 9 September 2011 in accordance with the legislation and this is currently under consideration in the context of deliberations on proposed new governance and administrative structures and enhanced accountability arrangements for the HSE.
- A report on performance against the HSE Corporate Plan 2008-2011 was published on www.hse.ie in May 2011. This report is considered the close off of the Corporate Plan 2008-2011 as the plan was June 2008 to June 2011.
- 'HealthStat' is a system of operational performance monitoring which gathers data from hospitals and community services to measure their performance. Some data is gathered from primary sources but most is drawn from existing databases, and HealthStat presents the information in an integrated report by hospital and operational areas. The monthly results are published online on www.hse.ie. Each month, the information generated through HealthStat is discussed at a HealthStat Forum, led by the HSE CEO and attended by the RDOs, hospital CEOs, Clinical Directors, area and local Managers. These meetings hold managers accountable for their individual performance. HealthStat facilitates the sharing of best practice and focuses on problem areas. It facilitates a link between information and action at all levels of the health system. The aim of HealthStat and the HealthStat Forum is to share best practice and address problem areas in a positive way. The Forum discusses suggestions for improvement and identifies performance issues that need a national approach.
- The Corporate Planning and Corporate Performance Directorate (CPCP) is responsible for the implementation of a comprehensive integrated cross system planning function, a business intelligence unit and operational performance reporting and measurement. The HSE has a comprehensive planning, performance monitoring and management framework. The HSE Performance Monitoring Control Committee, chaired by the National Director of Finance, continued in its role of reviewing and validating organisational performance in the key areas of finance, human resource management and the achievement of targets identified in the National Service Plan. CPCP provides key performance reports to the Performance Management and Control Committee which provide a view of performance and support decisions on remedial action required to meet financial, HR and activity targets.
- The HSE Performance Report provides an integrated analysis of key financial, human resources, acute and non-acute performance data and is published monthly on the HSE website, www.hse.ie. The activity data reported is based on the Performance Activity and Key Performance Indicators outlined in the National Service Plan. A Supplementary Report is also produced each month which provides more detailed data on the metrics covered in the Performance Report. Biannual reports were also published on the website to show progress against specific actions as set out in the National Service Plan and regular progress reports are provided against an agreed set of performance indicators and measures.
- A detailed standardised appraisal process is conducted for all capital projects budgeted in excess of €0.5 million. The process involves presenting a project brief to the National Director of Commercial and Support Services setting out service need in the context of capital priorities as expressed in the Corporate and Service Plans. A cost-benefit analysis of all proposed major capital projects is carried out. Those which are budgeted in excess of €30 million are subject to a detailed cost benefit analysis carried out in accordance with Department of Finance 2005 Guidelines for the Appraisal and Management of Capital Expenditure Proposals in the Public Sector as amended by the Value for Money circular of January 2006. Board reviews of the capital programme take place on a regular basis.
- 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 SCA has a statutory duty to provide advice and assistance to the HSE under the various schemes. It collaborates with HSE risk management, clinical and administrative personnel to support patient safety and to help minimise the occurrence of claims. The SCA hosts a national electronic reporting system (STARSWeb) which facilitates the identification of clusters of adverse incidents and allows for root cause analysis of claims. 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 2011. The SCA provides insurance advice 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 HSE has an Internal Audit function with appropriately trained personnel which operates in accordance with a written charter/terms of reference which the Board 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 controls on a rolling basis over a reasonable period. The Internal Audit function is reviewed periodically by the Audit Committee, which reports to the Board. Procedures are in place to ensure that the reports of the Internal Audit function are followed up. The National Director of Internal Audit reports to the Board of the HSE through the Chairman of the Audit Committee and has a close working relationship with the CEO and is a member of the HSE management 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. In 2011 the Department of Finance carried out a review of the "Internal Audit Standards for Government Offices and Departments" and, as a result of that review, revised draft standards to reflect the latest version of International Standards for the Professional Practice of Internal Auditing, were issued to Accounting Officers for their observations. A requirement of these revised standards, when adopted, will be for external quality reviews of Internal Audit functions in Government Offices and Departments to be carried out within five years of adoption of the Department of Finance standards. HSE Internal Audit had planned to commence an external review of the Directorate in 2011, however due to the lowest level of staffing since the establishment of the HSE, a loss of senior staff through the various exit schemes, an increased work load (which included an increased level of FOI requests, attendances at PAC, an increased level of potential irregularities reported and an increased level of special requests from senior management) it was not possible to commence this review. HSE Internal Audit Directorate will arrange to commence an external review of the Directorate in accordance with the requirements of the Department of Finance Standards when the standards are formally issued by the Department of Finance.
- An Audit Committee chaired by a Board member other than the Chairman of the Board was in place. It comprised three Board members. This committee met three times between January and April 2011. Following changes to Board membership in May 2011, a new Audit Committee was formed with an independent chair, comprising three Board members and one independent member. The Chairman of the Audit Committee is not a member of the HSE Board but reports to the Board on all significant issues considered by the Committee. The Committee operates under agreed Terms of Reference and met on three occasions between May and December 2011. The National Director of Finance and the National Director of Internal Audit attend meetings of the Committee, while the CEO and other members of the executive management team attend when necessary. The external auditors attend as required and have 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.
- Monitoring and review of the effectiveness of the system of internal financial control is informed by the work of the Internal Audit function, 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 of the utmost importance and monitoring and review of their implementation is overseen by the Audit Committee.
- A Risk Committee chaired by a Board member other than the Chairman of the Board was in place. It comprised six Board members and an external specialist nominee. This Committee met three times between January and April 2011. Following changes to Board membership in May 2011, a new Risk Committee was formed with an independent chair, comprising four Board members, one independent member and three members of HSE senior management. The Chairman of the Risk Committee is not a member of the HSE Board but reports to the Board on all significant issues considered by the Committee. The Risk Committee operates under agreed Terms of Reference and focuses principally on assisting the Board in fulfilling its duties by providing an independent and objective review of non-financial risks. The Committee also considered internal audit reports concerning the effectiveness of non-financial internal controls and HIQA reports including the implementation of HIQA recommendations. This Committee met on three occasions between May and December 2011. Full liaison between the Audit and Risk Committees of the Board is essential to the proper functioning of these two inter-related Board committees. Liaison is facilitated by joint meetings of the two committees and ongoing engagement between the two committee chairs.

- The Special Delivery Unit (SDU) Committee was established during 2011. The Committee provides the appropriate leadership and oversight within the HSE to ensure the SDU's processes to improve the effectiveness and quality of services for patients are integrated with existing implementation plans of the HSE. The SDU Committee is chaired by a Board member other than the Chairman of the Board. In addition to the Chair, the Committee comprises two Board members and three senior officials from the HSE and the Department of Health. The SDU Committee operates under agreed Terms of Reference as set out by the Board.
- A Remuneration and Organisation Committee chaired by a Board member other than the Chairman of the Board was in place. It comprised two other Board members. This committee met twice between January and April 2011. Following changes to Board membership in May 2011, a new Remuneration and Organisation Committee, chaired by the Chairman of the Board and comprising two other Board members met on one occasion between May and December 2011. The Remuneration and Organisation Committee operates under agreed terms of reference and is responsible for making recommendations to the Board on remuneration and organisational matters in the HSE.
- At 31 December 2010 the Office of Tobacco Control was dissolved under legislation and it was subsumed into the HSE on 1 January 2011. All assets and liabilities of this entity, along with staff, were transferred to the HSE at the dissolution 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 this entity.
- The HSE has put in place procedures designed to ensure compliance with all pay and travel circulars issued by the Department of Finance. Any exceptions identified are addressed and are reported on an annual basis to the Minister, in accordance with the Code of Practice for the Governance of State Bodies.
- Grants to outside agencies are governed by Sections 38 and 39 of the Health Act, 2004. In line with the recommendations of the 2005 Comptroller & Auditor General Report on value for money in the disability sector, a Register of Non-Statutory Agencies – Service Arrangements and Grant Aid Agreements is in operation. This provides local, regional and national management information on 2,878 separate Agencies which operate 3,879 separate funding arrangements to a value of approximately €3.45 billion. This Register is managed by the National Business Support Unit (NBSU) and monthly performance monitoring statistics and reports are prepared, and made available on the HSE intranet site for reference by all HSE managers. 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 has been mandatory since 2009 and at the end of December 2011 signed service arrangements and grant aid agreements were in place for over 98% of the value of funding for agencies recorded on the national register. All of the 16 Voluntary Hospitals had signed Service Arrangements in place for 2011. Significant progress has been made with the non acute sector agencies. Organisations which did not complete the signing process for 2011 have been formally communicated with and the appropriate actions have been taken, resulting in some cases in the cessation of contracts. A project was commissioned in 2011 to further develop the governance framework for agencies funded by the HSE. The project had two main strands comprising the review and updating of Service Arrangement and Grant Aid Agreement documentation and the strengthening of the overall management and governance framework. The updated Service Arrangement and Grant Aid Agreement documentation will be implemented for 2012 funding. The effective management of the relationship with funded agencies is a critical responsibility for each budget holder. Based on the outcome of this project budget holders must ensure that the appropriate management arrangements and processes are in place at national, regional and local level to enable the HSE to effectively manage its relationship with the non-statutory sector and meet its accountability obligations.
- 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 National Director of Commercial and Support Services has authority to approve proposed property transactions up to a limit of €2 million exclusive of VAT, once recommended for approval by the Property Committee. Transactions in excess of this amount must be approved by the CEO, once recommended for approval by the Property Committee and endorsed by the National Director of Commercial and Support Services. Transactions in excess of €2 million once approved by the CEO must then be submitted to the HSE Board for final approval.
- 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, attesting to the existence and operation of controls which are in place in their area of responsibility. The level of compliance by managers in completing Controls Assurance Statements was audited on a sample basis by Internal Audit in 2011, with the audit recommendations implemented for the year end 2011 process.

In 2010 and 2011 the HSE appeared before the Committee of Public Accounts on three occasions in relation to the findings contained in HSE Internal Audit reports on the SKILL Programme (3 reports) and the Health Services National Partnership Forum (HSNPF) (1 report). These audits identified weaknesses in the

governance, control of and accountability for funds disbursed in respect of administration of the SKILL programme and funds disbursed under the Action Plan for People Management Programme. The audit reports identified governance issues and control weaknesses which arose from the nature of the operating model – existing as it did – as satellite entities outside of the mainstream management control system. The result of the audits and related recommendations were reported to the Audit Committee and the Board during 2010 and the implementation of these recommendations by management was continually monitored in 2011. The HSE has also taken the appropriate steps required to ensure comprehensive compliance with its regulations in relation to payments, travel and procurement and to address in full the recommendations of Internal Audit and the C&AG to ensure that these failures do not recur.

A Revenue audit concluded in 2011 found underpayment of VAT, giving rise to a tax, interest and penalty settlement with Revenue totalling €0.1 million. Where areas of non-compliance are detected, either in the course of Revenue audit or arising from self review exercises, immediate steps are taken to settle the liability with Revenue and ensure that the necessary action is taken to eliminate the scope for such errors. In conjunction with the co-operative compliance programme in place with Revenue, the HSE went to tender in Q4 2011 for specialist tax assistance with a full-scope compliance review that has been commissioned by the HSE in 2012 across all the tax heads for which it must account. The HSE is committed to exemplary compliance with taxation laws.

The project to deliver centralisation of medical card processing in the Primary Care Reimbursement Service (PCRS) was completed in July 2011 and introduced changes to deliver improvements in control and standardisation within primary care and medical card schemes. Following centralisation of card processing on 1 July 2011, PCRS assumed responsibility for examining all card renewal applications. In the six month period to December 2011, 231,004 completed renewal applications were received of which 2,723 cases (1.18%) did not qualify for either a medical card or a GP Visit card. 2,976 cases (1.29%) did not meet the eligibility criteria for a full medical card and were given a GP Visit card. In 225,305 cases the review found that eligibility criteria were met. Based on the findings of the case review, PCRS has commissioned a body of work to fully examine the results of the case review and to develop a risk-based control framework to ensure appropriate governance and probity measures are in place to control the regularity of medical card issuing. Government has indicated its intention to introduce legislation during 2012 to facilitate the sharing of information with other State Departments and agencies which would facilitate the cross referencing of applicants' details and enable a risk based approach to review and audit.

The HSE has undertaken a number of strategic reviews in areas such as the more effective provision of clinical and other client services focused upon improving quality and driving value. The implementation of these reviews, for example in acute medicine and surgery will improve the efficiency and effectiveness and support the elimination of waste within the health system.

The controls assurance process of the HSE is directed at enabling the CEO as Accounting Officer and the Board and Chairman of the 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 2011 a formal Review of the System of Internal Control in the Health Service Executive 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 methodology which has been further developed in carrying out this review in 2011. The scope of the review extended for the first time to clinical management in the HSE, who participated in the controls assurance process for 2011. It is intended to further expand the scope of the review for clinical functions in subsequent years, to replicate the established methodology applied to the review of internal controls in administrative functions. The methodology of the 2011 review involved reference to:

- Controls Assurance Statements (CAS) completed by all senior managers, administrative and clinical, from National Director level to Grade VIII (or equivalent) 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 structured bilateral interviews with a cross section sample of approximately 110 managers and heads of service and their responses to an internal controls questionnaire completed during each interview;
- Internal Audit reports;
- Reports and management letters of the Comptroller and Auditor General;
- Reports of the Committee of Public Accounts;
- The 2011 audit programme of the Comptroller and Auditor General for the HSE and in particular, the audit risk identified therein;
- Assessment of the progress against the implementation of recommendations contained in previous Internal Audit reports and reports of the Comptroller and Auditor General as presented quarterly to the Audit Committee;
- Internal news/media releases;
- HSE Board and Board Committee minutes;
- Reports of the Health Information and Quality Authority;

- Reports of the Mental Health Commission;
- Quality Patient Safety Audit Reports;
- Clinical Audit Reports;
- Periodic status reports to the Audit Committee and to the Risk Committee.
- Any other relevant material, e.g. Programme for Government.

Extension of the controls assurance process

The extension in scope of the CAS process introduced a requirement that clinical managers at the equivalent of Grade VIII level and above would, for the first time, sign Controls Assurance Statements in 2011. This is a major addition to the assurance process of the HSE. In the first year of its implementation we have not achieved full compliance with the completion of the assurance returns by all clinical staff but have taken a significant step forward in broadening the assurance available to the Board and integrating the clinical and financial risk management approaches. This process will be completed in 2013 and reflects the maturing of the approach to controls assurance in the HSE.

Of the 1,128 staff on the Integrated Services Directorate Register, 777 (or 69%) had signed as of the 21 March 2012. The CAS Registers identify the staff who have and have not signed their statements. This is not an acceptable outcome. The absence of a signed CAS 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. It was necessary to conclude the 2011 Controls Assurance process to enable the National Director provide assurance to the CEO. However each RDO has been instructed to:

- Conclude the 2011 assurance process to the maximum extent possible.
- Arrange training/briefing sessions for clinical managers where this is required.

Conclusion

The report of the Review of the System of Internal Control in the Health Service Executive was circulated to senior management in March 2012. In assessing the effectiveness of the system of internal financial control, regard must be had to the relative immaturity of the HSE as an organisation and the cultures of the various organisations incorporated within the HSE. The HSE was initially an amalgamation of 17 different bodies and has subsumed 11 additional bodies since its establishment. The HSE remains dependent upon the legacy systems of these entities pending the implementation of a single enterprise wide financial, procurement and HR system. 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 2012 review of the system of internal controls.

Changes in Health Structures and Management

The Programme for Government envisages significant changes in the structures and management arrangements of the Irish health services in the coming years. Ultimately, the HSE will cease to exist and new bodies will be created to deliver upon the health strategy of Government.

The first elements of this change became visible in 2011 with the appointment by the Minister of Board members who are senior HSE and Department of Health officials. The Chairman of the Board is the Secretary General of the Department of Health. These initial changes are designed to give the Minister a more direct authority and accountability in health management matters. The Minister has also announced his intention to introduce legislation in 2012 to establish a Directorate, comprising a number of senior HSE employees/national directors, in place of the HSE Board, to strengthen the Minister's authority and reinforce the HSE's accountability for the health services.

The Minister for Health established a Special Delivery Unit (SDU) within the Department of Health in June 2011 and the unit became operational in September 2011. The SDU was established to actively intervene in health management processes with a view to improving access to acute services by improving the flow of patients through the hospital system. At this time an additional SDU committee of the Board of the HSE was established to support the initiative.

The SDU is focusing initially on emergency departments and is working to support hospitals in addressing excessive waiting times for admission to hospital. The SDU is working directly with key teams in the HSE and the National Treatment Purchase Fund, building on initiatives already underway including the HSE clinical programmes. The SDU is intended to provide a performance improvement function for the Irish hospital system and reduce waiting times for elective surgery.

In January 2012, the Minister announced further planned changes to the organisation of the health services. These included the proposed creation of group management structures for the mid west (Limerick, Ennis and Nenagh) and western (Galway, Roscommon and Portiuncula) hospitals and the filling of the two posts of CEO. The HSE Clinical Programmes which are spearheading clinical leadership across the health service will be moved from the HSE to be located in the Department of Health. The HSE National Cancer Control Programme, which has seen significant improvements in cancer outcomes, will also in the future be located in the Department of Health.

The management of control risks in this time of change is a key component of a safe transition to a new health environment. Some of the key risks that could emerge include uncertainty about structures and transitional arrangements, a loss of business/corporate intelligence as services relocate and staff are reassigned and a consequential loss of focus on accountability for resources. It will be essential to manage pro-actively the risks which will arise in the transition. The CEO has established a governance group comprising finance, internal audit and corporate governance specialists. It will accord a high priority to a due diligence exercise on the change programme to ensure that the changing structures and governance arrangements are advanced and supported, and the HSE reform plans concurrently follow the reforms being set out by the Minister for Health.

Dr Ambrose McLoughlin
Chairman

18 May 2012

Report of the Comptroller and Auditor General for Presentation to the Houses of the Oireachtas

Health Service Executive

I have audited the financial statements of the Health Service Executive for the year ended 31 December 2011 under 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 reporting framework that has been applied in their preparation is applicable law and accounting standards specified by the Minister for Health.

Responsibilities of the Members of the Board

The Board 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.

The Health Service Executive also produces an Appropriation Account for transactions reflected in the account to which this report relates. I will report separately on that account and any matters arising out of my audit that I consider merit reporting will be outlined in my Annual Report on the Accounts of the Public Services for 2011.

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 all the financial and non-financial information in the 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.

Without qualifying my opinion, I draw attention to the basis of accounting in the Accounting Policies which explains how the accounting standards specified by the Minister for Health differ from Generally Accepted Accounting Practice in Ireland.

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 2011 and of its income and expenditure for the year then ended.

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 moneys have 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 for the year for which the financial statements are prepared is not consistent with the 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.

I draw attention to note 35 to the financial statements which discloses details of the level of medical cards in issue to ineligible persons during 2011.

I have nothing to report in regard to those other matters upon which reporting is by exception.

Gerard Smyth
For and on behalf of the
Comptroller and Auditor General

21 May 2012

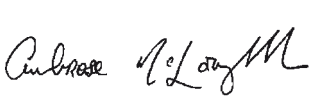
Revenue Income and Expenditure Account

For Year Ended 31 December, 2011

	Notes	2011 €'000	2010 €'000
Income			
Exchequer Revenue Grant	*3*	**12,111,829**	10,599,546
Receipts from certain excise duties on tobacco products		**167,605**	167,605
Health Contributions	*3*	**0**	2,017,657
Income from services provided under EU regulations		**270,000**	320,000
Recovery of costs from Social Insurance Fund		**2,600**	12,982
Patient Income	*4*	**365,320**	320,241
Other Income	*5*	**768,148**	760,825
Dormant Accounts		**1,118**	2,337
		13,686,620	14,201,193
Expenditure			
Pay and Pensions			
Clinical	*6 & 7*	**3,245,547**	3,270,752
Non Clinical	*6 & 7*	**1,073,966**	1,144,641
Other Client/Patient Services	*6 & 7*	**732,275**	729,408
		5,051,788	5,144,801
Non Pay			
Clinical	*8*	**829,711**	904,442
Patient Transport and Ambulance Services	*8*	**56,033**	56,662
Primary Care and Medical Card Schemes	*8 & 35*	**2,831,471**	2,980,609
Other Client/Patient Services	*8*	**65,357**	75,639
Grants to Outside Agencies	*8*	**3,449,704**	3,647,081
Housekeeping (catering, crockery, linen, etc.)	*8*	**227,815**	227,190
Office and Administration Expenses	*8*	**378,441**	415,783
Long Stay Charges Repaid to Patients	*8*	**9,397**	20,962
Hepatitis C Insurance Scheme	*8*	**980**	560
Other Operating Expenses	*8*	**45,679**	44,543
Payments to State Claims Agency under the Clinical Indemnity Scheme	*8*	**81,204**	79,283
Nursing Home Support Scheme (Fair Deal)	*8 & 33*	**560,614**	479,714
		8,536,406	8,932,468
Net Operating Surplus for the Year		**98,426**	123,924

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 143-146.



Chairman

Chief Executive Officer

Capital Income and Expenditure Account

For Year Ended 31 December, 2011

	Notes	2011 €'000	2010 €'000
Income			
Exchequer Capital Funding		**332,830**	355,058
EU Funding		**2,333**	536
Revenue Funding Applied to Capital Projects		**486**	417
Dormant Accounts		**124**	3,782
Application of Proceeds of Disposals		**6,812**	3,586
Government Departments and Other Sources	*19(c)*	**2,839**	5,838
		345,424	369,217
Expenditure			
Capital Grants to Outside Agencies (Appendix 2)	*19(b)*	**132,755**	130,164
Capital Expenditure on HSE Capital Projects	*19(b)*	**204,311**	240,202
Adjustment to Liability to the Exchequer*	*19(b)*	**(19,388)**	0
		317,678	370,366
Net Capital Surplus/(Deficit) for the Year		**27,746**	(1,149)
Balance at 1 January		**(206,865)**	(205,716)
Balance at 31 December		**(179,119)**	(206,865)

* Adjustment to Liability to the Exchequer relates to balance on capital proceeds of disposal account indirectly remitted by way of a reduced technical adjustment on the establishment of the HSE in 2005, netted against historical capital expenditure deficits in 2011.

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 143-146.

Chairman

Chief Executive Officer

Balance Sheet

As at 31 December, 2011

	Notes	2011 €'000	2010 €'000
Fixed Assets			
Tangible Fixed Assets			
Land and Buildings	9	**4,970,094**	4,957,521
Other Tangible Fixed Assets	10	**296,100**	317,142
Investments			
Financial Assets	11	**3**	3
Total Fixed Assets		**5,266,197**	5,274,666
Current Assets			
Stocks	12	**121,521**	128,087
Debtors	13	**309,340**	237,771
Paymaster General and Exchequer Balance	14	**87,782**	87,691
Cash at Bank or in Hand		**28,350**	21,451
Current Liabilities			
Creditors	15	**(1,520,524)**	(1,562,061)
Net Current Liabilities		**(973,531)**	(1,087,061)
Creditors (amounts falling due after more than one year)	16	**(52,445)**	(68,847)
Deferred income	17	**(9,634)**	(6,253)
Total Assets		**4,230,587**	4,112,505
Capitalisation Account	18(a)	**5,266,194**	5,274,663
Capital Reserves	18(b)	**(179,119)**	(206,865)
Revenue Reserves	18(c)	**(856,488)**	(955,293)
Capital and Reserves		**4,230,587**	4,112,505

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 143-146

Chairman

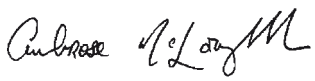
Chief Executive Officer

Cash Flow Statement

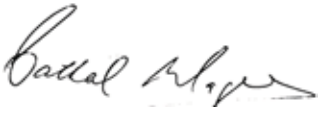
For Year Ended 31 December, 2011

	Notes	2011 €'000	2010 €'000
Net Cash Inflow/(Outflow) from Operating Activities	*20*	**19,055**	(17,083)
Net Cash Inflow/(Outflow) from Returns on Investments and Servicing of Finance			
Interest paid on loans and overdrafts		**(9)**	(8)
Interest paid on finance leases		**(1,340)**	(1,434)
Interest received		**199**	24
Net Cash Outflow from Returns on Investments and Servicing of Finance		**(1,150)**	(1,418)
Capital Expenditure			
Capital expenditure – capitalised		**(157,297)**	(206,392)
Capital expenditure – not capitalised		**(179,769)**	(163,974)
Payments from revenue re: acquisition of fixed assets (net of trade-ins)		**(18,832)**	(22,791)
Revenue funding applied to Capital		**486**	417
Receipts from sale of fixed assets (excluding trade-ins)		**6,857**	3,516
Net Cash Outflow from Capital Expenditure		**(348,555)**	(389,224)
Net Cash Outflow before Financing		**(330,650)**	(407,725)
Financing			
Capital grant received		**332,830**	355,058
Capital receipts from other sources		**5,296**	10,156
Payment of capital element of finance lease and loan repayments		**(486)**	(446)
Net Cash Inflow from Financing		**337,640**	364,768
Net Cash Flow		**6,990**	(42,957)
Increase in cash in hand and bank balances in the year	*21*	**6,990**	(42,957)

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 143-146.



Chairman



Chief Executive 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, and the provisions of FRS 17 Retirement Benefits are not applied.
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. Details of the estimated liability attaching to this scheme are set out in Note 29 to the financial statements.

Basis of Preparation

The Programme for Government commits to the HSE ceasing to exist over time. Government has approved the drafting of legislation involving significant changes in the governance of the HSE. This legislative change is the first step in a process of transformation which will require detailed planning. This initial step is designed to avoid disruptive change at a difficult and challenging time for health and social services. Legislation which will have the cumulative effect of abolishing the HSE will be brought forward on a sequential basis, as part of the overall health reform programme, with functions transferring elsewhere as part of the move towards a system of Universal Health Insurance. In addition, functions relating to child protection will transfer from the HSE to the proposed new Children and Families Support Agency. The financial statements for the year ended 31 December 2011 have been prepared on a going concern basis.

Legislation enacted in the Public Health (Tobacco) Act 2010, provided for the dissolution of the Office of Tobacco Control on 31 December 2010 and the transfer of its functions to the HSE. In accordance with the legislation, the assets, liabilities and reserves of the Office of Tobacco Control were taken into the HSE's balance sheet at net book value on 1 January 2011.

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 this entity.

The Nursing Homes Support Scheme (A Fair Deal)

The Nursing Homes Support Bill was enacted on 1 July 2009 and the Nursing Homes Support Scheme commenced on 27 October 2009.

The scheme provides eligible people with financial support towards the cost of their long term residential care and involves a co-payment arrangement between the person and the State. The scheme applies to people accessing long term residential care from 27 October 2009 onwards and replaces the Subvention Scheme which has been in existence since 1993.

Payments received from eligible people are accounted for as long stay charges within patient income. Payments in the amount of €561m made to private long term residential care facilities are accounted for in non-pay expenditure (Note 8). The balance of the total €1.026bn funding provided for Fair Deal in 2011 is incurred in the provision of long term residential care in public facilities and this expenditure is distributed across pay and non-pay headings in the Revenue Income and Expenditure Account.

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 Revenue. Charges so deferred are not accounted for in the financial statements of the HSE.

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. 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.

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 19 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. 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. The related aggregate depreciation account balance was also included in the opening balance sheet.

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.

All capital funded asset purchases are capitalised, irrespective of cost. 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. A breakdown of asset additions by funding source is provided in Note 19 (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 18 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.

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. Contributions from employees who are members of the schemes are credited to the income and expenditure account when received.

In previous years, no provision was made in respect of accrued pension benefits payable in future years under the pension scheme. This continues to be the treatment adopted by the HSE following the accounting specifications of the Minister.

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. The deduction of the levy took effect from 1 March 2009. 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.

Voluntary Early Retirement and Voluntary Redundancy Schemes

The Government announced in November 2010 that it had provided up to €400m for two targeted incentivised exit schemes for management, administrative and support staff in the health services. These schemes were designed to achieve a permanent reduction in the numbers employed in these grades of the health services from 1 January 2011 and help to maintain essential frontline services. In total 2,025 employees (1,626 whole time equivalents) from HSE and other voluntary health service providers funded by the HSE availed of the schemes. The entire cost of the scheme totalled €100m, of which €73m related directly to staff employed by the HSE. The balance of €27m related to staff employed by voluntary health service providers funded by the HSE. Scheme costs relating to the HSE employees are accounted for in 2010 under superannuation, within the pay classification (see Note 7). Scheme costs relating to the voluntary health service providers' employees are accounted for in 2010 under grants to outside agencies within the non-pay classification (see Note 8 and Appendix 1)

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. The audits of these accounts are either completed or in the process of completion for the year ended 31 December 2011.

Notes to the Financial Statements

Note 1 Segmental Analysis by Area of Operation

	ISD Hospital Services 2011 €'000	ISD Community Services 2011 €'000	Support Services 2011 €'000	Total 2011 €'000	Total 2010 €'000
Expenditure					
Pay and Pensions					
Clinical	1,464,925	1,410,629	369,993	**3,245,547**	3,270,752
Non Clinical	350,587	442,579	280,800	**1,073,966**	1,144,641
Other Client/Patient Services	198,022	461,257	72,996	**732,275**	729,408
	2,013,534	2,314,465	723,789	**5,051,788**	5,144,801
Non Pay					
Clinical	529,108	246,434	54,169	**829,711**	904,442
Patient Transport and Ambulance Services	37,111	18,555	367	**56,033**	56,662
Primary Care and Medical Card Schemes	28,664	2,799,900	2,907	**2,831,471**	2,980,609
Other Client/Patient Services	757	63,009	1,591	**65,357**	75,639
Grants to Outside Agencies	2,270,257	1,171,341	8,106	**3,449,704**	3,647,081
Housekeeping	104,010	119,132	4,673	**227,815**	227,190
Office & Administrative Expenses	96,791	162,299	119,351	**378,441**	415,783
Long Stay Charges Repaid to Patients	0	0	9,397	**9,397**	20,962
Hepatitis C Insurance Scheme	0	0	980	**980**	560
Other Operating Expenses	12,344	27,776	5,559	**45,679**	44,543
Payments to State Claims Agency under the Clinical Indemnity Scheme	0	0	81,204	**81,204**	79,283
Nursing Home Support Scheme (Fair Deal)	0	560,614	0	**560,614**	479,714
	3,079,042	5,169,060	288,304	**8,536,406**	8,932,468
Gross expenditure for the year	5,092,576	7,483,525	1,012,093	**13,588,194**	14,077,269
Total Income (not analysed by area of operation)				**13,686,620**	14,201,193
Net Operating Surplus for the Year				**98,426**	123,924

Note 2 **Net Operating Surplus**

	2011 €'000	2010 €'000
Net operating surplus for the year is arrived at after charging:		
Audit fees	**559**	559
Executive board members' remuneration*	**416**	420
Non-executive board members' remuneration*	**85**	162
Executive board members' remuneration comprises the following elements:		
Chief Executive Officer's (CEO) basic pay**	**322**	362
CEO Superannuation scheme payments	**80**	44
CEO Car allowance	**14**	14
	416	420

	2011 €	2010 €
Board members' expenses were paid as follows:		
Cathal Magee (expenses incurred in CEO capacity only, not as Board member)***	**505**	360
Liam Downey	**0**	1,524
Professor Brendan Drumm	**0**	3,457
PJ Fitzpatrick	**0**	3,635
John Fitzgerald	**41**	88
Anne Scott	**0**	116
Dr Frank Dolphin****	**8,110**	5,192
Laverne Mc Guinness (expenses incurred in senior management capacity only, not as Board member)*****	**3,476**	0
Brian Gilroy (expenses incurred in senior management capacity only, not as Board member)*****	**2,144**	0
Dr. Barry White (expenses incurred in senior management capacity only, not as Board member)*****	**324**	0
	14,600	14,372

** At a HSE Board meeting on 28 April 2011, The Minister for Health informed the Board that, in line with the Programme for Government, it was intended to make changes to the composition of the Board of the HSE. In order to facilitate this policy change the Minister requested the Board Members resign and all Board members agreed to the request.*

Non Executive Board members' remuneration includes members of the outgoing board only.

The Board comprises senior officials from the Department of Health and 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.

*** From this amount, the CEO has gifted €24,158 to the Minister for Finance, in line the Government's request for senior personnel across the public sector to voluntarily waive an element of pay in line with the announced pay ceilings.*

**** Cathal Magee's expenses were incurred in his capacity as CEO. He did not incur expenses in his capacity as a Board member. For comparative purposes, the 2010 expenses have been restated to include his expenses.*

***** Dr. Frank Dolphin's expenses have been restated for 2010 in respect of expenses paid in 2011 relating to 2010.*

****** Laverne Mc Guinness, Brian Gilroy and Dr. Barry White's expenses are stated from the date of their appointment to the board, these were incurred in their capacity as senior managers of the HSE. They did not incur expenses in their capacity as Board members.*

Note 3 **Exchequer Revenue Grant***

	2011 €'000	2010 €'000
Net Estimate voted to HSE (HSE Vote 40)	**12,460,440**	11,123,581
Less net Surplus to be surrendered (Note 22)	**(15,781)**	(168,977)
Net recourse to Exchequer	**12,444,659**	10,954,604
Less: Capital services funding from the State (HSE Vote 40)	**(332,830)**	(355,058)
Exchequer Revenue Grant*	**12,111,829**	10,599,546

** In 2010 health contributions were collected as an appropriations-aid to the HSE Vote. From 1 January 2011 this was replaced with a new universal social charge; receipts from this charge are paid directly to the Central Fund. This change has the effect of increasing the Exchequer Revenue Grant by approximately €2 billion in 2011.*

Note 4 **Patient Income**

	2011 €'000	2010 €'000
Private Charges*	**240,328**	192,266
Inpatient Charges*	**32,036**	26,886
Emergency Department Charges	**9,472**	11,054
Road Traffic Accident Charges	**4,599**	6,949
Long Stay Charges	**78,885**	83,086
	365,320	320,241

** The analysis of Patient Income for 2010 has been re-classified on a basis consistent with the current year. The total figure is unchanged.*

Note 5 **Other Income**

(a) Other Income

	2011 €'000	2010 €'000
Superannuation Income	**197,874**	203,278
Other Payroll Deductions	**9,626**	10,232
Pension levy deductions from HSE own staff	**249,566**	250,875
Pension levy deductions from service providers	**111,277**	112,652
Agency/Services	**8,545**	9,609
Canteen Receipts	**12,654**	13,941
Income from other Agencies (See Note 5(b) analysis below)	**25,844**	33,216
Miscellaneous Income (See Note 5(c) analysis below)	**152,762**	127,022
	768,148	760,825

Note 5 **Other Income** *(continued)*

(b) Income from Other Agencies

	2011 €'000	2010 €'000
National Council for Professional Development of Nursing & Midwifery	**739**	1,399
Department of Health, Drugs Program Unit (formerly Department of Community Rural & Gaeltacht Affairs, OMD (Office of the Minister for Drugs))*	**21,592**	23,408
Department of Arts, Heritage & The Gaeltacht – Helicopter Services*	**48**	85
Department of Children & Youth Affairs – Young Peoples Facilities and Services*	**1,205**	1,280
Department of the Environment	**0**	92
Health Research Board	**1,333**	1,474
National Cancer Screening Service	**0**	5,172
EU Income**	**274**	101
Co-operation And Working Together – CAWT	**457**	0
Department of Social Community & Family Affairs – Monetary Advice & Budgeting Service (MABS)***	**196**	205
	25,844	33,216

** The Drugs Program Unit, Helicopter Services and Young Peoples Facilities and Services were funded in 2010 by the Department of Community Rural & Gaeltacht Affairs. 2010 figures have been re-stated to reflect the current funding source.*

*** EU Income was not separately disclosed in 2010, it was included in Other Miscellaneous Income, now re-stated for 2010.*

**** Department of Social Community & Family Affairs – Monetary Advice & Budgeting Service (MABS) was not separately disclosed in 2010, included in Other Miscellaneous Income, now re-stated for 2010.*

(c) Miscellaneous Income

	2011 €'000	2010 €'000
Rebate from Pharmaceutical Manufacturers	**43,523**	41,457
Prescription Levy Income	**27,629**	6,605
Certificates and Registration Income (Births, Deaths and Marriages)	**8,999**	8,440
Parking	**11,625**	11,084
Other Miscellaneous Income	**60,986**	59,436
	152,762	127,022

Note 6 **Pay and Pensions Expenditure**

	2011 €'000	2010 €'000
Clinical HSE Staff		
Medical/Dental	**692,994**	698,522
Nursing	**1,462,071**	1,491,497
Health & Social Care Professional (formerly Paramedical)	**611,409**	592,160
Superannuation	**353,630**	379,184
	3,120,104	3,161,363
Clinical Agency Staff		
Medical/Dental	**53,702**	39,970
Nursing	**49,901**	51,257
Health & Social Care Professional (formerly Paramedical)	**21,840**	18,162
	125,443	109,389
Non Clinical HSE Staff		
Management/Administration	**574,759**	599,328
General Support Staff	**345,392**	362,782
Superannuation	**136,362**	159,849
	1,056,513	1,121,959
Non Clinical Agency Staff		
Management/Administration	**5,683**	4,690
General Support Staff	**11,770**	17,992
	17,453	22,682
Other Client/Patient Services HSE Staff		
Other Patient & Client Care	**621,409**	629,572
Superannuation	**77,192**	78,530
	698,601	708,102
Other Client/Patient Services Agency Staff		
Other Patient & Client Care	**33,674**	21,306
	33,674	21,306
Total Pay Expenditure	**5,051,788**	5,144,801

Note 7 **Employment**

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

	2011	2010
Hospital Care (incl. National Cancer Control Programme)	**27,388**	27,856
Primary Care	**35,051**	37,391
Ambulance Services	**1,535**	1,494
Corporate & Shared Services	**2,751**	2,988
Population Health	**997**	1,060
Total HSE employees	**67,722**	70,789
Voluntary Sector – Hospital Services	**22,076**	22,225
Voluntary Sector – Primary and Community Services	**14,594**	14,958
Total Voluntary Sector employees	**36,670**	37,183
Total Employees per Department of Health methodology as encompassed in the Employment Control Framework	**104,392**	107,972
Employees from subsumed agencies	**4,397**	4,234
Total Employees	**108,789**	112,206

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.

Employment costs charged to the Revenue Income and Expenditure account:

	2011 €'000	2010 €'000
Wages and Salaries	**4,164,785**	4,215,464
Social Welfare Costs	**319,819**	311,773
Pension Costs	**567,184**	617,564
	5,051,788	5,144,801

Following a Government decision, on 1 November 2010, the HSE introduced two new schemes aimed at effecting a reduction in staffing numbers in the Health Service. They include a Voluntary Early Retirement (VER) Scheme targeted at staff aged over 50 years of age, and a Voluntary Redundancy Scheme (VRS) targeted at management, administrative and support staff grades.

Consequently the total cost of lump sums increased significantly in 2010 and includes a sum of €37m for 2010 VRS exit schemes and €36m for 2010 VER exit schemes.

A further 4,515 individual members of staff had indicated that they would leave the HSE before the end of the "grace period" in February 2012, under which retirement benefits were based on salary levels that applied prior to the introduction of pay cuts by the Government over recent years. Of these, 1,759 had left prior to 31 December 2011.

Note 7 **Employment** *(continued)*

Summary Analysis of Pay Costs

	Clinical	Non Clinical	Other Client/ Patient Services	Total	Total
	2011 €'000	2011 €'000	2011 €'000	2011 €'000	2010 €'000
Basic Pay	2,244,185	795,144	511,351	**3,550,680**	3,574,545
Allowances	86,163	18,868	17,361	**122,392**	124,009
Overtime	134,345	16,924	18,588	**169,857**	177,079
Night duty	55,965	6,617	11,599	**74,181**	73,054
Weekends	111,930	27,643	42,799	**182,372**	189,795
On-Call	47,687	1,410	776	**49,873**	55,353
Arrears	11,049	3,182	1,199	**15,430**	21,629
Employer PRSI	200,593	67,816	51,410	**319,819**	311,773
Superannuation	353,630	136,362	77,192	**567,184**	617,564
	3,245,547	1,073,966	732,275	**5,051,788**	5,144,801

HSE 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.

Note 8 **Non Pay Expenditure**

	2011 €'000	2010 €'000
Clinical		
Drugs & Medicines (excl. demand led schemes)	**221,388**	253,713
Blood/Blood Products	**36,837**	34,939
Medical Gases	**8,583**	8,458
Medical/Surgical Supplies	**217,624**	230,460
Other Medical Equipment	**81,912**	84,461
X-Ray/Imaging	**26,411**	28,186
Laboratory	**105,544**	105,575
Professional Services	**85,665**	81,383
Education & Training	**45,747**	77,267
	829,711	904,442
Patient Transport and Ambulance Services		
Patient Transport	**42,987**	45,514
Vehicles Running Costs	**13,046**	11,148
	56,033	56,662

Note 8 **Non Pay Expenditure** *(continued)*

	2011 €'000	2010 €'000
Primary Care and Medical Card Schemes		
Doctors' Fees & Allowances	**475,672**	495,781
Payments to Former District Medical Officers/Dependents	**4,640**	5,135
Pharmaceutical Services	**1,934,279**	2,020,274
Dental Treatment Services Scheme	**52,277**	76,101
Community Ophthalmic Services Scheme	**27,956**	26,891
Cash Allowances (Blind Welfare, Domiciliary Care, etc)	**59,937**	54,986
Fostering Payments	**104,545**	100,066
Capitation Payments	**172,165**	201,375
	2,831,471	2,980,609
Other Client/Patient Services		
Professional Services	**57,638**	67,378
Education & Training	**7,719**	8,261
	65,357	75,639
Grants to Outside Agencies		
Revenue Grants to Outside Agencies (Appendix 1)	**3,431,395**	3,623,329
Grants funded from other Government Departments/State Agencies (Appendix 1)	**18,309**	23,752
	3,449,704	3,647,081
Housekeeping		
Catering	**57,542**	64,100
Heat, Power & Light	**70,340**	60,111
Cleaning & Washing	**80,735**	81,204
Furniture, Crockery & Hardware	**7,117**	8,474
Bedding & Clothing	**12,081**	13,301
	227,815	227,190
Office and Administration Expenses		
Maintenance	**45,149**	67,817
Bank Loan & Finance Leases	**486**	446
Bank Interest	**9**	8
Prompt Payment Interest	**327**	279
Lease Interest	**1,340**	1,434
Bank Charges	**569**	666
Insurance	**5,206**	7,384
Audit	**559**	559
Legal & Professional Fees	**54,259**	64,026
Bad & Doubtful Debts	**13,640**	7,377
Education & Training	**9,300**	9,036

Note 8 **Non Pay Expenditure** *(continued)*

	2011 €'000	2010 €'000
Travel & Subsistence	**57,016**	57,112
Vehicle Costs	**705**	707
Office Expenses/Rent & Rates	**149,422**	161,812
Computers & Systems Maintenance	**40,454**	37,120
	378,441	415,783
Long Stay Repayments Scheme		
Long Stay Charges Repaid to Patients (see Note 31)	**8,222**	19,193
Non-Pay Costs of Administering the Repayments Scheme	**1,175**	1,769
	9,397	20,962
Hepatitis C Insurance Scheme		
Insurance Premium Loadings and Claims (see Note 32)	**968**	558
Non-Pay Costs of Administering the Insurance Scheme	**12**	2
	980	560
Other Operating Expenses		
Miscellaneous (Appendix 3)	**45,679**	44,543
	45,679	44,543
Payments to State Claims Agency under the Clinical Indemnity Scheme		
Awards paid in settlement of claims	**81,204**	79,283
	81,204	79,283
Nursing Home Support Scheme (Fair Deal)*		
Nursing Home Support Scheme (A Fair Deal)	**560,614**	479,714
	560,614	479,714

* Nursing Home Support Scheme (Fair Deal) expenditure above relates to payments to private nursing homes for (i) contract beds, (ii) subvention payments and (iii) Nursing Home Support Scheme payments. Expenditure incurred in the running of HSE public long stay residential care units is reported across a range of pay and non pay expenditure headings in the HSE's financial statements. The total provision in 2011 for the Nursing Home Support Scheme (for both public and privately-run facilities) in the HSE's Vote was €1,026m. Expenditure in 2010 has been re-classified to extract the Fair Deal expenditure out of Capitation Payments, consistent with 2011.

Note 9 Tangible Fixed Assets Land and Buildings

	Land	Buildings*	Work in Progress	Total 2011
	€'000	€'000	€'000	€'000
Cost/Valuation				
At 1 January 2011	2,028,693	3,217,958	396,620	**5,643,271**
Additions	1,318	12,305	111,965	**125,588**
Transfers from Work in Progress	10	240,713	(254,261)	**(13,538)**
Disposals	(8,188)	(2,362)	(678)	**(11,228)**
At 31 December 2011	2,021,833	3,468,614	253,646	**5,744,093**
Depreciation				
Accumulated Depreciation at 1 January 2011	0	685,750	0	**685,750**
Charge for the Year	0	88,821	0	**88,821**
Disposals	0	(572)	0	**(572)**
At 31 December 2011	0	773,999	0	**773,999**
Net Book Values				
At 1 January 2011	2,028,693	2,532,208	396,620	**4,957,521**
At 31 December 2011	2,021,833	2,694,615	253,646	**4,970,094**

** The net book value of fixed assets above includes €35.3m (2010: €38.5m) in respect of buildings held under finance leases; the depreciation charged for the year above includes €1.8m (2010: €2m) on those buildings.*

Note 10 Tangible Fixed Assets Other than Land and Buildings

	Motor Vehicles	Equipment	Work in Progress	Total 2011
	€'000	€'000	€'000	€'000
Cost/Valuation				
At 1 January 2011	93,589	1,147,811	2,500	**1,243,900**
Additions	1,016	45,105	4,420	**50,541**
Transfers from Work in Progress	6,693	13,538	(6,693)	**13,538**
Disposals	(10,340)	(19,259)	0	**(29,599)**
At 31 December 2011	90,958	1,187,195	227	**1,278,380**
Depreciation				
Accumulated Depreciation at 1 January 2011	78,607	848,151	0	**926,758**
Charge for the Year	7,608	74,261	0	**81,869**
Disposals	(8,534)	(17,813)	0	**(26,347)**
At 31 December 2011	77,681	904,599	0	**982,280**
Net Book Values				
At 1 January 2011	14,982	299,660	2,500	**317,142**
At 31 December 2011	13,277	282,596	227	**296,100**

Note 11 **Investments**

	2011 €'000	2010 €'000
Unquoted Shares	**3**	3
	3	3

Note 12 **Stocks**

	2011 €'000	2010 €'000
Medical, Dental and Surgical Supplies	**32,610**	34,050
Laboratory Supplies	**6,193**	6,478
Pharmacy Supplies	**17,974**	19,361
High Tech Pharmacy Stocks	**32,403**	30,926
Pharmacy Dispensing Stocks	**1,716**	2,001
Blood and Blood Products	**1,300**	1,408
Vaccine Stocks	**17,601**	21,655
Household Services	**8,881**	9,217
Stationery and Office Supplies	**2,275**	2,387
Sundries	**568**	604
	121,521	128,087

Note 13 **Debtors**

	2011 €'000	2010 €'000
Patient Debtors	**117,693**	96,539
Prepayments and Accrued Income	**17,330**	18,475
Other Debtors*	**174,317**	122,757
	309,340	237,771

* Other Debtors includes €23.759m cash advance to support Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital as agreed with the Minister.

Note 14 **Paymaster General and Exchequer Balance**

	2011 €'000	2010 €'000
Paymaster General Bank Account	**103,513**	105,668
Net Liability to the Exchequer	**(15,731)**	(17,977)
Paymaster General and Exchequer Balance	**87,782**	87,691

Note 15 **Creditors**

	2011 €'000	2010 €'000
Finance Leases	**1,556**	1,684
Non Pay Creditors – Revenue	**134,597**	138,513
Non Pay Creditors – Capital	**15,851**	26,157
Accruals for Non Pay – Revenue	**588,177**	652,147
Accruals Non Pay – Voluntary Hospitals & Outside Agencies	**277,515**	253,718
Accruals Non Pay – Capital	**32,773**	26,763
Accruals Pay	**313,792**	309,603
Income Tax and Social Welfare	**138,189**	133,414
Lottery Grants Payable*	**1,067**	686
VHI Advance**	**–**	187
Sundry Creditors	**17,007**	19,189
	1,520,524	1,562,061

** The HSE administers the disbursement of National Lottery grants for local programmes under the National Lottery's Health and Welfare Funded Schemes.*

*** The HSE negotiated the introduction of improved payment arrangements with VHI in Q4 2009 which included a once-off advance payment on account of €50m for a period of six months. VHI have deducted the €50m from future claims received from the HSE, and by early 2011 the €50m was recovered in full by VHI.*

Note 16 **Creditors (amounts falling due after more than one year)**

a) Finance lease obligations

	Land and Buildings 2011 €'000	Other 2011 €'000	Total 2011 €'000	Total 2010 €'000
After one but within five years	4,194	0	**4,194**	3,675
After five years	33,799	0	**33,799**	34,951
	37,993	0	**37,993**	38,626

	2011 €'000	2010 €'000
(b) Department of Environment and Local Government Subsidised Loans	**1,062**	0

* The €1.062m Department of Environment and Local Government subsidised loans relates to loans taken out by Aontacht Phobail Teoranta, a former subsidiary which has been subsumed into the HSE. The subsidised loans were provided by the Department of Environment and Local Government under a Capital Funding Scheme for the Provision of Rental Accommodation by Approved Housing Bodies (Voluntary and Co-operative Housing).

The loans constitute ten different mortgages with a twenty year term and under the terms of the agreement are non-repayable provided they are used to accommodate homeless people. The last mortgage was taken out in 1995, therefore by 2015, provided the terms of the agreement are adhered to, it is expected that these loans will not be repayable.

Note 16 **Creditors (amounts falling due after more than one year)** *(continued)*

(c) 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 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 used for Mental Health and other projects as sanctioned.

	2011 €'000	2010 €'000
Gross Proceeds of all disposals in year	**6,875**	3,546
Less: Net expenses incurred on disposals	**(18)**	(30)
Net proceeds of disposal	**6,857**	3,516
Less Application of Proceeds	**(6,812)**	(3,586)
At 1 January	**19,408**	19,478
Balance at 31 December	**19,453**	19,408
Less written off against historical capital expenditure deficits	**19,388**	0
Balance at 31 December after write back of historical deficits	**65**	19,408
Liability to the Exchequer Sale Proceeds – Other Sales/Capital Grant Refunds	**1,665**	1,651
Liability to the Exchequer – Statutory Rebate Claim	**11,660**	9,162
Total Liability to the Exchequer	**13,390**	30,221
Total Creditors (amounts falling due after more than one year)	**52,445**	68,847

Note 17 **Deferred Income**

Deferred income comprises (i) unspent income of €7.233m arising from funding, donations and bequests where the purposes to which money may be applied has been specified but the related expenditure has not been incurred and (ii) income of €2.401m from sales of land which have not been concluded.

Note 18 **Capital and Reserves**

(a) Capitalisation Account

	2011 €'000	2010 €'000
At 1 January	**5,274,663**	5,143,374
Additions to fixed assets in the year	**176,129**	338,666
Less: Net book value of fixed assets disposed in year	**(13,908)**	(12,310)
Less: Depreciation charge in year	**(170,690)**	(195,067)
Balance at 31 December	**5,266,194**	5,274,663

(b) Capital Reserves

	2011 €'000	2010 €'000
At 1 January	**(206,865)**	(205,716)
Net Operating (Deficit)/Surplus for the year	**27,746**	(1,149)
Balance at 31 December	**(179,119)**	(206,865)

(c) Revenue Reserves

	2011 €'000	2010 €'000
At 1 January	**(955,293)**	(1,077,914)
Revenue Reserves Post Graduate Medical and Dental Board	**0**	0
Revenue Reserves Eastern Community Works	**0**	371
Revenue Reserves EVE Holdings Ltd	**0**	974
Revenue Reserves Bradóg Trust	**0**	(445)
Revenue Reserves Crisis Pregnancy Agency	**0**	0
Revenue Reserves Aontacht Phobail Teoranta (see Note 27)	**255**	105
Revenue Reserves St. Luke's Hospital	**0**	94
Revenue Reserves National Cancer Screening Service Board	**0**	(2,402)
Revenue Reserves Office of Tobacco Control	**123**	0
Revenue Reserves Health Service National Partnership Forum	**0**	0
Revenue Reserves Tolco Ltd	**1**	0
Net Operating Surplus for the year	**98,426**	123,924
Balance at 31 December	**(856,488)**	(955,293)

Note 18 **Capital and Reserves** *(continued)*

(d) Reconciliation of Movement on Reserves

	2011 €'000	2010 €'000
Closing Creditors at 31 December	**1,572,969**	1,630,908
Less Opening Creditors at 1 January	**1,630,908**	1,795,686
	(57,939)	(164,778)
Less Increase/(Decrease) in Current Assets	**71,993**	(40,628)
(Increase)/Decrease in Deferred Income	**(3,381)**	(2,678)
	(126,551)	(121,472)
Net Operating Surplus	**(98,426)**	(123,924)
Revenue Reserves from subsumed agencies	**(379)**	1,303
Net Capital Surplus/(Deficit)	**(27,746)**	1,149
	(126,551)	(121,472)

Note 18(d) above illustrates the reconciliation between the Movement in Reserves (surplus/(deficit) for the year) and the changes to Assets and Liabilities on the Balance Sheet.

Note 19 **Capital Expenditure**

(a) Additions to Fixed Assets

	2011 €'000	2010 €'000
Additions to Fixed Assets (Note 9) Land and Buildings	**125,588**	250,038
Additions to Fixed Assets (Note 10) Other than Land and Buildings	**50,541**	88,628
	176,129	338,666
Transferred from subsumed agencies	**1,358**	109,483
Funded from Capital	**157,297**	206,392
Funded from Revenue	**17,474**	22,791
	176,129	338,666

Note 19 **Capital Expenditure** *(continued)*

(b) Analysis of expenditure charged to Capital Income and Expenditure Account

	2011 €'000	2010 €'000
Expenditure on HSE's own assets (Capitalised)	**157,297**	206,392
Expenditure on HSE projects not resulting in Fixed Asset additions	**47,014**	33,810
Adjustment to Liability to the Exchequer*	**(19,388)**	0
Total expenditure on HSE Projects charged to capital	**184,923**	240,202
Capital grants to outside agencies (Appendix 2)	**132,755**	130,164
Total Capital Expenditure per Capital Income & Expenditure Account	**317,678**	**370,366**

* Adjustment to Liability to the Exchequer relates to balance on capital proceeds of disposal account indirectly remitted by way of a reduced technical adjustment on the establishment of the HSE in 2005, netted against historical capital expenditure deficits in 2011.

(c) Analysis of Income from Government Departments and Other Sources

	2011 €'000	2010 €'000
Department of Health, Drugs Program Unit (formerly Department of Community Rural & Gaeltacht Affairs, OMD (Office of the Minister for Drugs))*	**519**	1,114
Department of Environment, Community & Local Government – RAPID*	**49**	386
Central Remedial Clinic – CRC at Waterford Regional Hospital	**0**	1,394
Employment Response – employment initiatives for persons with a disability	**205**	205
Sustainable Energy Ireland (SEI) – energy savings in acute hospitals	**673**	610
Friends of St. Luke's Hospital	**0**	683
The Stroke Unit Limerick	**0**	486
Department of Education	**0**	305
St. Colemans Care Centre Ltd – Care Centre, Achill**	**413**	80
Friends of Castlecomer District Hospital – construction of front entrance	**131**	0
Other Miscellaneous Income	**849**	575
	2,839	5,838

* The Drugs Program Unit and RAPID were funded in 2010 by the Department of Community Rural & Gaeltacht Affairs. 2010 figures have been re-stated to reflect the current funding source.

** St. Colemans Care Centre Ltd was not separately disclosed in 2010, it was included in Other Miscellaneous Income which has now been re-stated.

Note 20 Net Cash Inflow/(Outflow) from Operating Activities

	2011 €'000	2010 €'000
Surplus for the current year	**98,426**	123,924
Capital element of lease payments charged to revenue	**486**	446
Less Interest and dividend income	**(199)**	(24)
Purchase of equipment charged to Revenue Income and Expenditure	**18,832**	22,791
All interest charged to Revenue Income and Expenditure	**1,349**	1,442
(Increase)/Decrease in Stock	**6,566**	18,520
(Increase)/Decrease in Debtors	**(71,569)**	(20,849)
Increase/(Decrease) in Creditors	**(41,537)**	(174,571)
Revenue Reserves from Subsumed Agencies	**379**	(1,303)
Increase/(Decrease) in Creditors (falling due in more than one year)	**1,879**	9,863
Increase/(Decrease) in Deferred Income	**3,381**	2,678
(Increase)/Decrease in Long Term Loan	**1,062**	0
Net Cash Inflow/(Outflow) from Operating Activities	**19,055**	(17,083)

Note 21 Reconciliation of Net Cash Flow to Movement in Net Funds

	2011 €'000	2010 €'000
Change in net funds resulting from cash flows		
Net funds at 1 January	**109,142**	152,099
Movement in net funds for the year from cash flow statement	**6,990**	(42,957)
Net funds at 31 December	**116,132**	109,142

Note 22 **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. In practice it is almost impossible to achieve an actual outturn which matches the exact Vote amount. As a result, it is inevitable that this prudent approach will result in small surpluses. The surplus to be surrendered amounts to €15.8m, which represents 0.1% of the total Vote of the HSE.

(b) Summary Appropriation Account, prepared under Government Accounting rules:

	Estimate	Outturn	Estimate	Outturn
	2011 €'000	2011 €'000	2010 €'000	2010 €'000
HSE Vote 40 Gross Expenditure	**13,942,487**	**13,902,830**	14,791,431	14,477,921
Appropriations-in-Aid	**1,482,047**	**1,458,171**	3,667,850	3,523,317
Net Vote Expenditure	**12,460,440**	**12,444,659**	11,123,581	10,954,604

	2011 €'000	2010 €'000
Surplus to be Surrendered	**15,781**	168,977

(c) Analysis of Surrender

	2011 €'000	2010 €'000
Net surplus to be surrendered	**15,781**	168,977
	15,781	168,977

Note 22 **Vote Accounting** *(continued)*

(d) For information purposes see below Note 3 extract from HSE's 2011 Appropriation Account:

	2011 €'000	2010 €'000
Statement of Assets and Liabilities as at 31 December 2011		
Capital Assets	**5,266,194**	5,274,663
Financial Assets	**3**	3
	5,266,197	5,274,666
Current Assets		
Bank and cash	**28,350**	21,451
PMG Balance	**103,513**	105,668
Stocks	**121,521**	128,087
Debtors and Prepayments	**229,792**	169,996
Other debit balances	**79,548**	67,775
Total Current Assets	**562,724**	492,977
Less Current Liabilities		
Creditors	**150,448**	164,670
Accrued expenses	**1,246,230**	1,289,321
Deferred Income	**9,634**	6,253
Other credit balances	**176,291**	176,917
Net Liability to the Exchequer	**15,731**	17,977
Total Current Liabilities	**1,598,334**	1,655,138
Net Current Assets	**(1,035,610)**	(1,162,161)
Net Assets	**4,230,587**	4,112,505
Net Liability to the Exchequer at 31 December		
Surplus appropriations to be surrendered	**15,781**	168,977
Exchequer grant undrawn	**(50)**	(151,000)
Net Liability to the Exchequer	**15,731**	17,977
Represented by:		
Debtors		
Net Paymaster General Position and Cash	**131,862**	**127,119**
Debit Balances: Suspense	**55,788**	**67,775**
	187,650	**194,894**
Creditors		
Due to State	**(138,190)**	**(133,414)**
Credit Balances: Special Income & Expenditure	**(15,229)**	**(11,849)**
Credit Balances: Suspense	**(18,500)**	**(31,654)**
	(171,919)	**(176,917)**
Net Current Liabilities	**15,731**	**17,977**

Note 23 **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. Superannuation contributions from employees who are members of these schemes are credited to the income and expenditure account when received. To date, no formal actuarial valuations of the HSE's pension liabilities have been carried out.

Note 24 **Capital Commitments**

	2011 €'000	2010 €'000
Future tangible fixed assets purchase commitments:		
Within one year	**363,030**	353,174
After one but within five years	**434,050**	543,272
After five years	**0**	10,870
	797,080	907,316
Contracted for but not provided in the financial statements	**237,304**	223,862
Included in the Capital Plan but not contracted for	**559,776**	683,454
	797,080	907,316

The HSE has a multi-annual capital investment plan which prioritises expenditure on capital projects in line with strategic objectives in the Corporate Plan and the Annual Service Plan. The commitments identified above are in respect of the total cost of projects for which specific funding budgets have been approved at year end. These commitments may involve costs in years after 2012 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 HIQA compliance and the new Central Mental Hospital.

Note 25 **Property**

The HSE estate comprises 2,655 properties.

Title to the properties can be analysed as follows:	2011 Number of Properties	2010* Number of Properties
Freehold	**1,666**	1,672
Leasehold	**989**	1,088
Total Properties	**2,655**	2,760
Primary utilisation of the properties can be analysed as follows:		
Delivery of health and personal social services	**2,559**	2,661
Administration and Support Services (including medical card processing, etc)	**96**	99
Total Properties	**2,655**	2,760

* 2010 properties have been re-stated to be consistent with the reporting format in 2011 which reflects the number of HSE properties, rather than buildings. The reduction in the number of properties is as a result of property disposals and the removal of properties from the estate during the year through the Lease Cost Reduction Initiative, the Mental Health Disposals Initiative and the transfer of properties to the Department of Social Protection.

Note 26 Operating Leases

Operating lease rentals (charged to income and expenditure account)

	2011 €'000	2010 €'000
Land and buildings	**37,991**	32,531
Motor Vehicles	**91**	68
Equipment	**543**	37
	38,625	32,636

The HSE has the following annual lease commitments under operating leases which expire:

	2011 Land and Buildings	2011 Other	2011 Total	2010 Total
	€'000	€'000	€'000	€'000
Within one year	8,367	592	**8,959**	7,541
In the second to fifth years	9,271	34	**9,305**	9,816
In over five years	19,748	0	**19,748**	15,216
	37,386	626	**38,012**	32,573

Note 27 Subsidiary Undertakings

In 2011, Tolco Ltd, which was set up in 1975 for the purposes of providing services including residential care and training facilities for persons with special needs to the then Eastern Health Board, was subsumed into the HSE.

Aontacht Phobail Teoranta was partially subsumed at 31 December 2010 and the transfer of remaining balances was completed in 2011.

The HSE has no other subsidiary undertakings.

Note 28 Taxation

The HSE has been granted an exemption in accordance with the provisions of Section 207 (as applied to companies by Section 76), Section 609 (Capital Gains Tax) and Section 266 (Deposit Interest Retention Tax) of the Taxes Consolidation Act, 1997. This exemption which applies to Income Tax/Corporation Tax, Capital Gains Tax and Deposit Interest Retention Tax, extends to the income and property of the HSE. The exemption is subject to review by the Revenue Commissioners and, if conditions as specified are not met, the exemption may be withdrawn from the date originally granted.

Note 29 Insurance

Up to 31 December 2009 the HSE was insured against employers liability and public liability risks up to an indemnity limit, under both retro-rated and flat-rated bases. Under the retro-rated 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 2011 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 €4,699 and €2,394,662 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.

Note 29 **Insurance** *(continued)*

State Claims Agency

Since 1 July 2009 the HSE is funded for claims processed by the State Claims Agency under the terms of the Clinical Indemnity Scheme. From 1 January 2010 the National Treasury Management Agency (Delegation of Functions) Order 2009 extended the State indemnity to personal injury and third party property damage claims against the HSE. Awards paid to claimants under the terms of the scheme are accounted for on a pay-as-you-go basis. At 31 December 2011, the estimated liability incurred to that date under the Clinical Indemnity Scheme and State indemnity was €866m. In accordance with the directions of the Minister for Health, no provision has been made for this liability in the financial statements.

Note 30 **Contingent Liabilities – Actions by Pharmacists**

Pharmacists lodged a claim with the HSE for loss of retail mark up on products dispensed under the terms of the over 70 Medical Card, products which would otherwise have been subject to higher margin where full eligibility did not exist. The claim is in the amount of €100m, over and above the amount of €30 million currently paid per annum. The Irish Pharmaceutical Union (IPU) indicated that they would engage in non-binding mediation but may pursue the HSE through the courts if they are dissatisfied with the outcome. The matter of universal entitlement to a medical card for persons aged 70 years and over was removed by the Minister for Health in 2009. The Department of Health have confirmed that the HSE has applied the policy as set out and intended over the period during which automatic eligibility was in place for persons aged 70 years and over. On this basis the financial effects of this contingent liability have not been provided in the financial statements and the HSE have advised the IPU that the HSE has no historical liability in relation to this matter.

Contingent Liabilities – General

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 public and employer liability, fire and specific all risk claims. In most cases such insurance would be sufficient to cover all costs, but this cannot be certain. The financial effects of any uninsured contingencies have not been provided in the financial statements.

Note 31 **The Health (Repayment Scheme) Act, 2006**

The Health (Repayment Scheme) Act 2006 provides the legislative basis for the repayment of what has been referred to as 'long stay charges' which were incorrectly levied on persons with full 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

Under the provisions of the Act, the HSE appointed an external third party to act as Scheme Administrator. A special account is set up which is funded by monies provided by the Oireachtas and from which repayments are made. An amount of €12m was set aside in 2011 by way of a supplementary estimate for this purpose. The best estimate of the total cost of repayments, at the inception of the Scheme based on the terms as set out in the Act was up to €1bn. Repayments were expected to be made to approximately 20,000 living patients and to the estates of approximately 40,000 to 50,000 deceased former patients.

The Scheme closed to new applicants on the 31 December 2007 and nearly 14,000 claims have been received in respect of living patients and 26,000 claims in respect of estates. The Scheme is now estimated to cost in the region of €480m. 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. Proceedings have been instituted in 318 cases, involving patients who spent time in private nursing home facilities. None of the cases have yet proceeded to a hearing. In addition, the HSE with the Department of Health and Children has lodged an appeal to the High Court in respect of determinations by the Appeals Officer granting eligibility to clients of certain disability services. Consequently, it is considered inappropriate to attempt to estimate any potential future liability arising from these actions or to detail the uncertainties attaching thereto since to do so might prejudice the outcome of court proceedings.

Note 31 **The Health (Repayment Scheme) Act, 2006** *(continued)*

In 2011, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Repayments Scheme:

	2011 €'000	2010 €'000
Pay	**479**	971
Repayments to Patients (see Note 8)	**8,222**	19,193
Payments to Third Party Scheme Administrator	**885**	1,190
Legal and Professional Fees	**249**	508
Office Expenses	**41**	71
	9,876	21,933

Note 32 **Hepatitis C Compensation Tribunal (Amendment) Act, 2006**

The Hepatitis C Compensation Tribunal (Amendment) Act 2006 established a statutory scheme to address insurance difficulties experienced by persons infected with Hepatitis C and HIV through the administration within the State of blood and blood products. This scheme addresses the problems faced by these persons due to their inability to purchase mortgage protection and life assurance policies as a result of contaminated blood products being administered to them. The scheme will cover the insurance risk for the 1,700 or more people entitled to avail of assurance products, regardless of any other medical conditions these people may have, once they pay the standard premium that an uninfected person of the same age and gender would pay. The life assurance element of the scheme was launched by the HSE in September 2007. A further element, providing for travel insurance cover, was introduced in March 2009. The overall cost over the lifetime of the scheme is estimated at €90m.

In 2011, the following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Insurance Scheme:

	2011 €'000	2010 €'000
Pay	**93**	131
Payments of premium loadings	**352**	347
Payments of benefits underwritten by HSE	**616**	211
Office Expenses	**12**	2
	1,073	691

Note 33 **Nursing Home Support Scheme (Fair Deal)***

The Nursing Home Support Scheme (Fair Deal) commenced in 2009 and phases out the former Nursing Home Subvention Scheme and the 'contract beds' system. Under the Scheme, people who need nursing home care have their income and assets assessed, and then contribute up to 80% of assessable income and up to 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. The funding provision for this Scheme is fixed in the HSE's Vote each year.

The following expenditure has been charged to the Revenue Income and Expenditure Account in respect of the Nursing Home Support Scheme:

	2011 €'000	2010 €'000
Payments to private nursing homes under the Nursing Home Support Scheme	**417,712**	260,785
Private nursing home contract beds & subvention payments	**142,902**	218,929
	560,614	479,714

* Nursing Home Support Scheme (Fair Deal) expenditure per Note 8 to the financial statements relates to payments to private nursing homes for (i) contract beds, (ii) subvention payments and (iii) Nursing Home Support Scheme payments. Expenditure incurred in the running of HSE public long stay residential care units is reported across a range of pay and non pay expenditure headings in the HSE's financial statements. The total provision in 2011 for the Nursing Home Support Scheme (for both public and privately-run facilities) in the HSE's Vote was €1,026m.

Note 34 **Ancillary State Support**

Ancillary State Support is an optional extra feature of the Nursing Home 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 2011 from the commencement of the Nursing Home support Scheme was €3.8 million representing 384 client loans and Revenue have confirmed to the HSE that they had received €1.3 million of loan repayments representing 175 client loans.

Note 35 Primary Care and Medical Card Schemes

Note 8 outlines the expenditure on Primary care and Medical Card Schemes which includes expenditure on doctors' fees and pharmaceutical and other services that are based on entitlements to a means tested medical card. As at 31 December 2011 there were 1,694,063 medical cards in issue with an additional 125,657 GP Visit cards. Of these cards, 74,281 medical cards and 16,251 GP Visit cards were issued on discretionary hardship grounds.

The total expenditure under the medical card scheme in 2011 was €1,774m.

The project to deliver centralisation of medical card processing in the Primary Care Reimbursement Service (PCRS) was completed in July 2011 and introduced changes to deliver improvements in control and standardisation within primary care and medical card schemes.

The medical card database contains a card renewal date and, in advance of that date, a notification is issued to the card holder advising that a completed card renewal application is required to maintain eligibility to services. Where the PCRS does not receive a renewal application or responses to follow-up correspondence the eligibility to services is removed.

Following centralisation of card processing on 1 July 2011, PCRS assumed responsibility for examining all card renewal applications.

In the six month period to December 2011, 231,004 completed renewal applications were received of which 2,723 cases (1.18%) did not qualify for either a medical card or a GP Visit card. 2,976 cases (1.29%) did not meet the eligibility criteria for a full medical card and were given a GP Visit card. In 225,305 cases the review found that eligibility criteria were met.

Based on the findings of the case review, PCRS has commissioned a body of work to fully examine the results of the case review and to develop a risk-based control framework to ensure appropriate governance and probity measures are in place to control the regularity of medical card issuing. Government has indicated its intention to introduce legislation during 2012 to facilitate the sharing of information with other State Departments and agencies which would facilitate the cross referencing of applicants' details and enable a risk based approach to review and audit.

As the purpose of the review was to determine whether card holders continued to be eligible, the review did not record the financial impact of card withdrawals such as the cost of services provided in respect of ineligible persons.

Note 36 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 Board, which would require adjustment or disclosure in the financial statements.

Note 37 Related Party Transactions

In the normal course of business the Health Service Executive may approve grants and may also enter into other contractual arrangements with undertakings in which HSE Board 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 members. These procedures have been adhered to by the Board members and the HSE during the year. During 2011 two agencies in which Board members declared an interest were approved grants of €71,872 and €1,066,863 respectively. The Board members concerned did not receive any documentation on the transactions nor did the members participate in or attend any Board discussion relating to these matters. A Board member has declared an interest in a company and another Board member has declared an interest in a partnership, both of which trade from time to time with the HSE on terms which are negotiated on an arm's length basis.

Note 38 Approval of Financial Statements

The financial statements were approved by the Board on 18 May 2012.

Appendices to the Financial Statements

Appendix 1 **Revenue Grants and Grants Funded by Other Government Departments/State Agencies**

(Analysis of Grants to Outside Agencies in Note 8)

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Total Grants under €100,000 (2,349 Grants)	**42,821**	**1,484**	**44,305**
Ability West Ltd	23,304		23,304
Abode Hostel and Day Centre	1,059		1,059
Acquired Brain Injury Ireland (Formerly Peter Bradley Foundation)	8,494		8,494
Active Retirement Ireland	247		247
Adapt House Women's Refuge Centre, Limerick	628		628
Adapt Kerry Ltd	174		174
Addiction Response Crumlin (ARC)	299	744	1,043
Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital	188,686		188,686
Adoption Authority of Ireland	457		457
Aftercare Recovery Group	117		117
Age Action Ireland	542		542
Age and Opportunity	626		626
AIDS Fund Housing Project (Centenary House)	383		383
AIDS Help West	235		235
Aiseiri	190		190
Aislinn Centre, Kilkenny	447		447
Alcohol Action Ireland	150		150
ALJEFF Treatment Centre Ltd	57	392	449
All Communicarers Ltd	573		573
All In Care	4,163		4,163
Alliance	244		244
Alpha One Foundation	149		149
Alzheimer Society of Ireland	9,926		9,926
Amber Kilkenny Women's Outreach	440		440
AMEN	164		164
Ana Liffey Drug Project	798	367	1,165
Anne Sullivan Foundation for Deaf/Blind	1,242		1,242
Aoibhneas Foundation Ltd	969		969
Aosóg	207		207
Aras Mhuire Day Care Centre (North Tipperary Community Services)	301		301

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
ARC Cancer Support Centre	211		211
Ard Aoibhinn Centre	2,817		2,817
Ardee Day Care Centre	292		292
Arlington Novas Ireland	2,798	84	2,882
Arthritis Ireland	194		194
Asperger Syndrome Association of Ireland (ASPIRE)	331		331
Associated Charities Trust	113		113
Association for the Healing of Institutional Abuse (AHIA) (Previously known as the Aislinn Centre, Dublin)	355		355
Athlone Community Services Council Ltd	390		390
Autism Initiatives Group	3,791		3,791
Autism West Ltd	580		580
Aware	207		207
Baile Mhuire Recuperative Unit for the Elderly	203		203
Balcurris Boys Home Ltd	638		638
Ballinasloe Social Services	139		139
Ballincollig Senior Citizens Club Ltd	364		364
Ballyboden Children's Centre	152		152
Ballyfermot Advanced Project Ltd	0	517	517
Ballyfermot Home Help	2,387		2,387
Ballyfermot Star Ltd	71	321	392
Ballymun Day Nursery (Tir na nOg)	323		323
Ballymun Local Drugs Task Force	52	221	273
Ballymun Youth Action Project (YAP)	602	51	653
Ballyowen Meadows Childrens Residential Centre	885		885
Barnardos	8,416	296	8,712
Barretstown	183		183
Barrow Valley Enterprises for Adult Members with Special Needs Ltd (BEAM)	366		366
Base Youth Centre	210		210
Bawnogue Youth and Family Support Group (BYFSG)	122	268	390
Beaufort Day Care Centre	183		183
Beaumont Hospital	248,791		248,791
Before 5 Nursery and Family Centre	143		143
Belong to Youth Services Ltd	139		139
Belvedere Social Service	605		605
Bernard Van Leer Foundation	106		106

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Blakestown and Mountview Youth Initiative (BMYI)	556	65	621
Blanchardstown and Inner City Home Helps	3,978		3,978
Blanchardstown Local Drugs Task Force	100	258	358
Blanchardstown Youth Service	180	67	247
Bluebell Development Project Ltd	0	121	121
Bluebird Care	783		783
Bodywhys The Eating Disorder Association of Ireland	286		286
Bon Secours Sisters	2,215		2,215
Bonnybrook Day Nursery	248		248
Brainwave – Irish Epilepsy Association	820		820
Bray Area Partnership	45	65	110
Bray Community Addiction Team	0	781	781
Bray Lakers Social and Recreational Club Ltd	144		144
Bray Travellers Group	0	109	109
Bray Women's Refuge	629		629
Brothers of Charity Services Ireland	164,149		164,149
Bushy Park Treatment Centre	53	57	110
Cabra Resource Centre	173	79	252
Cairde	417		417
Cairdeas Centre Carlow	273		273
Camphill Communities of Ireland	1,097		1,097
Cancer Care West	699		699
Cappagh National Orthopaedic Hospital	26,325		26,325
Capuchins	118		118
Cara Housing Association	209		209
Care for the Elderly at Home Ltd	237		237
Care Of the Aged, West Kerry	111		111
Caredoc GP Co-operative	6,710		6,710
Careline	116		116
Caremark Ireland	1,480		1,480
Carers Association Ltd	4,017		4,017
Careworld	422		422
CARI Foundation	322		322
Caring and Sharing Association (CASA)	218		218
Caring For Carers Ireland	925		925
Caritas	2,029		2,029

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Carlow Day Care Centre (Askea Community Services)	101		101
Carlow Regional Youth Service	129		129
Carlow Social Services	468		468
Carlow Women's Aid	139		139
Carlow/Kilkenny Home Care Team	230		230
Carnew Community Care Centre	151		151
Carrickmacross Parent and Friends Association	741		741
Carriglea Cairde Services Ltd (formerly Sisters of the Bon Sauveur)	9,135		9,135
Casadh	0	200	200
Castle Homecare	436		436
Cavan County Childcare Committee	134		134
CAWT (Cooperation And Working Together)	0	441	441
CDA Trust Ltd (Cavan Drug Awareness)	0	185	185
Central Remedial Clinic	16,817		16,817
Centres for Independent Living (CIL)	10,461		10,461
Charleville Care Project Ltd	101		101
Cheeverstown House Ltd	23,212		23,212
Cheshire Foundation Ireland	22,759	44	22,803
Childrens Sunshine Home	3,906		3,906
Chrysalis Community Drug Project	0	273	273
Cill Dara Ar Aghaid	0	448	448
Clann Mór	918		918
Clare Immigrant Support Centre	179		179
Clare Youth Services	110		110
Clarecare Ltd Incorporating Clare Social Service Council	6,624		6,624
Clarecastle Daycare Centre	431		431
Clarehaven Women and Children Refuge Centre	491		491
Clareville Court Day Centre	185		185
CLASP (Community of Lough Arrow Social Project)	147		147
Clondalkin Addiction Support Programme (CASP)	570	291	861
Clondalkin Drugs Task Force	223	133	356
Clones Branch of the Mentally Handicapped	116		116
Clonmany Mental Health Association	114		114
Clonmel Community Resource Centre	146		146
Clontarf Home Help	2,316		2,316

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
CLR Home Help	2,377		2,377
CLUB 91 (Formerly Chez Nous Service)	137		137
Co-Action West Cork	6,145		6,145
Cobh General Hospital	1,719		1,719
Comfort Keepers Ltd	3,267		3,267
Community Creations Ltd	130		130
Community Games	220		220
Community Home Maker and Family Support Service	506		506
Community Nursing Unit North West	647		647
Community Response, Dublin	219	119	338
Connaught St Family Centre	450		450
Console (Living with Suicide)	240		240
Contact Care	844		844
Convent House Daycare and Resource Centre Ltd	103		103
Coolmine Therapeutic Community Ltd	1,035	777	1,812
Coombe Women's Hospital	49,344		49,344
COPE Foundation	44,705		44,705
COPE Galway	2,381		2,381
Cork Association for Autism	3,310		3,310
Cork Family Planning Clinic	175		175
Cork Foyer Project	300		300
Cork Mental Health Association	156		156
Cork Social and Health Education Project (CSHEP)	400		400
Cork University Dental School and Hospital	2,134		2,134
Cottage Home Child and Family Services	1,530		1,530
County Limerick VEC	115		115
County Wexford Community Workshop, Enniscorthy/ New Ross Ltd	4,232		4,232
County Wexford Partnership Ltd	103		103
CPL Healthcare	1,072		1,072
Criticare Services	286		286
Croí	283		283
Crosscare	5,465		5,465
Crumlin Home Help	3,058		3,058
Cuan Mhuire	812	36	848
Cuan Saor Women's Refuge and Support Service	448		448

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Cuanlee Ltd	209		209
Cumas Teo	224	149	373
Cura	914		914
Cúnamh	118		118
Dara Residential Services	1,813		1,813
Darndale Belcamp Child Care	400		400
Darndale Belcamp Drug Awareness	187	73	260
Daughters of Charity	97,628	207	97,835
Daughters of Charity (Formerly Sisters of the Sacred Hearts of Jesus and Mary)	15,260		15,260
Day Activation Unit for Children and Windmill Therapeutic Training Unit	479		479
Deansrath Family Resource Centre	272		272
Delta Centre Carlow	2,835		2,835
Dental Health Foundation Ireland	193		193
Depaul Ireland	2,011		2,011
Diabetes Federation of Ireland	297		297
Disability Federation of Ireland (DFI)	2,055		2,055
Dóchas	443	71	514
Dolmen Clubhouse Ltd	128		128
Domestic Violence Advocacy Service	307		307
Domestic Violence Association, Laois	125		125
Don Bosco Teenage Care Housing Association	2,514		2,514
Donegal Women's Refuge Group (DDVS)	446		446
Donegal Youth Services	116		116
Donnycarney Youth Project Ltd	293	73	366
Donnycarney/Beaumont Home Help	1,496		1,496
Donnycarney/Beaumont Local Care	118		118
Donore Community Development	21	214	235
Down Syndrome Ireland	167		167
Drogheda Community Services	119		119
Drogheda Homeless Aid Association	175		175
Drogheda Women's Refuge	491		491
Dromcollogher and District Respite Care Centre	380		380
Drug Treatment Centre Board	8,381		8,381
Drumcondra Home Help	1,296		1,296
Drumkeerin Care Of The Elderly	211		211

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Drumlin House Training Centre	252		252
Dublin AIDS Alliance (DAA) Ltd	419	76	495
Dublin City Council Homeless Agency	822	148	970
Dublin Dental Hospital	6,363		6,363
Dublin North East Drugs Task Force	105	106	211
Dun Laoghaire Home Help	892		892
Dun Laoghaire Rathdown Community Addiction Team	0	489	489
Dun Laoghaire Rathdown Outreach Project	185	113	298
Edenmore Day Nursery	296		296
Edward Worth Library	140		140
Empowerment Plus	475		475
Enable Ireland	37,322		37,322
Ennis Community Development Project	118		118
Extern Ireland	5,502		5,502
Extra Care for the Elderly	532		532
Familiscope	88	74	162
Father McGrath Multimedia Centre (Family Resource Centre)	148		148
Fatima Home, Tralee	307		307
Ferns Diocesan Youth Services	214		214
Festina Lente Foundation	376		376
Fighting Blindness Ireland	118		118
Finglas Addiction Support Team	0	429	429
Fingal Home Care	3,091		3,091
Finglas Home Help/Care Organisation	4,464		4,464
First Step	288		288
Five Rivers Ireland	451		451
Focus Ireland	3,962		3,962
Fold Ireland	1,849		1,849
Foróige	3,240		3,240
Friedreich's Ataxia Society in Ireland	123		123
FRS Homecare	170		170
Galway City and County Childcare Strategy Group	129		129
Galway Hospice Foundation	3,525		3,525
Genio (The Person Centre)	2,000		2,000
Gheel Autism Services Ltd	5,524		5,524

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Good Shepherd Sisters	2,552		2,552
Graiguenamanagh Elderly Association	131		131
Greater Blanchardstown Response to Drugs	89	63	152
GROW	1,301		1,301
Guardian Ad Litem and Rehabilitation Office (GALRO)	1,627		1,627
Hail Housing Association for Integrated Living	419		419
Hands On Peer Education (HOPE)	0	114	114
Headstrong	1,037		1,037
Headway the National Association for Acquired Brain Injury	2,474		2,474
Holy Angels Carlow, Special Needs Day Care Centre	774		774
Holy Ghost Hospital	165		165
Home Again (Formerly Los Angeles Society)	1,579		1,579
Home Care Plus	145		145
Home Help Services Ballymun	1,642		1,642
Home Instead Senior Care	6,020		6,020
Home Youth Liaison Service	563		563
HomeCare North East Bay Ltd	1,332		1,332
Homeless Girls Society Ltd	730		730
Homestart Family Support Services	156		156
Howth Peninsula Drugs Awareness	0	110	110
IADP Inter-Agency Drugs Project UISCE	0	121	121
Iar Ros Teicneolaiocht	132		132
ILAM (Ireland) Ltd	150		150
Immigrant Counselling and Psychotherapy (ICAP)	368		368
Inchicore Community Drugs Team	266	131	397
Inchicore Home Help	1,343		1,343
Inclusion Ireland	453		453
Incorporated Orthopaedic Hospital of Ireland	7,285		7,285
Institute of Community Health Nursing	132		132
Irish Advocacy Network	811		811
Irish Association for Spina Bifida and Hydrocephalus (IASBH)	977		977
Irish Association of Suicidology	134		134
Irish Association of Young People in Care (IAYPIC)	373		373
Irish Carers Association	125		125
Irish Family Planning Association (IFPA)	1,257		1,257

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Irish Foster Care Association (IFCA)	413		413
Irish Guide Dogs for the Blind	813		813
Irish Haemophilia Society (IHS)	577		577
Irish Hard of Hearing Association (IHHA)	4,799		4,799
Irish Heart Foundation	282		282
Irish Homecare Services	2,116		2,116
Irish Kidney Association (IKA)	211		211
Irish Motor Neurone Disease Association	286		286
Irish Osteoporosis Society	156		156
Irish Patients Association	117		117
Irish Pre-School Playgrounds Association (IPPA)	207		207
Irish Prison Service	279		279
Irish Society for Autism	3,743		3,743
Irish Society for the Prevention of Cruelty to Children (ISPCC)	491	210	701
Irish Sudden Infant Death Association (ISIDA)	264		264
Irish Travellers Movement (ITM)	6,079	196	6,275
Irish Wheelchair Association (IWA)	36,566		36,566
Jack and Jill Childrens Foundation	657		657
Jobstown Assisting Drug Dependency Project (JAAD Project)	223	71	294
K Doc (GP Out of Hours Service)	1,754		1,754
KARE, Newbridge	15,198		15,198
KARE Plan Ltd	1,925		1,925
KASMHA (Kilkenny Association for Severely Mentally Handicapped Adults)	1,065		1,065
Kerry Diocesan Youth Service	265		265
Kerry Parents and Friends Association	8,250		8,250
Kilbarrack Coast Community Programme Ltd (KCCP)	288	60	348
Kilbarrack/Foxfield Day Centre	158		158
Kildare and West Wicklow Community Addiction Team Ltd	0	298	298
Kildare Youth Services (KYS)	955		955
Killinarden (KARP)	150	50	200
Kilmaley Voluntary Housing Association	158		158
Kilnamanagh Family Recreation Centre	110		110
Kingsriver Community	210		210

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
L'Arche Ireland	2,717		2,717
Leitrim Association of People with Disabilities (LAPWD)	545		545
Leitrim Development Company	253		253
Leopardstown Park Hospital	12,143		12,143
Letterkenny Women's Centre	307		307
Letterkenny Youth And Family Service	109		109
Liberties and Rialto Home Help	1,137		1,137
Life Pregnancy Care Service	374		374
Lifestart Foundation	1,050	153	1,203
Limerick Social Services Council	1,157		1,157
Limerick Youth Service Community Training Centre	415	57	472
Link (Galway) Ltd	157		157
Liscarne Court Senior Citizens	125		125
Lochrann Ireland Ltd	140		140
Longford Community Resources Ltd	186		186
Longford Social Services Committee	243		243
Loughboy Child Care Project	188		188
Lourdes Day Care Centre	162		162
Mahon Family Resource Centre	200		200
Marian Court Welfare Home Clonmel	138		138
Marian Day Nursery and Family Centre	175		175
Marino/Fairview Home Help	831		831
Martin Hospital	109		109
Mater Misericordiae University Hospital Ltd	232,903		232,903
Matt Talbot Adolescent Services	1,342		1,342
Mayo Women's Support Services	484		484
Mead Village Day Care Centre	235		235
Meath Partnership	0	295	295
Meath Women's Aid Housing Association Ltd	269		269
Mental Health Associations (MHAs)	1,724		1,724
Mental Health Ireland	218		218
Merchant's Quay Ireland (MQI)	1,892	59	1,951
Mercy Family Centre Ltd	407	24	431
Mercy University Hospital, Cork	59,159		59,159
MIDWAY – Meath Intellectual Disability Work Advocacy You Ltd	2,056		2,056

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Migraine Association of Ireland	153		153
Milford Care Centre	11,157		11,157
Millennium Carving Ltd	263		263
Miss Carr's Housing Association Ltd	337		337
Moatview Day Nursery	160		160
Molyneaux House for the Blind	890		890
Moorehaven Centre Tipperary Ltd	1,103		1,103
Mount Cara House	120		120
Mounttown Neighbourhood Youth Project	185	20	205
Mountview/Blakestown Community Drugs Team	289	75	364
MS Ireland – Multiple Sclerosis Society of Ireland	2,697		2,697
Muintir na Tire Ltd	146		146
Mulhuddart/Corduff Community Drugs Team	275	81	356
Multiple Sclerosis North West Therapy Centre Ltd	254		254
Muscular Dystrophy Ireland	1,237		1,237
National Association of Housing for the Visually Impaired Ltd	515		515
National Council for the Blind of Ireland (NCBI)	6,871		6,871
National Council for the Professional Development of Nursing and Midwifery (NCNM)	0	200	200
National Federation of Voluntary Bodies in Ireland	441		441
National Maternity Hospital	46,830	13	46,843
National Network of Women's Refugees and Support Services, Athlone	394		394
National Office of Victims of Abuse (NOVA)	801		801
National Rehabilitation Hospital	25,592		25,592
National Service Users Executive	188		188
National Suicide Research Foundation (NSRF)	885		885
National University of Ireland, Galway (NUIG)	375		375
National Youth Council of Ireland	133		133
Nazareth House, Mallow	3,931		3,931
New Beginnings Childcare and Residential Service	768		768
New Ross Community Hospital	242		242
Newbridge and Dun Laoghaire Community Training Centre	101		101
Newbury House Family Centre, Mayfield, Cork	140		140
Newport Social Services, Day Care Centre	245		245

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Nightingale TLC	295		295
No Name Youth Club Ltd	165		165
North and West Connemara Rural Project	114		114
North Dublin Inner City Homecare and Home Help Services	2,402		2,402
North Tipperary Community and Voluntary Association (CAVA)	473		473
North Tipperary Disability Support Services Ltd	550		550
North Tipperary Leader Partnership	475		475
North West Alcohol Forum	229		229
North West Parents and Friends Association	1,965		1,965
Northside Community Health Initiative (NICHE)	295		295
Northside Homecare Services Ltd	1,324		1,324
Northside Inter-Agency Project (NIAP)	260	128	388
Northside Partnership	0	115	115
Northstar Family Support Project	0	181	181
Northwest Hospice	1,072		1,072
Northwest Inner City Training and Development	0	110	110
Nua Healthcare Services	512		512
Nurse on Call – Homecare Package	555		555
Oasis Counselling Service	0	177	177
O'Connell Court Residential and Day Care	198		198
Offaly Local Development Company	123		123
One Family	423		423
One in Four	637		637
Open Door Day Centre	430		430
Open Heart House	277		277
Order of Malta	489		489
Ossory Youth Services	135		135
Our Lady's Children's Hospital, Crumlin	130,088		130,088
Our Lady's Hospice, Harold's Cross	29,216		29,216
Our Lady's Nursery Ballymun Ltd	418		418
Outhouse Ltd	204		204
Outreach Project Network – OASIS Project	568		568
Oznam House	180		180
Pact	607		607
Parentstop Ltd	126		126

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Partnership Care West	263		263
Patient Focus	216		216
Paul Partnership Limerick	104	40	144
Peacehaven Trust	714		714
Peamount Hospital	25,125		25,125
Peter McVerry Trust (previously known as The Arrupe Society)	976	91	1,067
PHC Care Management Ltd	453		453
Phoenix Community Resource Centre	118		118
Pieta House	212		212
Pobal	1,118		1,118
Positive Action	558		558
Post Polio Support Group (PPSG)	414		414
Prague House	131		131
Praxis Care Group	2,634		2,634
Presentation Sisters	364		364
Private Home Care, Lucan	178		178
Prosper Fingal Ltd	6,661		6,661
Rape Crisis Network Ireland (RCNI)	4,211		4,211
Rathmines Home Help Services	505		505
Red Ribbon Project	278		278
Regional and Local Drugs Task Forces	304	1,113	1,417
Rehab Group	41,984		41,984
Renewal Women's Residence	100		100
Respond! Housing Association	834		834
Rialto Community Development	135		135
Rialto Community Drugs Team	245	153	398
Rialto Partnership Company	340	420	760
Right of Place Second Chance Group	229		229
Ringsend and District Response to Drugs	251	49	300
Roscommon Home Services Co-op	1,471		1,471
Roscommon Partnership Company Ltd	104		104
Roscommon Support Group Ltd	921		921
Rotunda Hospital	47,391		47,391
Rowlagh Day Nursery	177		177
Royal College of Physicians	380		380

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Royal College of Surgeons in Ireland	151		151
Royal Hospital Donnybrook	19,725		19,725
Royal Victoria Eye and Ear Hospital	21,825		21,825
Ruhama Women's Project	130	102	232
Runway Medical – Homecare Package	858		858
Rural Community Care Network (RCCN) Ltd	2,793		2,793
S H A R E	217		217
SAFE Ireland	110		110
Saint Aidan's Services	3,810		3,810
Salesian Youth Enterprises Ltd	352		352
Salvation Army	3,513		3,513
Samaritans	301		301
Sandra Cooneys Homecare	512		512
Sandymount Home Help	388		388
Saoirse Housing Association Ltd	755		755
SAOL Project	281	62	343
Schizophrenia Ireland Lucia Foundation	1,538		1,538
Servisource Recruitment	746		746
Sevenoaks Nursery	189		189
Shalamar Finiskilin Housing Association	212		212
Shannondoc Ltd (GP Out Of Hours Service)	4,780		4,780
Shanty Educational Project Ltd	680	82	762
Sheltered Housing	116		116
SHINE	107		107
Simon Communities of Ireland	7,196		7,196
Sisters of Charity	15,415		15,415
Sisters of Charity of Jesus and Mary, Moore Abbey	40,789		40,789
Sisters of Charity St Mary's Centre for the Blind and Visually Impaired	3,418		3,418
Sisters of La Sagesse Services	16,526		16,526
Sisters of Mercy	482		482
Slí Eile Support Services Ltd	192		192
Sligo County Child Care Committee	126		126
Sligo Family Centre	147		147
Sligo Family Support Ltd	225		225
Sligo Social Services Council Ltd	996		996

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Smyly's Trust Services	1,906		1,906
Snug Community Counselling	6	154	160
Society of St Vincent De Paul (SVDP)	2,946		2,946
Sonas Housing Association	1,313		1,313
Sophia Housing Association	538		538
South Doc GP Co-operative	7,715		7,715
South Dublin Senior Citizens Club	114		114
South Infirmary Victoria University Hospital	46,065		46,065
South Meath Response Project	0	117	117
South West Counselling Centre	128		128
Southern Drug and Alcohol Services Ltd	193		193
Special Olympics Ireland	130		130
Spinal Injuries Ireland	317		317
Spiritan Asylum Services Initiative (SPIRASI)	448		448
Springboard Projects	2,454		2,454
St Aengus Community Action Group	149		149
St Andrew's Resource Centre	383	53	436
St Anne's Day Nursery Ltd	198		198
St Anne's Youth Centre Ltd	360		360
St Bridget's Day Care Centre	122		122
St Carthage's House Lismore	128		128
St Catherine's Association Ltd	6,638		6,638
St Catherine's Community Services Centre, Carlow	111		111
St Christopher's Services, Longford	7,921		7,921
St Cronan's Association	877		877
St Dominic's Community Response Project	234	22	256
St Fiacc's House, Graiguecullen	383		383
St Francis Hospice	7,280		7,280
St Gabriel's School and Centre	2,064		2,064
St Helena's Day Nursery	334		334
St Hilda's Services For The Mentally Handicapped, Athlone	4,135		4,135
St James' Hospital	329,044	3	329,047
St James' Hospital, Jonathan Swift Hostels	4,402		4,402
St John Bosco Youth Centre	110	59	169
St John of God Hospitaller Services	135,416	0	135,416

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
St John's Hospital	18,500		18,500
St Joseph's Foundation	12,200		12,200
St Joseph's Home For The Elderly	760		760
St Joseph's School For The Deaf	1,939		1,939
St Joseph's School For The Visually Impaired	4,308		4,308
St Kevin's Home Help Service	361		361
St Laurence O' Toole SSC	1,031		1,031
St Lazarian's House, Bagenalstown	245		245
St Luke's Home	6,182		6,182
St Luke's Hospital (UK)	249		249
St Mary's School For The Deaf	1,371		1,371
St Michael's Hospital, Dun Laoghaire	27,459		27,459
St Michael's House	75,097		75,097
St Michael's Day Care Centre	149		149
St Monica's Community Development Committee	337	77	414
St Monica's Nursing Home	1,752		1,752
St Mura's Adoption Society	102		102
St Patrick's Hospital	357		357
St Patrick's Special School	174		174
St Patrick's Wellington Road	8,881		8,881
St Vincent's Hospital Fairview	14,544		14,544
St Vincent's Trust, St Mary's Day Nursery	261		261
St Vincent's University Hospital, Elm Park	211,864		211,864
Star Project Ballymun Ltd	153	51	204
Steer Ireland	102		102
Stella Maris Facility	159		159
Stewart's Hospital	45,341		45,341
Stillorgan Home Help	606		606
Streetline	651		651
Sunbeam House Services	20,218		20,218
Tabor House Trust Ltd	116	78	194
Tabor Lodge	272		272
Tabor Society	710		710
Tallaght Home Help	1,445		1,445
Tallaght Partnership	27	271	298
Teach Mhuire Day Care Centre	153		153

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
Teach Tearmainn, Kildare	135		135
TEAM Project Mullingar	104		104
Teen Challenge Ireland Ltd	13	286	299
Temple Street Children's University Hospital	78,824		78,824
Templemore Community Social Services	215		215
Terenure Home Care Service Ltd	969		969
The Beeches Residential Home	134		134
The Care People	158		158
The Cavan Centre	295		295
The Sexual Health Centre	151		151
The Sexual Violence Centre	302		302
Thurles Community Social Services	349		349
Tipperary Association for Special Needs	136		136
Tipperary Hospice Movement	232		232
Togher Pre-School and Family Centre	121		121
Tolco Ltd	511		511
Tolka River Project	0	147	147
Transfusion Positive	309		309
Treoir	508		508
Trinity College Dublin	436		436
Tullow Day Care Centre	165		165
Turners Cross Social Services Ltd	169		169
Union of Our Lady of Charity	100		100
Valentia Community Hospital	672		672
Vincentian Housing Partnership	226		226
Vita House Family Centre, Roscommon	110		110
Walkinstown Association For Handicapped People Ltd	4,274		4,274
Walkinstown Greenhills Resource Centre	0	251	251
Wallaroo Pre-School	106		106
Waterford and South Tipperary Community Youth Service	306		306
Waterford Association for the Mentally Handicapped	2,211		2,211
Waterford Hospice Movement	213		213
Welfare Home Callan/Kilmoganny	212		212
Well Woman Clinics	575		575
Wellsprings	681		681

Name of Agency	Revenue Grants 2011 €'000	Grants Funded by other Government Departments/ State Agencies 2011 €'000	Total Grants 2011 €'000
West Cork Carers Support Group Ltd	132		132
West Limerick Resources Ltd	152		152
West Of Ireland Alzheimer Foundation	1,049		1,049
Westdoc (GP Out Of Hours Service)	959		959
Western Care Association	28,732		28,732
Westmeath Community Development Ltd	270		270
Wexford Homecare Service	213		213
Wexford Women's Refuge	353		353
White Oaks Housing Association Ltd	264		264
Wicklow Community Care Home Help Services	5,854		5,854
Women's Aid	723		723
Womens Aid Dundalk Ltd	463		463
Young Men's Christian Association (YMCA)	411		411
Youth Action Programmes	567		567
Youth Advocacy Programme	2,546		2,546
Youth For Peace Ltd	161		161
Youth Work Ireland	121		121
Total Grants to Outside Agencies (see Note 8)	**3,431,395**	**18,309**	**3,449,704**

Appendix 2 **Analysis of Capital Grants to Outside Agencies**

(Capital Income and Expenditure Account)

Name of Agency	Capital Grants 2011 €'000
Total Grants under €100,000 (20 Grants)	**604**
Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital	4,864
Beaumont Hospital	2,363
Cappagh National Orthopaedic Hospital	1,173
Catholic Institute for Deaf People	3,000
Children's Sunshine Home	100
Coombe Women's Hospital	1,330
Curraheen Hospital	1,676
Daughters of Charity	140
Local Drugs Task Forces (LDTFs)	125
Mater and Children's Hospital Development Ltd	73,431
Mater Misericordiae University Hospital Ltd	5,372
Mercy University Hospital, Cork	202
National Maternity Hospital	2,265
National Paediatric Hospital	8,029
National Rehabilitation Hospital	1,495
Our Lady's Children's Hospital, Crumlin	2,022
Pobal	124
Rotunda Hospital	1,442
Royal Victoria Eye and Ear Hospital	322
South Infirmary Victoria University Hospital	1,589
St Francis Hospice	1,500
St James' Hospital	3,594
St Michael's Hospital, Dun Laoghaire	200
St Vincent's Hospital Fairview	567
St Vincent's University Hospital, Elm Park	14,189
Temple Street Children's University Hospital	777
The Mater Hospital	260
Total Capital Grants to Outside Agencies (Note 19(b))	**132,755**

Appendix 3 **Miscellaneous**

(Analysis of Miscellaneous Expenditure in Note 8)

	2011 €'000	20110 €'000
Maintenance Farm and Grounds	2,050	**2,154**
Security	18,262	**19,090**
Fluoridation	1,241	**2,290**
Memberships	541	**105**
Licences	898	**646**
Subscriptions	725	**618**
Sundry Expenses	11,786	**10,171**
Burial Expenses	144	**147**
Secondment Charges	3,006	**2,553**
Recreation (Residential Units)	1,399	**1,210**
Materials for Workshops	2,380	**2,549**
Home Adaptations	792	**1,036**
Meals on Wheels Subsidisation	1,880	**1,619**
Refunds	575	355
Total Miscellaneous Expenditure (see Note 8)	**45,679**	**44,543**

2011 HSE Calendar

January

- National Director appointed for the HSE's new **Directorate of Quality and Patient Safety**.
- First National Director for **Children and Family Services** appointed.
- The **Civil Partnership and Certain Rights and Obligations of Cohabitants Act** 2010 came into effect.
- The **Office of Tobacco Control** subsumed into the HSE

February

- On the eve of WHO World Cancer Day, HSE announced the selection of 15 candidate **colonoscopy centres** to support the national colorectal cancer screening programme.
- Further price reductions implemented to significantly lower the **cost of medicines** to the State.
- Minister for Health gives approval for the HSE to progress a multi-million euro extension to **Sligo General Hospital**.

March

- National office for **Organ Donation and Transplantation** established.
- HSE South Ambulance Services respond to **aircraft crash** at Cork Airport and CUH initiates its Emergency Plan.
- **Midland Regional Hospital**, Tullamore officially opens.

April

- Changes to **HSE Board** announced with existing Board members stepping down.
- New **Radiation Oncology Units** at St. James's and Beaumont Hospitals opened.
- HSE partakes in **European Immunisation Week**.
- Roll out of the **Newborn Hearing Screening Programme** commenced.

May

- Over 9,000 children and young people took part in national finals of **HSE Community Games**.
- Members of **HSE Interim Executive Board** announced.
- Programme announced to deliver the catch-up **cervical cancer vaccinations** for all girls in 6th year.

June

- Minister for Health established a **Special Delivery Unit** in the Department of Health.
- HSE begins a new health education campaign encouraging smokers to **QUIT**.
- Cork University Maternity Hospital becomes the first **European Robotic Gynaecological Epicentre**.

July

- Revised **HSE Code of Governance** approved by HSE Board.
- National Newborn Bloodspot Programme (Heel Prick Test) extended to also include screening newborn babies for **Cystic Fibrosis**.
- The processing of **Medical Card** applications fully centralised in Finglas, Dublin.

August

- Drafting of legislation approved to transfer responsibility for procurement of clotting factor concentrate products from the Irish Blood Transfusion Service to the **National Haemophilia Centre**.
- HIQA published its report on emergency transport for people requiring **transplant surgery** outside Ireland.
- HSE responds to **DePuy hip replacement** safety alert and advice from Irish Medicines Board regarding recall from circulation.

September

- Minister for Children and Youth Affairs launches **Child Protection and Welfare Practice Handbook** to promote accountable, consistent and transparent practices in line with **Children First Guidance**.
- Launch of **Healthcomplaints**, an initiative to help members of the public understand where and how to complain about health and social care services

October

- **BreastCheck** first round of national breast screening completed for women aged 50-64 years.
- **National Breastfeeding Week** from 1st to 7th October.
- Transfer of 1,020 **Community Welfare** staff from HSE to Department of Social Protection.

November

- Framework announced to reform and modernise the governance structures of **AMNCH (Tallaght Hospital), Dublin**.
- Launch of new campaign to raise awareness on the correct use of **antibiotics**.
- Confirmation from Government of **capital investment** of €1.95 billion for health infrastructure 2012-2016.

December

- Minister approves **HSE 2012 National Service Plan**.
- Cabinet approval received to prepare for legislation to abolish the Board of the HSE. Minister announces **interim structural arrangements** to commence in early 2012.
- New structural arrangements for **West and Mid-West Hospital Groups** established with CEOs appointed.

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