SUMMARY AND CONCLUSIONS

This summary presents the findings, conclusions and recommendations arising from our review of The Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMINCH). It should be read in conjunction with the full text of this report.

1. BACKGROUND TO THE HOSPITAL

The Adelaide and Meath Hospital, incorporating the National Children's Hospital, ("AMINCH") is established under a Charter as amended by an Order passed by both houses of the Oireachtas in July 1996. AMINCH came into being on 1 August 1996.

AMINCH reflects the merger of the three separate entities of the Adelaide Hospital, the Meath Hospital and the National Children's Hospital, each of which had in its own right a long tradition of providing hospital services in the Dublin area.

AMINCH has operated from the new hospital in Tallaght since 21 June 1998.

The Charter under which AMINCH is established is derived from the Charter of the former Adelaide Hospital. It sets down the religious character of the Hospital and provides for a multi-denominational and pluralist approach to the provision of services in the Hospital.

These matters are discussed in greater detail in section 2 of this report.

2. BACKGROUND TO FINANCIAL ISSUES

The results for the six months to 30 June 1998 were in line with budget. In the month of July 1998 alone, in the immediate aftermath of the move to the new facility in Tallaght, the Hospital's results showed levels of net expenditure some IR£2.4m in excess of budget. The results for August 1998 were some IR£1.4m in excess of budget. By the end of August 1998, net expenditure was running almost IR£9m in excess of Determination on a year to date basis. In September 1998, management prepared a projection of the outturn to 31 December 1998, which indicated a total overrun of some IR£21m against Determination. This included the IR£5.9m excess over Determination included in its service plan, costs of a capital nature of IR£4.5m, estimated payments relating to the Co-operation Agreement and pension lump sum in excess of budget of c.IR£800,000, and proposed developments of IR£1.6m. Following a request from the DOH&C, the Board confirmed on 24 September 1998 that the deficit projected for the year was indeed of the order of IR£21m in excess of Determination. As a consequence of this excess expenditure and the problems facing the Hospital, the Minister for Health and Children commissioned an independent review of the Hospital, which is the subject of this report.

The review was carried out in the context of the recent merger of the base hospitals and the move to the new Hospital in Tallaght.

These matters are discussed in greater detail in sections 4 to 9 of this report.

3. CURRENT FINANCIAL POSITION

At 31 October 1998, AMINCH had incurred net expenditure in excess of Determination of approximately c.IR£11m. In addition, liabilities for capital expenditure of the order of IR£3.2m exist which are as yet not agreed by AMINCH as they regard them as liabilities of the TRHB, and as such the liabilities are not reflected in their books. The total deficit of c.IR£14m is being funded in the main by a combination of creditors and the forward draw down of allocation. Liabilities to trade creditors overdue in excess of 45 days amounted to c.IR£6m at 31 October 1998 (which includes the IR£3.2m of capital expenditure). In addition, amounts owing to the Collector General in respect of PAYE/PRSI deductions at 31 October 1998 amounted to IR£3.9m, of which IR£1.3m was for the then current month of October 1998. The balance of IR£2.6m due relates to August and September 1998. The August PAYE/PRSI liability of IR£1.3m. was paid in November 1998. The approved bank overdraft facility of IR£4m is being fully utilised at the present time.

The current level of recurring net expenditure being incurred on a monthly basis is c.IR£6.1m The funding available under the Letter of Determination is c.IR£4.5m per month on average. It is evident that the deficit is increasing at the rate of c.IR£1.6m per month on this basis. Due to the profile of the drawdown schedule for cash, only IR£3.5m and IR£2m remains to be drawn down by the Hospital in cash terms in November and December 1998 respectively against the amount provided in the Determination. In addition, supplementary funding of c.IR£3m was claimed by the Hospital in November 1998. At current levels of available funding, the deficit is increasing on a daily basis. The Hospital cannot continue to operate in this way; at present, it is not in a position to meet its liabilities as they fall due and is incurring fresh liabilities which, at the level of funding available to it, it cannot meet. It will be unable to fund its activities from creditors for much longer. The Hospital is in a financial crisis of the most serious nature. Immediate action is required to resolve the situation.

These matters are discussed in greater detail in sections 7 to 10 of this report.

4. PROJECTED OUTTURN FOR YEAR ENDED 31 DECEMBER 1998

4.1 SUMMARY

The projected outturn for the year ended 31 December 1998, as prepared by management of AMINCH, is shown below. The projection has been prepared on the basis of minimum spend to year-end.

IR£m	*Management accounts Eight Mths to 31 Aug 1998*	*Projected Sept to Dec 1998*	*Projection For the Year Ended 31 Dec 1998*	*Service Plan*	*Letter of Determination & IR Budget*
Net Revenue Expenditure	41.6	24.9	66.5	59.5	53.7
IR Costs	1.9	0.5	2.4	-	2.0
	43.5	25.4	68.9	59.5	55.7
Capital Expenditure					
- recorded in AMINCH Books	1.0	-	1.0	-	-
- Other incurred including Unattributed	3.3	-	3.3	-	-
	47.8	25.4	73.2	59.5	55.7

4.2 KEY POINTS

4.2.1 Net Revenue Expenditure

The total projected overrun in AMINCH over Determination for the year ended 31 December 1998 is IR£17.5m. This arises from three principal sources:

(a) an excess of net revenue expenditure over Determination of IR£12.8m before adjustments in respect of pay awards and supplementary items; this includes IR£1.9m of expenditure in respect of which the Hospital submitted a claim for supplementary funding on 11 November 1998, covering, inter alia, PRSI for new employees, payments in respect consultant common contracts, non nursing pay increases, and increases in medical defence;

(b) IR£0.4m of IR related costs over the available budget of IR£2m. The Hospital submitted a claim for supplementary funding for c.IR£0.9m of this amount in respect of pension lump sum payments on 11 November 1998;

(c) IR£4.3m of capital expenditure. IR£1m of this is recorded in the books of AMINCH, for which it had no budget. Further expenditure of IR£3.3m (described as unattributed) has been incurred in relation to building modifications and equipment, but is not shown in AMINCH's books as it is regarded by AMINCH as a liability of the TRHB. Each of these elements of excess expenditure is reviewed in further detail below.

The projected net revenue expenditure for the year is IR£12.8m in excess of Determination and IR£7m in excess of the AMINCH Service Plan. This is because the Service Plan adopted by AMINCH for 1998 was IR£5.9m in excess of Determination.

When the claim for supplementary funding is taken into account, the excess net revenue expenditure, including IR related costs, for the year is c.IR£10.5m. A claim for supplementary funding of c.IR£3m was made by the Hospital in November 1998.

4.2.2 IR Payments

The IR costs relate to payments under the Co-operation Agreement (IR£1.5m) and lump sum payments on retirements (IR£0.9m). We understand that the DOH&C held a separate budget of IR£2m relating to IR issues arising in respect of the move to Tallaght. It should be noted that 28.5 WTE positions were approved by the DOH&C in June 1998 (as part of the Task Force) on the basis that there would be funding available within the IR budget. As noted above, the IR£0.9m pension lump sums paid are the subject of a separate claim by AMINCH for supplementary funding.

4.2.3 Capital Expenditure

The TRHB had responsibility for the planning, building, equipping and furnishing of the Hospital. A summary of total capital expenditure on the project is given below. These costs include the total of IR£4.3m of capital expenditure shown as relating to either AMINCH or as unattributed referred to above.

IR£m	*DOH&C Approved (Provisional)*	*Total Costs*	*TRHB Costs*	*AMINCH Costs*	*Unattributed*
Committed Building Costs	109.9	114.7	111.7	2.1	0.9
Committed Equipment Costs	24.9	25.8	24.5	1.0	0.3
	134.8	140.5	136.2	3.1	1.2
Projected Building Costs	-	0.4	0.1	-	0.3
Projected Equipment Costs	-	4.5	3.5	0.8	0.2
	134.8	145.4	139.8	3.9	1.7

(Figures supplied by DOH&C and TRHB and not verified by Deloitte &Touche)

Key Points

(a) Committed capital expenditure incurred is IR£140.5m, IR£5.7m over the DOH&C provisionally approved level of IR£134.8m. IR£4.8m of this excess relates to buildings, IR£1.8m of which is shown as a liability of the TRHB. The balance of IR£3.0m is split IR£2.1m as to AMINCH and IR£0.9m unattributed.

(b) Potential further capital expenditure of IR£4.9m is shown. This has yet to be incurred. It represents expenditure which AMINCH/TRHB considers necessary for the completion of the building and equipping of the Hospital. IR£4.5m of the IR£4.9m relates to equipping issues.

The further capital spend in relation to the development of the private wing is not included in the above assessment.

These matters are discussed in greater detail in Section 5 and Sections 7 to 10 of this report.

5. THE CONTEXT OF THE MOVE AND THE MERGER

The terms of reference of the study require this review to be carried out in the context of the recent merger of the base hospitals and the move to the new hospital in Tallaght. An overview of these issues is provided below.

The TRHB were responsible for the planning, building, equipping and furnishing of the Hospital. The planning was undertaken in close consultation with the Hospital. The Hospital is the largest single capital investment in the history of the health services. The base hospitals received a total of IR£3.7m in 1996 and 1997 in revenue resources to meet expenditures relating to the new Hospital. The DOH&C also approved a capital budget for IT of IR£4m for the project.

5.1 THE MOVE TO TALLAGHT

The move to Tallaght was a very major operational and logistical task, one which involved staff at all levels in the base hospitals to a high degree in its planning and execution. Detailed operational plans for all clinical and non-clinical areas were drawn up and responsibilities assigned to individuals to oversee the execution of the move to Tallaght. A structured approach to identifying and carrying out critical tasks was undertaken, a process in which management were assisted by external management consultants.

The physical move to Tallaght, and the logistical issues associated with it, can be regarded as a success. There were undoubtedly aspects of the move that might have been planned or organised better and earlier, and as such these are likely to have contributed to the need for management to deal with a large number of issues in a short timeframe in the period preceding the move. In the final analysis, the move to Tallaght on 21 June 1998 happened on time and it is widely held that patient care was not compromised at the time of, or after the move to the new facility, a significant achievement.

5.2 THE MERGER

The objective of the merger was to create, before the move to Tallaght one organisation from the three base hospitals operating from the sites of the Adelaide, Meath and National Children's Hospital.

The merger strategies adopted appear to have been successful in merging the cultures of the base hospitals. Indeed there is a strong sense of commitment to the new organisation among the Board, management and staff. The merger process is however incomplete in a number of important respects:

- Better integration and organisation of certain administrative and support services functions, (for example, personnel, technical services and finance) is required. A particular concern is the continuing use of the personnel/payroll and financial systems from the base hospitals. This has adversely affected the production of reliable management information, on a timely basis in the new hospital, particularly on personnel matters.

- The organisation structure at senior management level, a product of the merger process, is not suited to the effective management of the Hospital.

- There is a lack of standardisation in operational policies. Operational policies need to be defined for the new Hospital.

- Paediatric services, previously carried out by the National Children's Hospital, have yet to be satisfactorily integrated into the structures of the new hospital.

The move to Tallaght and the merger process involved significant effort at all levels of the base Hospitals in a period of major change. It is also important to record the considerable support and assistance which the DOH&C gave to the project. Both the DOH&C and the Hospital also acknowledge the co-operation from the unions in effecting the move to Tallaght.

These matters are discussed in greater detail in Sections 2 and 3 of this report.

6. NET REVENUE EXPENDITURE FOR 1998

6.1 SUMMARY

A summary of net revenue expenditure for 1998 is shown below.

IR£m	*Projected for Year*	*AMINCH Budget*	*Variance*
Pay			
Base staff and developments	46.5	42.6	3.9
Commissioning	1.9	2.3	(0.4)
	48.4	44.9	3.5
Non-pay			
Base	21.6	19.1	2.5
Commissioning	3.4	3.2	0.2
	25.0	22.3	2.7
Total Expenditure	73.4	67.2	6.2
Income	(6.9)	(7.7)	0.8
	66.5	59.5	7.0

(Note: the AMINCH budget is consistent with its service plan, i.e. IR£5.9m over Determination, therefore the projected outturn of net revenue expenditure for the year is in fact IR£12.8m over Determination. The above figures are before claims for supplementary funding amounting to c.IR£3m submitted on 11 November 1998)

This matter is discussed in greater detail in section 10 of this report.

6.2 PAY COSTS

6.2.1 Pay Cost Variance

The projected variance on pay costs for the year ended 31 December 1998 of c.IR£3.5m relates to the following factors:

(a) Higher numbers of persons employed

There were 1936 Whole Time Equivalents (WTE'S) on the payroll on 11 October, the date of a Hospital wide census. This compares with a DOH&C approved level of staff of 1797, a difference of 139 WTE's. An analysis of staff numbers per the census, the AMINCH service plan, and DOH&C approvals is shown below.

(WTE's)	*Per Census*	*Per Service Plan*	*DOH&C Approved*
Employment Control			
Staff in Base Hospitals	1,640.8	1,593	1,651.3
Developments & New Posts			
Laboratory	93.5	93.5	93.5
ISIT	15.6	21.0	15.0
Other	21.5	38.0	9.0
Nursing	28.0	-	14.0
Paediatric A&E	12.0	12.0	-
Paediatric Nursing	28.5	12.0	14.5
Medical (NCHD's)	13.0	-	-
Environmental Services	28.0	28.0	-
Materials Management	16.0	-	-
Radiology	13.5	-	-
Staff recruited re future developments	35.0	-	-
	1,961.4	1,797.5	1,797.3
Commissioning	40.7	-	-
	2,002.1	1,797.5	1,797.3
Positions not filled at census	(66.3)	-	-
	1,935.8	1,797.5	1,797.3

Key Points

- Staff numbers on the payroll on 11 October 1998 were 139 WTE in excess of DOH&C approved levels. There were in addition 66 WTE positions considered by AMINCH as vacant at the time of the census, a total difference of 205 WTE's if all positions were filled. A high level comparison of AMINCH personnel numbers with other hospitals of similar size in the Irish hospital system indicates this level of staffing is high. Direct comparison may not be entirely appropriate given factors such as the recent merger, different specialties, focus on paediatric care in AMINCH; however the extent of variation points to a need to examine the level of staff currently employed in AMINCH.

- The staff complement includes 40.7 WTE commissioning staff remaining primarily in Patient Flow Management (26 WTE) and ISIT (12.7 WTE). The budget for the year anticipated that most commissioning staff would be released shortly after the opening of the Hospital. AMINCH has indicated that the retention of staff in Patient Flow Management is due to significant operational difficulties in establishing this new department in areas such as patient registration, sourcing of medical records is further affected by space constraints in the department, and staff turnover. ISIT staff are required regarding the implementation of the Order Communications project. AMINCH anticipates that all commissioning staff will be released by April 1999.

- The staff complement includes the 35 staff recruited in relation to future developments. These relate principally to enhancements to improve patient management systems in the Hospital, planned to commence in the last quarter of the year. These were agreed in principle with the DOH&C at the time agreement was reached between AMINCH, the DOH&C and the Eastern Health Board on the transfer of certain psychiatric services from St Loman's.

The DOH&C's indicated at the time agreement in principle was reached that final approval was dependent on detailed costings and proposals being received; they have also indicated that a service justification was required from AMINCH in respect of these developments. The Hospital had were of the view that the necessary costings had been submitted, regarded agreement as having been reached, and had commenced recruitment for the developments planned.

- A Task Force was established in June 1998 to focus on the staffing levels critical to the running of the Hospital, which could not otherwise be agreed at sectoral meetings. The Task Force comprised hospital management, a representative of the HSEA, trade union representatives, and representatives of the DOH&C. 28.5 WTE's were approved at the Task Force on the assumption that they would be in the Hospital for the last quarter of the year. The DOH&C estimated that these could be funded from an element of the IR£2m IR budget projected to be unutilised.

- There are a further 129.1 WTE posts which the Hospital regards as necessary. The DOH&C stated that it approved 16 of these positions for structure (materials management (9) and technical services (7)) without commitment to an increased ceiling and on the basis that they would be funded from within Determination.

  Of the remaining posts, the DOH&C regard 26 Nursing and Child Health posts as having been included in the Service Plan although not formally submitted for approval by the Hospital. The DOH&C listed the following posts which have not been the subject of any submissions by the Hospital: portering (11), telephonists (8), HSSD (16), radiology (12.5), MPBE (1), NCHD's (22) and additional clerical staff for Patient Flow (5). Some but not all of these are included in the Service Plan.

- The census indicates that there were 66 vacant posts within the AMINCH employment control total at 11 October 1998. These posts arise primarily in the areas of nursing (31 WTE). Not all vacancies are in respect of approved posts.

(b) Higher levels of overtime and on call payments than budget

These costs are currently running at c.IR£150,000 per month in excess of levels prior to the move.

(c) Payment of in respect of consultants common contracts

These amount to c.IR£1m, which includes payment of arrears over available funding. The increased recurring monthly costs associated with remuneration to consultants on foot of the common contract is c.IR£80,000.

(d) Higher levels of pension payments than budget

This is due to a higher number of retirements at the time of the move. This excess amounts to c.IR£20,000 per month, or c.IR£100,000 in 1998.

(e) Pay increases to non nursing staff on foot of national agreements

These amount to IR£270,000, paid in September 1998.

(f) PRSI in respect of new employees and medical indemnity

PRSI under this heading amounts to IR£345,000, and increases in medical indemnity to c.IR£100,000.

Based on the foregoing, certain pay costs fall within categories of expenditure eligible for supplementary funding under the Letter of Determination. The total of such costs for 1998 included in the above is estimated by management at c.IR£3m which is the subject of a separate claim for supplementary funding by AMINCH submitted on 11 November 1998.

The critical issue is that payroll costs are currently exceeding the Hospital's service plan by c.IR£550,000 per month. Approximately IR£150,000 – IR£175,000 of this can be regarded as due to factors outside the Hospital's control (increases in common contract, increased pension payments, pay awards etc). The remainder is due to primarily to increased staff numbers not approved or funded, and the increased level of overtime/on call payments in the Hospital.

6.2.2 Issues and Requirements regarding Pay Costs

(a) The Hospital prepared a manpower requirement plan for the new facility in Tallaght in late 1997. This showed a staffing requirement of 2578 WTE's. This level of staffing, by any benchmark, was unrealistic. The DOH&C rejected this plan. The AMINCH service plan showed that numbers employed would progressively increase to c.1800 WTE'S by the end of 1998. The actual number of 1936 WTE'S employed in October 1998 is significantly in excess of service plan. The Hospital never had a realistic manpower plan.

(b) Staff recruitment has occurred without adequate consideration being given to the consequent funding implications. Until recently, staff were being recruited without the sanction of the Director of Finance.

(c) There is a lack of accurate, timely information on personnel and pay. The Hospital has continued to operate the three separate payrolls of the base hospitals since the move. These systems operate different coding structures for like staff. A major once off exercise in early October 1998 was required so that the Hospital could accurately determine the number of staff employed, and their status. Regular, routine personnel data is fundamental to the control of pay costs. This has been singularly lacking in the Hospital. The lack of personnel data has been recognised as a problem in AMINCH for some time; it was identified and discussed at a meeting of the Resource Committee of the Board in April 1998.

It is imperative that the Hospital consolidates the three base hospitals' payrolls into one payroll for AMINCH. A set of routine personnel/payroll reports need to be specified and circulated to managers on a regular basis. Each Department head needs to monitor and control payroll costs, and be accountable for same. The consolidation of systems, and production of relevant and accurate reports is urgently required. It is a considerable failing of management that systems to control personnel numbers and employee

status have not been in place. In our view, the Hospital has not had adequate systems in place to manage and control increases in staff over the past year. The focus would appear to be too much on perceived requirements, and not enough on whether funding was available for staff increases. There is currently a complete absence of regular and reliable personnel information on matters such as numbers employed, status (temporary/permanent), absenteeism etc. Without regular, reliable information on personnel and payroll, it is not possible to manage and control payroll costs in an effective manner; such has been the position in AMINCH.

(d) The staffing requirements for the new Hospital have not been adequately assessed. The numbers of staff employed in various departments throughout the Hospital reflect a process of combining staff from the base hospitals, and the deemed staffing needs of certain new functions. The organisation of staff in certain functions (particularly support services) has not been rigorously evaluated to assess the optimum number and structure of staff in those functions. It is essential that an independent assessment of personnel requirements across the Hospital is carried out, having regard to optimum organisation structure and business processes. Because the requirements have not been critically assessed throughout the Hospital, it is not possible at this juncture to determine what the appropriate level of staffing for the Hospital should be. In particular, there is a need to assess requirements in terms of organisation and staffing in support service functions, such as technical services, finance, materials management, and human resources. A systematic review of all areas of the Hospital is needed to identify staffing required to operate the new facility.

(e) It is possible, on conclusion of the systematic review referred to above, that certain staff not approved by the DOH&C will be required to operate the Hospital in Tallaght. Given the fact that this Hospital is its infancy, it is essential that agreement is reached between the Hospital and the DOH&C on an approved level of staff, and that the approved level of staff is specifically funded. We recognise that in a stable environment, management have flexibility to fund incremental increases in approved staff levels out of Determination, and that the DOH&C could approve posts on this basis. In AMINCH's case, as in any other of significant change, it is essential that a specific relationship is established between approved staff levels and funding, if nothing else to optimise control over pay expenditure in an agency and to avoid any risk of a mismatch between employment control approvals and funding for what is the largest element of cost in a hospital.

(f) One would expect that the merger of three entities would ordinarily result in efficiencies in staffing. Whilst we have concerns that a systematic plan to identify the scope for synergies/redeployment was not in place, we recognise that the security of tenure given to staff under the IR Protocol places some limitation on the extent to which staff synergies could be achieved. Indeed, we would be surprised if this has not created inefficiencies in the organisation and staffing of certain functions of the Hospital. These may take some period of time to eliminate; at present, because a critical review of functions has not taken place, it is not possible to assess the extent of any such inefficiency.

(g) There are currently some 400 staff on the payroll on temporary contracts. The processes in place to manage such temporary staff are inadequate. It is essential that procedures are put in place to identify temporary staff being used in each Department on a regular basis, and rigorously assess whether

they continue to be needed. We are particularly concerned that the current inadequate arrangements could, by default, result in temporary staff gaining employment rights, an entitlement after one years continuous employment.

(h) The census indicates a significant level of vacancies in the Hospital. The filling of such vacancies would result in increased payroll costs. It is essential that vacancies are filled only in respect of approved and funded posts.

(i) Staff recruitment should be frozen until the aforementioned review of requirements is completed. Over the past year, staff recruitment was undertaken to meet the perceived needs of the Hospital, without adequate thought being given to funding available. All future recruitments should be approved by the Director of Finance.

(j) A systematic plan to reduce commissioning staff is required. There were 40 WTE commissioning staff on the October census. We recognise that all of these cannot be released immediately; some are involved in important aspects of continuing IT systems development. A definitive plan to effect the release of the remaining commissioning staff is however required to ensure the Hospital's objective of releasing the remainder of such staff by April 1999 at the latest is met.

(k) Improved controls over authorisation and approval of overtime payments are required. These should include prior approval of overtime over certain levels. We understand such controls have recently been established. Such controls were lacking in the immediate aftermath of the move.

These matters are discussed in greater detail in Section 8 of this report.

6.3 NON-PAY COSTS

6.3.1 Non-pay Cost Variance

The projected adverse variance on revenue costs for the year ended 31 December 1998 is IR£2.7m. The principal reasons for the variance are:

(a) Costs of an exceptional once-off nature associated with the move and the commencement of operations on the new site in Tallaght. Such costs will invariably arise on any project of this magnitude, and are not possible to budget with absolute accuracy. It is difficult to be precise about the quantum of such exceptional non-pay expenditure; our best estimate is that such costs amounted to between IR£400,000 and IR£500,000 in the period July to September 1998 for which no budget remained. These related to matters such as initial cleaning of the Hospital, initial bedding costs of the Hospital, initial stocking requirements for supplies and consumables, and once-off care costs associated with the move. Had operational plans been in place, these items could have been predicted and budgeted for with greater accuracy.

(b) Costs of medicines, blood and gases for the period to 30 June 1998 prior to the move which were running ahead of budget. By year end, these are projected to account for an excess over budget of IR£600,000. Management have indicated that these relate to the circumstances of the move and the level and nature of activity.

(c) Costs of medical and surgical supplies which have increased significantly since the move. Management attribute this largely to the significant increase in A&E activity at the Hospital relative to the base hospitals (up 17%) as well as initial stocking up in the new Hospital. By year end, an excess of c.IR£900,000 over budget is projected under this heading.

(d) Costs associated with the laboratory which have been running at c.IR£210,000 per month, which is c.IR£100,000 per month higher than budget. The budget allocated in the service plan by management was probably inadequate; the matter nevertheless deserves review.

The critical issue is that non-pay costs are currently running at c.IR£2.1m per month. The non-pay costs in the management accounts of the Hospital for each of the months of July to September 1998 have shown a significant level of exceptional expenditure not predicted by management. It is not clear yet what level of non-pay costs should arise in a stable environment in the Hospital. It is evident that significant increases in care costs (medicines, drugs, bloods, medical and surgical supplies) have arisen since the move; management attribute this in part to increased levels of A&E activity.

6.3.2 Issues and Requirements regarding Non-pay Costs

The following are required:

(i) A programme of cost review and reduction needs to be urgently implemented. A significant element of non-pay costs are controllable, and can be reduced through management action. The non-pay costs in Tallaght are high by comparison with established hospitals in the Irish health system of similar size.

(ii) All ordering of goods and services must, except in exceptional circumstances, be processed through the Materials Management function. All staff must be made aware of the procedures and the requirement for strict compliance. Compliance with procedures was lacking in a number of instances after the move. This was identified, and followed up; controls and compliance with procedures appear to have improved. Orders being placed need to be monitored against available budget before being placed, taking into account orders already committed.

(iii) A review is required of the level of costs in the laboratory (which are high) to assess where savings are possible. We understand that no activity data has been available from the laboratory to date – this needs to be provided and reviewed by management on a periodic basis.

(iv) Care costs need to be managed through management of activity. Activity data was not available in the aftermath of the move until late September 1998 because of difficulties with the use of the new Patients Information System. We understand that regular, timely data is now being provided on activity.

(v) A developed system of budgetary control system is required to make managers accountable for spending decisions. The current system of budgetary control is inadequate, as managers do not hold budgets nor manage their activities in a way which adequately recognises the financial consequences of decisions they are making.

These matters are discussed in greater detail in Section 9 of this report.

6.4 INCOME

Income earned has reduced on a monthly basis by c IR£150,000, primarily as a result of the reduced number of private/semi-private beds in the Hospital, pending the building of the private wing, scheduled for completion in late 1999/early 2000. There were also difficulties with the use of the Patient Information Management System after opening which adversely affected income; it appears that these arose partly because of a lack of user familiarity with the new system, a lack of operational policies, and system issues. These caused wrong identification of private patients as public patients at time of registration, and difficulties in billing public patients for A&E attendances.

Income is discussed in greater detail in Section 7 of this report.

7. CAPITAL EXPENDITURE

Capital expenditure incurred by AMINCH or unattributed amounts to IR£4.24m (IR£2.93m in respect of buildings, IR£1.31m on equipping)

BUILDING ISSUES

Additional building costs of IR£2.93m which have arisen relate to works considered by AMINCH to have been essential for the opening of the Hospital and for patient safety. These included:

- The total of building related capital expenditure attributed to AMINCH amounts to IR£2.03m. Of this total, building modification costs of IR£1.3m is in respect of a schedule of works (issues log) identified by AMINCH and agreed with the TRHB. The balance of IR£0.73m relates primarily to the cost of alterations to OPD and X-ray incurred by AMINCH of IR£0.65m.

- Costs incurred by AMINCH of c.IR£0.9m relating to modifications to building to accommodate IT and other support service staff, rectification of drainage problems, installation of security swipe card system, and theatre shelving.

EQUIPPING ISSUES

The equipping process for the Hospital appears to have been fraught with difficulty. The result in financial terms is that equipping costs of IR£1.31m have been incurred on equipment in excess of the budget held by the TRHB. Equipment for the laboratory accounted for c.IR£0.5m of the excess. In addition, further outstanding equipping requirements have been identified by AMINCH as necessary in the Hospital- these have yet to be incurred and amount to IR£4.5m in total. The major items relate to instrumentation for remaining theatres and HSSD.

The key points which have come to our attention in relation to the equipping process are set out below. This analysis may not be complete as the TRHB was outside our terms of reference.

(a) Process

There are many issues relating to the process for determining the equipment requirements. Whilst there was significant involvement of users, the users did not own the budget for equipping their departments, and as such were not able to prioritise the available funding. Prioritisation was carried out at the Equipment Steering group. There also seems to have been little feedback on prioritisation. Further difficulty arises from the disconnect between what user groups specified and the packaged bundles used for tendering. It was difficult for each department to assess what they were getting. Users who were best organised and involved were likely to do better. It is our view that the budget should have been allocated to the users and that these users should have been accountable for delivering the equipment requirements for their respective areas within budget. They should have prioritised how they wanted to spend the budget in their area, given the base equipment requirement was identified using the 'model room' concept.

(b) Project Management

Project management for the equipping and commissioning processes was contracted out. This proved to be problematic. We understand that a key individual initially nominated to manage this project by the external project managers left that firm at an early stage, and was not satisfactorily replaced until late in the process. The project managers did not adequately drive or control the processes. One consequence of this was the late ordering of equipment, and the resultant pressure to get decisions made quickly, late in the process.

(c) Role of Project Director

The Project Director of the TRHB also holds a position in the senior management team of AMINCH. This dual role was unsatisfactory, resulted in the approval by this individual of certain capital expenditure in the name of AMINCH when the TRHB budgets had been utilised, and has contributed to the disagreements over where liability for certain capital expenditure rests.

(d) Budgetary Control over Equipment

Budgetary control was poor; the packaging of equipment for the tendering process hindered this. All reporting was at package level rather than at department level. There was no audit trail from package to department. The processes initially allowed for purchase approval without consideration of budget constraints. This was changed in April 1998, when it was determined that items within packages approved for purchase though not yet ordered had to be re-tabled for prioritisation. Significant budget over-runs were predicted from 1996, but there is no evidence of a process being put in place from that time to control the costs. This and the high degree of under and over spending across all the packages is evidence of the lack of budgetary control. In particular the significant levels of costs that are not attributed (IR£1.2m) indicate lack of control and lack of budgetary responsibility.

(e) Equipment Requirements

There is no clear definition of net equipment requirements for each package. The packages did not reflect what was being transferred from the base hospitals. The asset register for the base hospitals was not developed until early 1998. It does not appear to have been used as a mechanism to control transfers from the base hospitals.

Because there is not a clear definition of net equipment requirements it is not possible to determine:

- Whether, too much or too little equipment was bought for each package.
- Whether, the cost over runs and under-runs reflect increased equipment costs or good negotiation skills or:
- Whether the Hospital is over or under equipped for the activities it planned in its service plan.

An assessment needs to be made on how the current budget was actually spent and prioritised, and on what actually transferred from the base hospitals.

(f) Future Spending

Some estimates of future costs to complete building modifications and meet deemed equipping needs have been provided by AMINCH. These amount to c.IR£4.9m, of which £4.5m is related to equipping. The projection for equipment comprises a long list of items, including instrumentation for the two theatres of c £800,000. Careful consideration needs to be given to effecting a complete freeze on any further capital related spending. Whilst, we recognise that this may be impossible, we would recommend that a rigorous process for reviewing any further requirements is developed. This process must take a strict objective view of requirements. This exercise should be carried out on the basis of there being no further funding available, otherwise there is a risk that the list of potential requirements will increase. All future requirements need to be prioritised, and a development plan needs to be prepared and agreed with the DOH&C.

(g) Capital Budget Overruns

There are some explanations for the over-run in capital costs. Some relate to changes in Health & Safety Standards or EU Directives, e.g. HSSD, others relate to changes in technology e.g. radiology systems. We have not been sought to ascertain the extent of any cost penalties relating to either inflation or currency fluctuations. In the original budget there was a contingency of 16% for inflation and currency. It is worth noting however that much of the equipment purchases have been sourced in the UK, and there have been considerable currency fluctuations between Ireland and the UK during the equipping period.

The total level of capital expenditure incurred within AMINCH or which is unattributed, amounts to IR£4.3m. There may be debate on the extent to which aspects of this expenditure were absolutely necessary. However, from our examination of the circumstances in which this excess capital expenditure was incurred, it appears to us that AMINCH had little choice but to incur a substantial element, if not all, of this expenditure in order to open the Hospital and rectify defects. These additional capital costs have arisen primarily because of deficiencies in planning for the requirements of the Hospital, late changes in the whole hospital and departmental organisational policies and what appears to be inadequate management /control of the equipping budget within the TRHB.

These matters are discussed in greater detail in Section 5 of this report.

8. IMPLICATIONS FOR 1999 AND BEYOND

At the levels of pay and expenditure currently being incurred by the Hospital (being c.IR£6.1m per month), and in the absence of cost reductions and corrective actions, annual net revenue expenditure of IR£73m would arise.

In addition, a list of developments proposed by the Hospital would, if implemented, give rise to net revenue expenditure of IR£11m in 1999 (full year cost c.IR£14m). These include the developments in patient management systems agreed in principle with the DOH&C (IR£5m in 1999), and 13 additional consultant appointments to come on stream as sought by AMINCH in late 1996 and projected to come on stream during 1999 (IR£3.6m in 1999).

The result is that total funding on a full year basis of c.IR£87m would arise if all developments proposed were to proceed, in the absence of cost reduction in the current expenditure base. This level of funding would be materially at variance with other hospitals of similar size and profile in the Irish health system.

Key points

- The first objective must be to stabilise the Hospital for its current operations; the review of staffing requirements, organisation, and pay and non-pay costs referred to above is necessary. This will enable an informed decision to be made on the appropriate level of funding for an approved level and type of service.

- The Hospital and the DOH&C need to agree a medium term development plan for the Hospital. This should clarify developments which are agreed, their funding implications, and the timescale for implementation. Particularly in the context of the current financial situation in the Hospital, we would expect any such plan to be phased over a number of years. An explicitly agreed approach would also leave no room for misunderstanding between the parties on future developments. All future developments and their associated funding must be specifically agreed between the Hospital and the DOH&C before implementation

- It would undoubtedly be financially prudent for the Hospital to stabilise its performance in financial terms before engaging in new areas of developmental expenditure, particularly as without the necessary improvements in controls and procedures, there are real risks that developments will themselves exceed budget. Clearly in the current climate, such a risk is untenable. We recognise that the developments proposed may be important in terms of patient care considerations, but such considerations would have to be compelling and urgent for developments to proceed at the present time.

- The Private wing is due to come on stream in late 1999/early 2000. This is being funded by borrowings of £7.5m. It has been approved by the DOH&C on the basis that it will be self financing. This needs to be critically evaluated to ensure that the strategy to operate the private wing in terms of staffing and funding will achieve the objective of being self financing. The capital costs associated with this development are outside the scope of this study

These matters are discussed in greater detail in Section 10 of this report.

9. THE 1998 SERVICE PLAN

9.1 THE CONTEXT

On 8 April 1998, the Board of AMINCH adopted a service plan which was IR£5.9m in excess of Determination.

The following matters are relevant to the background to the context in which this decision was taken.

- ***The Charter***

  Clause 5 of the Charter sets out the objects for which the Hospital is established. Clause 5 (a) states that the Hospital will "carry on ……the activities carried on by the Adelaide Hospital, Dublin, the Meath Hospital, and the National Children's Hospital" and to assume responsibility for "the hospital services and equipment provided and held by each of the said hospitals immediately before the transfer day". The Board of AMINCH regard the Charter as the basis of agreement with the DOH&C that the Hospital would carry on the same level and type of service in Tallaght as in the base hospitals.

- ***Parameters Letter***

  In February 1997, the Secretary General wrote to the Chief Executive of the Hospital to provide guidance to the CEO and the Board of AMINCH on the parameters in relation to services, non capital funding and employment ceiling with respect to the first full year of operation at Tallaght. This letter indicated that with the exception of the new pathology laboratory and psychiatric unit, services and funding at Tallaght should be made available from the existing service and funding base of the constituent AMINCH hospitals. The letter also indicated that new service needs arising from the new location in Tallaght would require either the redirecting of existing resources or prior agreement of additional funding with the funding agency, currently the DOH&C, and that funding in relation to proposed developments would of necessity normally be phased in over a number of years on an agreed basis. The letter stated an employment control ceiling of 1543.4 WTE posts, which included 11 posts approved in relation to pathology.

  The letter acknowledges that an incremental approach to service provision and funding was being adopted as being the most appropriate in the circumstances, and that any enhancements would be regarded as developmental, and thus would require Departmental agreement and approval. The DOH&C regard this letter as fundamental in that it set out, some 16 months in advance of the move, the policies and framework it expected to be followed for the transfer of services from the base hospitals

  This letter was intended to provide guidance to both the CEO and the Board, and on that basis should have been put to the Board to ensure that it was informed of the policies being laid down by DOH&C. It was not presented to the AMINCH Board as it was regarded by the CEO as the start of a process of negotiation with the DOH&C on future funding for the Hospital.

- ***Opening date confirmation-letter of 27 November 1997***

  The Minister was informed by AMINCH that following an in-depth analysis by management of all issues related to the opening of the hospital, the Board had

accepted the management team's recommendations to open the hospital on 21 June 1998.

- ***Letter from AMINCH to DOH&C of 1 December 1997***

  This letter enclosed draft 1998 budget proposals. The proposals were presented as three options, and were described as a "corporate overview" of the budgetary requirements for 1998. The letter stated that a detailed budgetary analysis would be forwarded on 5 December 1997. By this stage the Determination for AMINCH had been set.

  The three options presented were:

  Option 1: Net Expenditure for year IR£55.956m

  This option was based on current pay, non-pay and income levels projected to year end, no adjustment having been made for any incremental increases or changes in service profiles

  Option 2: Net Expenditure for year IR£61.318m

  The pay element of this proposal is as in Option 1; non-pay is adjusted to reflect those of a "comparable institution in Ireland".

  Option 3: Net Expenditure for year IR£66.954m

  This proposal attempted to identify the expenditure levels for the base hospitals remaining in situ for the first half of 1998, and that of a similar institution for the latter half of the year. The combination of both these elements gives option 3.

  None of the options included costs associated with developments or commissioning which may occur in 1998. The letter indicated that it would be prudent to provide for such costs at a similar level to 1997 i.e. IR£4m."

- ***Letter of Determination***

  On 4 December 1997, the DOH&C wrote to the Chief Executive of AMINCH setting out its determination of health expenditure for 1998. The letter advised that the approved expenditure level for 1998 in respect of non-capital expenditure (i.e. gross expenditure less minor income) determined for AMINCH was IR£53.659m as summarised below.

	IR£m
Revised allocation for 1997	49.973
Less once-off funding for 1997	(2.813)
Adjustments for 1998	2.499
Developments for 1998	4.000
Determination for year	53.659

The once-off funding for 1997 relates primarily to payments made by the DOH&C to the Meath Hospital of IR£1.3m and to the Tallaght Hospital project of IR£0.9m. AMINCH has indicated to us that the funding of IR£1.3m was required to deal with service pressures (principally in the Meath Hospital), and contends that this reflected

an underfunding being carried from 1993, and that as a consequence these amounts should have been carried forward into the 1998 base allocation. The DOH&C has stated that, in their view, the deficit arose because services over approved level were undertaken; their decision to provide this funding was to avoid having a deficit carried forward into 1998, the year of the move.

The funding of IR£4m was provided towards " the cost of essential developments related to the integration of the services in the base hospitals in advance of the opening of the new hospital at Tallaght, to the transfer of those services, and the anticipated additional costs arising subsequent to the opening of the hospital." In particular, this funding was designed "to meet additional staffing and related transitional costs, including approved consultants posts and pathology/laboratory staffing."

In their Letter of Determination, the Department indicated that whilst the Health (Amendment) (No.3) Act 1996 does not apply to AMINCH, the Department intended in an administrative way to apply any terms of the legislation that are relevant in the Department's dealings with the agency. This includes, inter alia, a requirement for the relevant agency to adopt a service plan specifying the services to be provided by it within the financial limits determined by the Minister within a period of 21 to 42 days of receipt of their determination, and to monitor expenditure to ensure that it does not exceed the amounts set by the Minister.

The letter indicated that the Department would in the normal course endeavour to incorporate all aspects of approved expenditure in the initial Letter of Determination, an important change introduced in relation to the Government's estimates and budget procedures. The Determination letter stipulated that estimates were now being prepared and considered on a multi-annual basis. The letter specifically drew attention to the policy which will apply from 1998 onwards in relation to supplementary funding and specified that supplementary estimates for the health services would only be granted on an exceptional basis in 1998 and in subsequent years. For 1998, the items that have been identified which may qualify for additional funding were demand led schemes (Health Boards only), superannuation, medical indemnity and PRSI.

The Letter of Determination was not tabled for consideration by the Board until the special Board meetings in late March. We are advised that this approach was taken to allow for discussions with the DOH&C on funding; once it became obvious to the CEO that the DOH&C would not agree to alter the funding level, the letter of Determination was put to the Board.

- ***Submission of Service Plan of 26 January 1998***

AMINCH submitted a draft service plan to the DOH&C on 26 January 1998. This indicated a deficit of c IR£900,000 for the full year [the copy retained by the CEO of AMINCH does not have this reference – it may be that an earlier draft is held by the DOH&C. Without the reference, the plan as presented was therefore a breakeven plan]. This plan was not put to or approved by the AMINCH Board. The DOH&C indicated that it was unhappy with the plan, and in particular expressed serious concerns that:

(a) the commissioning costs were only indicative, above budget and had not been prioritised;

(b) laboratory commissioning costs were high compared to available budget.

It was agreed at a meeting on 13 February 1998 that AMINCH would submit a revised Service Plan within determination as soon as possible for:

(a) the period to 21 June 1998, the date of opening of the new facility, and;
(b) for the new facility in Tallaght.

- ***Letters from CEO of 4 and 13 of March 1998***

The Chief Executive of the Hospital wrote to the Department on 4 March 1998 outlining the potential additional clinical and non clinical costs arising from the move to Tallaght.

The Chief Executive of the Hospital also wrote to the Department on 13 March 1998 stating that, whilst the funding process incorporated in the Letter of Determination provided adequate funding for the provision of services in the Service Plan, it did not adequately fund the following:

- revenue costs related to commissioning of the Hospital
- revenue costs for the pathology department
- revenue costs specific to the Tallaght site/facility
- revenue costs relating to additional approved posts
- revenue costs of the ISIT department
- additional paediatric and pharmacy costs

The letter costed these items in aggregate at IR£10.748m, an excess of IR£4.893m over the amount provided in the Letter of Determination. Of this, the Chief Executive's letter indicated that IR£2.4m was once-off. Potential savings were identified, but there remained a net deficit after savings of IR£3.272m; the letter indicated that a reduction in the service activity to achieve such a saving was not practicable, as it would require the closure of approximately 80 beds for the balance of the year.

- ***DOH&C Position***

Throughout the period from January 26 to 3 April 1998, DOH&C officials continued to stress the need to plan within Determination, emphasising that there would be no additional revenue funds available for the year, whatever about the possibility of getting some element of capital funding. A letter of 3 April 1998 from the DOH&C indicates that it was agreed at a meeting of 30 March 1998 that a strategy for presenting a 1998 Service Plan that would be within the level of Determination to the Board of AMINCH needed to be developed to deal with the projected deficit being identified in an AMINCH document entitled "Review of Budgetary and Commissioning Strategy". The letter also noted that an examination would be carried out by AMINCH to establish what element of the 1998 projected expenditure might have been inappropriately classified as being part of the Revenue Determination advised, i.e. to identify capital expenditure.

The letter states that, as had been emphasised at all times in their discussions, no further funding (either revenue or capital) would be available to bridge the gap between projected expenditure levels and the amount advised in the DOH&C's Letter of Determination of 4 December 1997.

- ***Approval of Service Plan***

  On 8 April 1998, after deliberations by the Resource Committee and Board of AMINCH, a final Service Plan for 1998 was submitted to the DOH&C. The plan approved by the Board did not meet the requirements of the letter of Determination in that it indicated an excess of net expenditure for 1998 of IR£5.883m. over the approved amount. At the Board meetings, the CEO indicated that it was his brief to ensure the same level of service in the new hospital as in the base hospitals, and the Board noted that this was a solemn agreement with the DOH&C. The CEO also indicated that maintaining the same level of activity in the new hospital would require an additional allocation of approximately IR£5m. The CEO advised the Board that negotiations were taking place with the DOH&C to reach an agreement that the capital items shown in a document presented to the meeting, and totalling £4.9m, could be funded outside the Letter of Determination.

9.2 THE SERVICE PLAN

The Service Plan adopted by the Board and submitted to the DOH&C on 8 April 1998 is summarised below:

	1997 Base net Expenditure IR£m	*1998 Development Expenditure IR£m*	*1998 Commissioning Expenditure IR£m*	*Total IR£m*
Pay	39.0	3.9	1.1	44.0
Non Pay	17.5	4.0	1.7	23.2
	56.5	7.9	2.8	67.2
Income	(7.7)	-	-	(7.7)
	48.8	7.9	2.8	59.5

The basis of the plan was to provide the same level and quality of the services as provided in the base hospitals during 1997. The position of the Board, stated in the plan, is that they were "of the view that an agreement exists with the Minister of Health to provide adequate funding to the Hospital to enable it achieve the historical level of service activity in the new Hospital". This reflects AMINCH's view that the Charter provides a basis for such agreement. The service plan adopted became the basis for the budget for the year, against which actual results were to be reported. The budget therefore sought to plan for a financial outturn some IR£5.9m above Determination.

The developments in the service plan are summarised below:

	Laboratory IR£m	*ISIT IR£m*	*New Posts IR£m*	*Site Costs – Tallaght IR£m*	*Paediatric A&E IR£m*	*Total IR£m*
Pay	2.2	0.6	0.6	0.2	0.3	3.9
Non Pay	1.3	1.0	0.3	1.4	-	4.0
	3.5	1.6	0.9	1.6	0.3	7.9

The 1998 base budget of IR£48.8m is based on the out-turn for 1997 in the three base hospitals adjusted for the increments and developments outlined in the Letter of Determination from DOH&C of 4 December 1997.

9.3 KEY ISSUES

(i) The Context

During our work, we had discussions with the Chairman of the Resources Committee, who is a board member of AMINCH, and with other members of the Board of AMINCH on the context in which the service plan was in the first instance recommended by the Resource Committee for approval by the Board on 7 April 1998, and ultimately so approved at the Board meeting of 8 April 1998. These members of the Board have stated that the decision to adopt a service plan in excess of Determination was not taken lightly, and was only done on the basis that the CEO, and certain of the members themselves, had the clear impression from discussions with representatives of the DOH&C that further funding could be obtained, and that a mechanism to achieve this was to assess the extent to which expenditure, contained in the service plan under revenue, could be reclassified as capital expenditure. They have stated that they believed that the Tallaght Project Team of DOH&C had sought IR£11m additional funding for AMINCH for 1998, and that this had effectively been halved because the opening was delayed from January 1998 to June 1998. They believed that the discussions on reclassification of items as capital were a recognition on the part of the DOH&C that there were funding difficulties associated with the reduction in incremental funding from the IR£11m initially sought to the IR£5.8m ultimately obtained in the Determination for developments and commissioning. In the service plan submitted, the funding deficit of IR£5.9m in the plan is shown as being bridged by a combination of savings (IR£1.5m) and reclassification of revenue items as capital expenditure (up to IR£4.9m).

They have also pointed to the statement on Page 2 of the Letter of Determination that the DOH&C would, "in the normal course endeavour to incorporate all aspects of approved expenditure in the ***initial*** letter of determination." (the emphasis on "initial" is ours). For this reason also, they had the impression that further funding would be available later in the year, although not incorporated in the initial letter of determination.

We have discussed the above position with representatives of the DOH&C. It is acknowledged that the Hospital had been informed that application had been made by the Tallaght Hospital Project Team of the DOH&C to the Finance Unit of the DOH&C for additional funding of IR£11m over and above the then existing budgets of the base hospitals on the basis that the Hospital would open in January 1998. However, the Board's decision to defer the opening until 21 June 1998 resulted in a related reduction in DOH&C funding for the Hospital for 1998. It is also acknowledged that meetings took place between AMINCH and representatives of the DOH&C at which the position emerging from the draft service plan was discussed.

The DOH&C has further acknowledged that discussions did take place on whether items included in the draft plan for 1998 could be treated as capital. The DOH&C have stated that this was because they were seeking a plan in accordance with the letter of Determination which should include revenue items only, and as such capital items should be excluded. The DOH&C has indicated that these latter discussions were undertaken at the request of AMINCH to assist the CEO and his management team develop proposals for their Board. Following a meeting of 30 March 1998, a letter dated 3 April 1998 was sent by the DOH&C to the CEO to clarify the context of the discussions and their outcome. This letter states that it was "agreed that a strategy for presenting to your Board a 1998 service plan that would be within the level of Determination…. needed to be developed to deal with the projected deficit….". It also states that the parties had agreed "that the strategy would include possible

corrective action relating to approximately IR£2m revenue costs and that an examination by you of expenditure would also take place with a view to determining what element of the projected expenditure might have been inappropriately classified as being part of the Revenue Determination advised e.g. capital expenditure." The letter states "that it was emphasised at all times that no further funding (either revenue or capital) was available to bridge the gap between your projected expenditure levels and the amount advised in the December 1997 Letter of Determination." This letter was discussed at the meeting of the Resource Committee on 7 April 1998.

(ii) The Primacy of the Letter of Determination

The Service Plan underpins the relationship between the Hospital and the DOH&C in relation to services being provided and related funding. The primacy of the Letter of Determination in setting the basis for this relationship should not be understated. The Letter of Determination of 4 December 1997 is unambiguous in relation to the basis on which funding is provided and the requirements in relation to service planning, reporting, employment control, the attainment of value for money and the delivery of better quality health services. The problems associated with the funding of the Hospital for 1998 must in no way undermine the primacy of the Letter of Determination in future years.

There are a number of references in the correspondence and minutes of meetings to the Hospital pursuing negotiations with the DOH&C on funding, on separate submissions on funding being made, on ongoing discussions etc. There is also reference to AMINCH regarding the letter of Determination as an initial letter of Determination. We are of the view that the letter of Determination is clear on the areas in which supplementary funding would be available, and that it could not reasonably be interpreted that the process allowed for further funding outside of the areas specified for supplementary funding. It is important to note that the Determination process does not provide for any such processes. The DOH&C refute the suggestion that they were involved in negotiations on funding, and are strongly of the view that they had consistently made the position clear that no further funding, capital or revenue, would be available.

(iii) Governance

In the final analysis, on 8 April 1998, the Board of AMINCH adopted a Service Plan which reflected net expenditure some IR£5.9m in excess of the amount included in the Letter of Determination. There was at that stage no definitive source of funding for that excess. The minutes of the Board meeting of 27 March 1998 acknowledge that the plan was to reflect the current level of activity in a deficit situation and that the CEO was to proceed with the conclusion of the Service Plan on this basis. The minutes of the Board meeting of 1 April 1998 state that the CEO indicated that officials from the Department had advised that the Minister is adamant that the provision of services must be carried out within the allocated budget. The Resource Committee meeting of 7 April 1998 concludes with a recommendation that the Board adopt the Service Plan, which included an excess of IR£5.9m over the amount included in the Letter of Determination. The minutes of Board meeting of 8 April 1998 also record that the CEO advised that negotiations were taking place with the DOH&C to seek to reach an agreement that this amount could be funded outside the Letter of Determination.

As we have noted earlier, members of the Board have stated to us that the decision to adopt a service plan in excess of Determination was not taken lightly and that the Board were aware of their legal responsibilities in this regard. They have stated that

the decision was made only on the basis that the CEO, and certain of the members themselves, had an indication from discussions with representatives of the DOH&C that a way to fund the deficit could be found, and that a mechanism to achieve this was to assess the extent that expenditure, contained in the service plan under revenue, could be reclassified as capital expenditure. The service plan reflects such an approach and reflects a reclassification of certain items as capital, amounting to c.IR£4.9m. For the most part, these were costs associated with the commissioning of the Hospital and pre opening costs relating to new developments, and could not, in strict terms, be regarded as capital expenditure.

It is evident from minutes of meetings and correspondence that discussions did take place on capital expenditure. As noted earlier, the minutes of the meeting of 31 March refer to no additional revenue funds being available, "whatever about the possibility of getting some element of capital funding", and suggest that the budget be examined with a view to separating out capital items. In other places, there are references to no additional capital funding being available (for example the meeting of 4 March 1998). The CEO of the Hospital has stated to us that, based on discussions with DOH&C representatives, he had the distinct impression that while there was no funding available at this time, that funding, particularly of a capital nature, would likely be provided by the end of the year. The DOH&C letter of 3 April 1998, the last correspondence on the matter before adoption of the service plan, is explicit on the matter, stating that no further funding (either revenue or capital), would be available to bridge the gap between projected expenditure levels and the amount advised in the DOH&C's Letter of Determination of 4 December 1997. The approach taken in the plan is at variance with the letter of 3 April 1998.

The Guide to Governance and Management of the Hospital issued in September 1998 sets out the responsibilities of the Board of Management. These include a requirement "to manage the property and finances of the Hospital in accordance with the powers set out in the Charter" and to "implement, evaluate and review appropriate management systems".

We are of the view that the adoption of a service plan some IR£6m in excess of Determination without certainty on how the excess would be funded does not meet the standard of good governance, whatever the circumstances and the perceived inadequacy of the Determination. We are of the view that the Board of AMINCH should not have adopted the service plan on governance grounds.

We are also of the view that the letter of Determination, given its significance to the funding of the Hospital, should have been presented to the Board at an early juncture, and that the service plan of 26 January 1998 should also have been presented to it for approval. We are advised that the letter was not tabled until such time as it was obvious that no further funding would be forthcoming from the DOH&C, despite many AMINCH efforts. As noted above, the letter of Determination is not a negotiable instrument. In our view, the letter of Determination should have been presented to and fully discussed by the Board at its December 1997 Board meeting, and that the service plan of 26 January 1998 should not have been presented to the DOH&C unless it had been Board approved.

(iv) The Handling of Service Plan in Excess of Determination

It is evident from the chronology that the DOH&C had emphasised to AMINCH that a service plan within Determination was required and that no further funding was available. Following receipt of the AMINCH service plan on 26 January 1998, the DOH&C, at their meeting on 13 February 1998 reiterated that no further funding

would be available and requested a revised service plan within Determination. Between 13 February 1998 and 8 April 1998 (date of submission of approved service plan by AMINCH board) there were numerous meetings at which these points were again emphasised. In the letter from DOH&C on 3 April 1998, it again stated that no further funding would be available to bridge the gap between projected expenditure levels and the amount advised in the Letter of Determination.

On 8 April 1998, the DOH&C received the board approved service plan from AMINCH, which indicated an excess over Determination of IR£5.9m. A letter issued from the DOH&C to one of the accountants in the hospital's finance department on 23 April 1998 in response to an earlier letter from him stating that the service plan was not an agreed document. The DOH&C have also stated to us that they clearly indicated that the service plan as submitted was unacceptable during meetings subsequent to 8 April 1998 with representatives of AMINCH. This was interpreted by AMINCH as the service plan being rejected and was recorded as such in the minutes of the meeting of 28 May 1998.

We accept that on many occasions the DOH&C made its position abundantly clear to AMINCH on the need for a service plan within Determination and in emphasising that no further funding was available. However, we would have expected the DOH&C to have issued a formal written response to the CEO of AMINCH rejecting the service plan submitted on 8 April 1998 because it did not plan within Determination and requesting the CEO to bring this matter to the attention of the Board who had approved the plan. No such formal written response issued. We are of the view that a formal written rejection of the service plan should have been sent to AMINCH particularly as we would have seen it as a natural consequence of the DOH&C applying the terms of the Accountability Legislation in an administrative way to AMINCH as stated in the Letter of Determination

This approach may have been taken by the DOH&C out of recognition of the significant workload and pressures falling on the Board and management at the time the service plan was submitted in April 1998, associated with the planning of the move and the opening of the Hospital on 21 June 1998, a date which was then only some ten weeks away. It is not possible to gauge whether a more formal rejection of the service plan by the DOH&C would have encouraged the Hospital to pursue a cost minimisation approach to expenditure in the Hospital; it could not have detracted from it.

(v) Appropriateness of using the Determination Process in this Case

We recognise that the system to fund the revenue expenditures of Hospitals is that provided in the Determination process. There is no other system. However, it is reasonable to examine if this system is well suited to the opening of a major Hospital.

The complex element of the AMINCH Determination concerned development and commissioning expenditures, and the estimation of costs which would arise in the new Hospital. This was also the area of the service plan which exceeded Determination. In arriving at the Determination for 1998, the DOH&C would have had to estimate in late 1997 the impact on the base hospitals' budget of development and commissioning expenditures for a hospital due to open on 21 June 1998. An amount of IR£4m. was included in the Letter of Determination in this regard, which, together with an amount of IR£1.9m included in the base allocation for prior years (which includes IR£0.4m relating to the FDVH), rendered the total figure of IR£5.9m. towards the costs of essential developments relating to the integration of the services in the base hospitals in advance of the opening of the new Hospital at

Tallaght, to the transfer of those services and the anticipated costs arising from approved consultant's posts and pathology laboratory staffing.

While the DOH&C provided an amount in the Determination for these matters, it would have been extremely difficult for it to estimate the requirements with any degree of precision at the time they were required to do so, particularly as the Hospital had itself not projected the requirements. By their nature, costs associated with developments in and transition of organisations are more difficult to predict, particularly as the ability to draw on historical experience is limited. The Determination in respect of developments and commissioning was therefore a relatively blunt instrument.

We are informed that prior to the letter of 14 February 1997, the DOH&C had carried out an exercise on potential funding requirements for the new hospital in Tallaght on a number of scenarios including one based on casemix, one by reference to a comparable hospital, and one on an incremental approach. In our view, the decision to base the 1998 Determination on the cost structure of the three base hospitals plus certain additional monies was inappropriate. We have concluded that the Determination process does not lend itself well to a situation of major change, such as the opening of a major new hospital unless supported by a fundamental review of the likely cost profile of the Hospital. This was never undertaken by the Hospital. Comparisons are now being made with the consolidated cost base of the base hospitals rather than with an expected cost profile for the Hospital itself. In our view, this is not appropriate. Our comments are not intended in any way to undermine the Determination process, but rather to recognise that its effectiveness in controlling healthcare costs is suited best to existing, more stable entities.

This raises the question as to how best to approach such a situation. What should have happened is that based on the design configuration of the Hospital, the number of beds, the anticipated levels of activity and discharges, a detailed operating profile for the Hospital should have been created by AMINCH. This would have detailed the numbers and type (category) of people including consultants, junior doctors, nurses, porters, support, administration etc. required to support the activity levels. This in turn would have produced a detailed pay cost and profile for the Hospital. Non-pay expenditure could be similarly assessed, profiled and costed based on the given activity levels. There are a number of comparable hospitals within the Irish healthcare system and appropriate benchmarks could have been established against which the cost and activity profile of the Hospital could have been compared and determined. The process would have to have been driven by the Hospital. The letter of 1 December 1997 from AMINCH to the DOH&C referred to above presented a very general view of such an approach – it was not done to anything like the level of detail required to make informed decisions.

Once developed, the profile and the related cost structures would form the basis for departmental budgets and would have driven the process by which people, materials and equipment were transferred from the base hospitals and defined their roles and duties within the Hospital. The adoption of this approach would also have helped identify the absolute need for efficient and effective information systems as a pre-requisite of any budget based management approach.

In terms of the relationship with the DOH&C, this approach, had it been undertaken by the Hospital on a timely basis during 1997, would have meant that a realistic and informed cost profile of the Hospital would have provided the basis for advance discussion in relation to the Letter of Determination. The financial plan would itself

underpin all other planning for the move and the operations in the new Hospital, thus linking future actions back to the level of funding which was available.

Many aspects of the new Hospital were subject to detailed planning; plans were developed, inter alia for building, equipping, the logistics of the move, the merger of the base hospitals etc. It is surprising that a detailed financial plan for commissioning, the move and the operations of the new Hospital had not been prepared by the Hospital. The first time the issues associated with such a plan were focussed on by the Hospital was in early 1998, when the service plan was being prepared. By then, it was too late to realise the benefits which earlier financial planning would have reaped.

(vi) Planning within Determination

Undoubtedly, the most contentious aspect of the 1998 Service Plan is that it did not meet the requirement of the Letter of Determination, i.e. that it did not plan the activities of AMINCH for 1998 within the level of funding available under the Determination.

There are a number of points of relevance in this regard:

- ***Activity***

  The letter of Determination requires a plan to be prepared within the given level of resources. It dos not specify any level of service. The decision to plan for a similar level of services as in the base Hospital for 1997 was the Hospital's. The Board of AMINCH regard the Charter as the basis on which the new Hospital is entitled to carry on the same level and type of services as in the base hospitals. Clause 5 of the Charter states that the new Hospital shall carry on the activities previously carried on by the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital and that the new Hospital shall assume responsibility for the hospital services and equipment provided and held by each of the base hospitals immediately before the transfer day. The Charter, however, is not explicit on level of service, nor do we believe it could be, as the level of service to be provided by any agency will vary one year with the next, and particularly as the concept of service agreements, which include specifying a level of service for a given level of funding on an annual basis, is at the heart of the Health Strategy "Shaping a Healthier Future".

  In our view, a strategy of service reduction, however undesirable AMINCH may have regarded it, was open to the Hospital, although it would in all probability only have partially reduced the planned excess of expenditure over Determination.

- ***Savings***

  One would ordinarily expect that in merging three like entities that significant synergies would arise. In the case of AMINCH, the ability to achieve savings in pay would clearly have had to relate largely to the redeployment of staff, given the protocols agreed with the unions over security of tenure of staff in the base hospitals. However, the Hospital had not planned the integration of functions in a systematic way and thus the scope for redeployment of staff was not well understood at the time of preparation of the Service Plan, particularly in relation to the reorganisation of support services staff in the

new Hospital. The considerable deficiencies in personnel systems in the base hospitals did not help in planning the process of integrating support service staff. It is probable that reductions in temporary and commissioning staff could have been achieved had the integration of the base hospital support service functions been better planned.

As far as efficiencies in non-pay are concerned, we would have expected some savings to arise from the funding of the base hospitals.

The service plan does not build savings into the budget for the year, but acknowledges the potential for savings of IR£1.5m in seeking to bridge the gap between budget and determination.

- ***The Laboratory***

The total costs projected for the laboratory in 1998 are IR£3.6m. Of this, pay costs account for IR£2.2m. The Hospital is strongly of the view that it would not have been appropriate on clinical grounds to open the new facility in Tallaght, unless it had the laboratory, fully staffed in line with DOH&C approval, in operation at the time of the opening. The DOH&C refute this view, and have stated that this position is not confirmed by the clinical advice it has received. The DOH&C's position on laboratory staffing is clear from their letter of 18 December 1997, i.e. that approval was given provided the development was carried out within Determination. This approval was given after the Determination but before the service plan was submitted.

The question arises as to whether the phased introduction of the laboratory would have made a difference to the ability of the Hospital to come within Determination. We have already outlined the Hospital's views that this was not appropriate on clinical grounds. From a financial perspective, it appears to us that a phased introduction of the laboratory, which would have resulted in savings in pay and non-pay, would have reduced but not eliminated the extent of any excess expenditure in the year.

The next option to consider is whether the Board could have decided not to open the laboratory at all during 1998. It appears to us that any such decision would have to have been made in early 1998 for it to have achieved a significant cost saving in 1998. By April, when the service plan had come to the Board for final approval, it was getting too late to make this decision, even if it was considered the appropriate thing to do.

The Hospital took the view that the laboratory was approved, and proceeded to put it in place. The Department position is laid out in its letter of 18 December 1997, i.e. approval was conditional on the costs being met from the Determination. Once a decision to proceed with the laboratory was taken, it was most unlikely given the nature of the other developments and commissioning involved, that AMINCH could have prepared a Service Plan in 1998 which was within the amount provided in the Letter of Determination.

It should be noted that at a meeting between DOH&C and AMINCH on 13 March 1998, following discussions on the parameters for funding (including the Secretary General's letter of 14 February 1997), the difficulties being faced by AMINCH appear to have been recognised: the minutes of the meeting record the DOH&C stating that it appreciated that it was very difficult for the Hospital to gauge service pressures in the new Hospital but that it is recognised that there would be ongoing

discussions concerning additional funding and that this would be sought over a number of years. It was however emphasised that despite these difficulties, the parameters letter of 14 February 1997 set out the basis on which planning should take place. The DOH&C stated that it "was not going to walk away from Tallaght in terms of its needs but its wants were a different matter" and also added that they "thought they had put enough aside, while it does not look like that now, the amount is set."

We have formed the following views:

- The fact that the Letter of Determination and service plan were not presented to the Board until late March 1998 limited the options open to the Board to plan within Determination. By the time the Board came to approve the service plan in April 1998, the opening was approaching, and decisions had been taken which committed AMINCH to courses of action and related expenditures. Implementation of the plan by management to open the laboratory was very advanced, with significant recruitment in hand or having already taken place.

- We have stated that, in our view, the Board of AMINCH on governance grounds should not have adopted the service plan in April 1998. We recognise that this would have been a continuing source of difficulty with the DOH&C. Because it took until April to approve the service plan, the Board had, by that stage, reduced its operational options to plan within Determination. It may well be that, by that stage, the only option was not to open the Hospital on 21 June 1998.

- It was clearly the responsibility of AMINCH to prepare and submit a service plan within Determination and which would take account of the policies and objectives of the Minister for Health & Children and of the Government. It may well have been possible to prepare a service plan within the Determination, however, in our view, in order to achieve this, a detailed planning process would need to have been commenced by AMINCH by mid 1997 at the latest. This would have allowed AMINCH, on receipt of the Determination of IR£53.6m, to readily access the profile of Hospital in Tallaght which could be operated from within the Determination amount. No such process was put in place. The Determination process imposes the obligation on every agency to prepare a service plan within the amount of Determination and this in turn dictates the profile of the hospital in terms of services, staffing and activity.

  In the service plan dated 8 April 1998, AMINCH set out its intentions for the Hospital for 1998: the profile of the Hospital presented reflected a level of service consistent with the base hospitals (a matter stated in the plan) and the costs associated with; a fully functioning laboratory at the time of opening employing c.100 employees, IT group, commissioning the hospital and costs arising from operating at the new site in Tallaght. This plan was IR£5.9m in excess of Determination and as such did not meet the requirement to plan within Determination. In our view, for this profile of hospital, the non-capital Determination for 1998 was never going to be sufficient to fund the intentions of the Hospital as set out in its service plan, for an opening date of 21 June 1998.

  Had the Hospital been in a position to prepare its service plan in advance of the setting of the Determination for 1998, it could have been used to inform

that process. Had this been the case, the Service Plan could have been used as a basis to seek to justify at the very most a need for further funding of c.IR£4m (i.e. after allowing for the savings in the cost base which were identified by the Hospital in its plan). We acknowledge that the DOH&C might not have accepted this and this may have required AMINCH to plan and operate a different profile of Hospital and thus reduce the funding requirement for the year. This amount of IR£4m is materially at variance with the level of non-capital expenditure now expected to be incurred in 1998 as outlined in section 10. Our opinion therefore that the Determination was never going to be sufficient to fund the intentions of the Hospital as set out in its service plan, should not in any way be taken as justifying the level of non-capital expenditure actually incurred.

It is also important to note that any perceived insufficiency in the Determination which the Hospital may have considered to exist did not in practice curtail actual expenditure incurred by the Hospital. For this reason there would be no justification for suggesting that any lack of funding or the perceived insufficiency of the Determination itself, caused or contributed to the deficiencies in the Hospital's management, reporting and control referred to elsewhere in this report.

- The Hospital's service plan projected that an additional IR£5.9m was required over Determination. Whether this amount was accurate or not, it is evident that this excess is significantly at variance with the actual excess of revenue expenditure over Determination projected for 1998 of IR£12.8m. The service plan therefore was not the basis of any actual plan against which actual events were measured nor was it used as the basis for staffing and other decisions; had it been used as the yardstick for performance since April, it would have caused spending decisions to be challenged before expenditures were incurred.

(vii) Improvements in Future Service Planning

There is room for significant improvement in the quality and content of the Hospital Service Plan in future years and in the process in which it is prepared. Most importantly, it needs to be set in a wider strategic context and not be predominantly an exercise in financial budgeting.

These matters are discussed in greater detail in Section 4 of this report.

10. RESULTS FOR 1997

There have been considerable delays in finalising the audit of the AMINCH Accounts for the year ended 31 December 1997, which has not been signed off at the time of this review. The audit sign off of the 1996 financial statements for the Meath Hospital is also outstanding. The inordinate delay in having audited accounts for AMINCH and the base hospitals is a completely unacceptable situation, particularly in the context of the Board's duty to be accountable for public funds. It is not acceptable that the Board does not have audited accounts for 1997, particularly as 1997 forms the basis of the 1998 service plan. Whatever the circumstances that caused this delay, and the Board needs to assess these, there is no scope for any delay in the completion of audited accounts for future years, particularly given the current financial circumstances of the Hospital.

These matters are discussed in greater detail in Section 6 of this report.

11. MANAGEMENT REPORTING AND CONTROL

The management reporting and control environment current in the Hospital is essentially one which has emerged from the base hospitals. These were small, established entities, which, because of their long track record in providing essentially the same level and type of service, were more predictable from a management perspective. Because of the limited extent of change, one year with another, and the smaller scale of operation, management of activities could be carried out to a greater extent in a hands on fashion, and required less in the way of structured information. The move to a much larger, more complex facility in Tallaght has exposed weaknesses in management, reporting, systems and controls, primarily because the tried and trusted methods of the past no longer suffice.

The following points recommend improvements in management reporting and control. Some of the points are not unique to the Hospital; some are matters, which could not reasonably have been in place at this early stage of operation. Others are matters that ought to have been addressed as part of the planning for the merged organisation on the new site. All matters are important for the future development of appropriate management reporting and control structures in the Hospital.

Strategic Planning

Limited strategic planning has been carried out to date. The Strategic Planning and Communications Committee of the Board has been directing the development of such a plan, a process which is still underway at the time of this report.

A strategic plan is necessary to give direction to the organisation as a whole, and to ensure that all elements of it adhere to the mission and objectives of the Hospital. The planning process must be rigorous and co-ordinated. The participation of managers and clinicians in the process is essential. The current strategic planning process has involved the medical specialties but has yet to involve senior management. For the planning to be effective, senior management must be intimately involved in the planning, as they will be key in ultimately ensuring the critical success factors are achieved and that plans are adhered to.

Any strategic planning exercise must involve a significant input from the Director of Finance. To date, planning has largely been focussed on the needs of the Tallaght area, and on the development of specialties. It is inconceivable that the planning process can be advanced in a meaningful way unless measured against available and projected resources. This will be necessary to manage expectations of Departmental managers throughout the Hospital.

The Role of the Board and its Committees

There are currently a number of sub committees of the Board, covering areas as diverse as Resources, Strategic Planning and Communications, Foundations, Academic Research and Development, Nursing, Patient Care, and Paediatrics.

In our view, the manner in which committees conduct their business is focused to a large extent on operational matters, some of which should be handled by the senior management team. This approach has in origins in the base hospitals, where governance and management were inextricably linked at Board level. This is a common feature of the way in which well intentioned and committed people in many voluntary agencies operate. However, in a Hospital as large and complex as Tallaght, it is essential that the Board and its Committees are structured to focus on strategic and policy matters.

There is therefore a need to better define the roles of the Board and its committees by reference to matters of a strategic and policy nature, and at the same time clarifying the powers and responsibilities of the Chief Executive and his senior management team. Such an approach will help empower the management, and should make decision making more effective and crisp. It will also avoid any confusion as to management accountability, an issue in the current environment.

The Management Team

The current management were to a large extent appointed to their current positions by internal competition from within the base hospitals.

The focus of this team to date has been on the move to Tallaght and the opening of the new Hospital. The team is now being asked to manage a large complex facility. Many of the members lack the management training required to *manage* in the new environment. This is not surprising given the very different hospital environment from which they came, which operated with looser, more informal structures and processes. **Management training is required to ensure the commitment of this team is harnessed, and to move the team on from the commissioning mode which they have been accustomed to for the past two years.**

We are also of the view that the senior management team is too large. The Chief Executive currently has a span of control of ten people. This structure may have been suited to the process of moving the base hospitals and merging the three organisations, but has outlived its usefulness. A tighter reporting structure is needed. The appointment of a General Manager – Operations or Deputy CEO reporting directly to the Chief Executive would help reduce the span of control.

An organisation study at senior management level is required to define more precisely the structure and reporting relationships to the Chief Executive, and to take into account how the structure may need to change particularly as the Hospital moves to a Programme Structure of management.

Decision Making Processes

The process under which decisions are made at senior management level is cumbersome, slow and ineffective. A significant part of the difficulty is that managers are not provided with the tools to manage in terms of regular, relevant information, and in any event generally come from a background where decision making based on structured information was not the norm. Weekly meetings of the management team have been seen as the appropriate forum to make decisions. As a result, decision making has not been effective.

Part of the problem is that a consensual approach to decision making has been encouraged. Again this probably helped the process of merging the management team, but it has created a situation in which management are involved in long weekly meetings, frequently on matters which could competently be dealt with at individual department level**. The style of openness and participation can be maintained, but in a structure which empowers managers to make decisions in their area of responsibility, and where they are ultimately accountable for their actions. The implementation of a devolved budgetary control system, described below, will be an essential part of the structures required to elevate accountability for actions taken throughout the organisation.**

Performance Measurement

The Hospital does not have an adequate focus on measuring performance at the present time. Once again, this reflects the modus operandi of the base hospitals. Part of the difficulty lies in the inadequacy of the current information systems in the Hospital, and the lack of integration between core systems, such as patient, financial and personnel/payroll systems.

There is a requirement:

- **To specify throughout the Hospital the appropriate measures of performance, both of a financial and non financial, and quantitative and qualitative nature. This will involve staff involved in clinical and non clinical activity. The process should initially not be over ambitious to allow personnel become familiar with performance being measured against set criteria, and to develop a culture of systematically measuring performance against appropriate criteria.**

- **To ensure information systems routinely trap information relevant to measuring performance.**

- **To routinely report performance on a timely basis to departments**.

Budgetary Control

The budgetary control systems in place in the new Hospital essentially derive from the base hospitals where a system of centralised budgetary commonly found in other hospitals of their size, was used.

One of the deficiencies of the base hospital arrangements was that managers throughout the Hospital did not hold budgets for their portfolios or areas of responsibility. This has continued into the new Hospital and applies at all levels of senior and middle management, and across clinical and non clinical areas.

Because of this lack of budget holding responsibility, there is a lack of awareness throughout the organisation of the financial implications of spending decisions. Furthermore, no formal process exists to make managers accountable for the financial implications of decisions they are making.

A budgetary control system is required which:

- Assigns responsibility and accountability for the achievement of certain objectives to specific departmental cost centres. It is essential that the Hospital develop a comprehensive budgetary control system which allocates the total budget for the Hospital into an appropriate and sufficiently detailed number of individual cost centres, and reports actual results against each cost centre in a timely manner.

- Involves budget holders in the budget setting process within overall financial parameters.

- Profiles the annual budget on a monthly basis to reflect any seasonal changes in activity/service provision.

- Plans the annual budget within the context of the medium term financial plans for the Hospital.

- Prepares budgets in the context of an activity based management. Such budgets will be drawn up having regard to both financial and activity drivers.

- Ensures budgets are finalised on a timely basis in advance of the commencement of the financial year to which they relate.

The Hospital intends to introduce a programme structure in the future. The greater devolution of decision making responsibility to clinicians within the programme structure will require major changes in the structure and operation of budgetary control systems, to ensure that financial accountability is appropriately assigned to clinical directorates. It will be particularly necessary to ensure that those involved in clinical areas obtain the necessary training in the discipline of budgetary control, in the interpretation and use of financial information, and that there is a full recognition within clinical directorates of the prime responsibility to manage their activities within a given financial budget.

Unless a comprehensive budgetary control system is implemented, it will not be possible, in an organisation as large as the new Hospital, to create a culture of financial awareness throughout the Hospital, nor hold managers accountable for the financial implications of decisions they are taking. If managers were responsible for identifiable departmental budgets, the environment in which spending decisions were made in the aftermath of the move would have been significantly different, and it is certain that such decisions would have been undertaken in the knowledge that accountability for variances from budget would have arisen. The lack of formal structures to enforce accountability undoubtedly created an environment in which it was less difficult to make spending decisions in the period after the move.

Information Systems

In May 1994, an ISIT Steering Committee was established within the TRHB to plan for and oversee the development and implementation of the IT strategy for the Hospital, and the selection, testing, and implementation by Hospital opening of the systems deemed necessary in the strategy. Responsibility for this committee subsequently passed to AMINCH in early 1997. On completion of the strategy study in March 1996, a detailed evaluation and selection process was undertaken to identify integrated "best of breed" systems for the new Hospital. The strategy sought to overcome the deficiencies evident in the systems in use in the base hospitals which were not integrated, had evolved over a period of time on an ad hoc basis, and were lacking in information provision. The principal system deliverables for opening were to be:

- Patient Management – Admissions, discharges, transfers, out-patients, waiting lists, chart tracking and patient billing.
- Accident & Emergency
- Laboratory
- Order Communications
- Financial Systems – General ledger, debtors, creditors, supplies management and ad hoc reporting. The system in place at the base hospitals were considered to be unsuitable for the new hospital and were criticised for their inflexibility, lack of suitable reporting facilities and cumbersome user interface.
- The transfer of a number of existing systems from the base hospitals – including the existing Payroll/Personnel system which was to be consolidated into a single database for all employees at the new hospital.

Following the development of the strategy, the Hospital appointed a Management Services and Information Officer and a number of information system project teams were established to address the specification requirements and selection of the appropriate solutions for the

systems required. Detailed evaluation of systems took place in 1996 with suitable "best of breed" solutions being selected in all cases. The financial systems were selected since October 1996.

Once this evaluation process was complete, an IT budget was drawn up, and the DOH&C committed to provide a IR£4m capital budget towards IT developments in the new Hospital. An IT Manager has been in place since early 1996 to implement the systems.

Change management was identified in the strategy as a crucial element in the successful delivery of information systems support for Hospital opening, in order to ensure that the information systems could be properly aligned with the business processes of the Hospital. In the event, the change management process was not effective.

The principal focus of the implementation phase of the strategy has been on the patient administration systems required at the time of opening. The systems not fully implemented at opening were the financial systems, consolidation of the payroll/personnel system and order communications. There have been considerable operational problems with some of the new systems, in part a function of lack of user familiarity with the new systems. It is essential that the training needs of users are identified and satisfied in the short term.

A new financial system was specified during the planning stage, and acquired in 1996. This has yet to be implemented, principally because of delays and difficulties in the implementation of the new materials management system in the Hospital. Because this system is a direct source of posting of financial information to the General Ledger, there were concerns over the integrity of inputs until the system was fully operational and proven. The Director of Finance took the decision to defer the implementation of the full new financial system until the materials management system was operating satisfactorily. However, this decision was not made known to the IS/IT steering committee. Project progress reports made available to the committee throughout the period in the lead up to the hospital opening, indicated that the financial systems would be in place for opening. The committee did not therefore give consideration to the implications of the failure to have the system fully implemented in time for opening, or the fall back arrangements to be put in place.

In the circumstances, it is difficult to question this decision not to implement the new financial system; the situation would be considerably worse if financial information for the Hospital was not available or deficient and the current financial difficulties had not been identified. At least, even using the old systems, the Hospital has been able to produce monthly management accounts on a timely basis. However, for the future and to support devolved decision making in a large hospital, the new financial system needs to be implemented. The Director of Finance plans to implement this system fully by January 1999.

It is absolutely essential that the new financial system is implemented in the new Hospital as soon as possible to provide reliable, meaningful information to managers on a timely basis.

There is an urgent need to implement one personnel/payroll system for the Hospital. The Hospital is continuing to use the three payroll systems from the base hospitals. This has been a major contributory factor in the lack of control of payroll costs in the period since the move. The Hospital had to engage in a major exercise in October 1998 to establish how many employees it had, and what the status of these employees were.

It is an understatement to say that the consolidation of one personnel/payroll system is urgent.

It is important that any systems implemented continue to be integrated with other core systems in the Hospital, and that solutions are not sought in ad hoc stand alone systems.

Controls

The Hospital suffered from inadequate controls in a number of areas including in the immediate aftermath of the move, as evidenced by:

- Staff numbers were inadequately controlled, as was the process of releasing commissioning staff after the move.
- Significant levels of overtime were incurred without the appropriate level of prior approval.
- Delays in obtaining activity data in the aftermath of the move.
- Material levels of expenditure were incurred by AMINCH in respect of building rectification work and equipping in July and August 1998. These orders were processed outside the Materials management function.
- There was a lack of clarity on precisely what service contracts had been signed on behalf of the Hospital, and what their financial implications were.
- Because the patient administration system by default treated all inpatients as public patients, no private patients were recognised in the Hospital for a period of approximately two weeks after the opening, with the result that income relating to private patients was not recorded. Procedures have changed to avoid a recurrence of the problem, and the Hospital is seeking to recover the income concerned.

In a memorandum to all members of the management team on 21 September, the Director Finance reiterated a number of financial policies and procedures to be applied in the Hospital. This memorandum was issued in view of his concern that these procedures were being ignored or because certain staff may have, for whatever reason, believed them to have changed.

While it appears that an attempt has been made to tighten financial control procedures**, it is now important that:**

- **A review be carried out of internal control procedures in the Hospital to assess their adequacy and operation in the new environment.**
- **A financial procedures manual be drawn up.**
- **The current vacancy in the Internal Audit function be filled as soon as possible, and a comprehensive programme of internal audit work be drawn up. We would expect this programme to address not only financial controls and systems, but also performance measurement and value for money issues.**
- **Staff briefings take place on the manner in which financial control procedures are to apply.**

These matters are discussed in greater detail in Section 3 of this report.

12. CONCLUDING COMMENTS

The new Hospital in Tallaght is in a financial crisis of the most serious kind. It has received a very significant commitment of public funds. The problem needs to be urgently addressed by AMINCH in consultation with the DOH&C. In the absence of an injection of funds in the short term, the Hospital will run out of funds. It is already significantly in arrears in paying its creditors, the principal funding source for the deficit.

The current relationship with the DOH&C is strained, considerably worsened by the current financial difficulties, and AMINCH grievances over patient management developments negotiated at the time that agreement was reached on the move of St Loman's to Tallaght. The relationship needs to be rebased; the agreement of a longer term strategy between the parties and funding for an approved level of service in the new facility in Tallaght is essential in this regard. Developments should be agreed on a phased basis as part of a medium term plan. The primacy of letter of Determination needs to be recognised by AMINCH going forward. Prompt service planning within Determination is also vital.

We have identified and commented on the primacy of the Letter of Determination as a means of controlling and managing costs in the Irish healthcare system. Every agency, whether public or private, should understand the absolute requirement to operate within its budget. There is no process which allows an agency to operate on the basis that any service level can be provided regardless of the costs involved. Accountability legislation means just that, everyone involved is accountable ultimately to the Oireachtas and the taxpayer. Although voluntary hospitals are outside the scope of the legislation, the DOH&C's application of this legislation to such agencies in an administrative way places a clear onus on the Boards of such agencies to be accountable for their use of public funds. The AMINCH Board are so accountable.

We find it difficult to reconcile the governance issues involved where the Board adopted a budget of IR£59.5m, some IR£5.9m in excess of its Letter of Determination, and failed to insist on the development and installation of adequate information systems which would enable the Hospital to be monitored even against its own budget and is now facing a net revenue expenditure outturn for 1998 which is IR£7m in excess of this budget and IR£12.8m in excess of Determination. We would also question whether authority exists for the current level of creditors, and which arise as a consequence of the Hospital continuing to operate at levels of expenditure in excess of income and Determination.

At the same time, there is a series of projects and developments being contemplated by the Hospital which will require IR£11m in net revenue expenditure in 1998, and if fully implemented, would leave the Hospital with an operating cost profile of IR£87m on a full year basis. A cost base of this magnitude is significantly out of line with other acute hospitals in the Irish healthcare service.

Given the difficulties experienced to date, there is an absolute requirement for the Board to devolve all management responsibility to a properly structured and effective hospital management team. At the same time, the Board should insist on the development and implementation of an effective management information system with an appropriate board reporting system which would enable the Board to monitor the care and financial performance of the Hospital.

The Board must insist that management manage the Hospital within its agreed cost and operating profile before any further developments are approved. Before the Board would approve any such developments, it needs to have a detailed breakdown of capital and net revenue expenditure and written confirmation from the DOH&C that the additional funding has been approved and the timing of such funding.

In our view, it is not acceptable for the Board to continue to seek exchequer funding or to continue to maintain that it must be made available to develop the Hospital until such time as it has demonstrated a capacity to create an effective management system for the present profile of the Hospital, and operate at net expenditure levels which are accepted as appropriate for the size, nature and circumstances of the Hospital, from its new location in Tallaght.

SECTION 1
INTRODUCTION

1.1 SCOPE AND BASIS OF REVIEW

1.1.1 TERMS OF REFERENCE

The Minister for Health & Children has commissioned this independent review of the Adelaide & Meath Hospital Dublin, incorporating the National Children's Hospital (AMINCH) in view of the Hospital's projected deficit for 1998 and current financial difficulties. The review is to be carried out in the context of the recent merger of the base hospitals and the move of the new Hospital to Tallaght.

The terms of reference for this review are as follows:

(i) To review the processes, systems and practices for top general management reporting and control, e.g:

- strategic planning process
- performance measurement process
- accountability process, i.e. planning, budgeting, measuring, reporting and analysing
- management information and supporting information systems

These matters are dealt with in Section 3 of the report

(ii) To review arrangements within the organisation for the development and determination of service plans, and associated staffing and financial budgets.

These matters are dealt with in Section 4 of the report

(i) To review the data submitted/prepared under an agenda dated 1 September 1998. This agenda covered the following:

(a) out-turn for the hospital for the year ended 31 December 1997 and implications. This is dealt with in Section 6.

(b) revenue costs of the Hospital for 1998
- position at opening date
- current position
- estimated minimum spend to year end
- implications

These matters are dealt with in Sections 7 to 10.

(c) Hospital opening costs
- Revenue
  approved
  unapproved
  continuing
- Capital
  approved

unapproved
continuing

- Not yet completed and current status
- In dispute with design team and/or suppliers

- IR issues
  amount spent to date and current status
  approved
  unapproved

  With the exception of those matters relating to Capital Expenditure, the above are dealt with in Sections 7 to 10. Capital Expenditure is dealt with in Section 5.

(ii) Development Costs

- costs approved to date
- expenditure to date
- irrevocable commitments
- further proposed developments and their timing

These matters are addressed in Section 10.

(iii) Management of Cash Situation

This is addressed in Sections 7 and 10.

(iv) 1999 and beyond

This is dealt with in Section 10.

(v) Agreed next steps

1.1.2 BACKGROUND TO REVIEW

The Adelaide and Meath Hospital (Dublin) incorporating the National Children's Hospital is a body corporate established in 1996 incorporating the former Adelaide, Meath and National Children's Hospitals and will include certain services transferring from St Loman's Psychiatric Hospital.

The Hospital moved to the new facility in Tallaght on 21 June 1998. Its results for the six months ended 30 June 1998 indicated the Hospital was operating in line with budget and within the service levels projected in its service plan. The budget for the year ending 31 December 1998 being used by the Hospital was some IR£6m in excess of the amount included in the Determination from the DOH&C.

In the month of July 1998 alone, in the immediate aftermath of the move, the Hospital's results showed levels of net expenditure some IR£2.4m in excess of budget. The results for August 1998 were some £1.4m in excess of budget. By the end of August 1998, net expenditure was running almost IR£9m in excess of Determination on a year to date basis. In September 1998, management prepared a projection of the outturn to 31 December 1998 which indicated a total overrun of some IR£21m against Determination. This included the IR£5.9m excess over Determination included in its service plan, costs of a capital nature of IR£4.5m, and payments relating to the Co-operation agreement and pension lump sum

payments some IR£800,000 in excess of budget. Following a request from the DOH&C, the Board confirmed on 24 September 1998 that the deficit projected for the year was indeed of the order of IR£21m in excess of Determination. As a consequence of this excess expenditure and the problems facing the Hospital, the Minister for Health and Children commissioned an independent review of the Hospital, which is the subject of this report.

The review was carried out in the context of the recent merger of the base hospitals and the move to the new Hospital in Tallaght.

1.1.3 BASIS OF REVIEW

This review was carried out at the Hospital during October and the first half of November 1998. It included discussions with members of the Board of AMINCH, top general management of the Hospital, representatives of the Medical Board and consultants, and certain staff. It also involved discussions with the DOH&C, the Project Director of TRHB and the Administrator of the FDVH.

1.1.4 LACK OF VERIFICATION

Our procedures and enquiries did not include verification work or constitute an audit in accordance with Auditing Standards except where we indicate to the contrary. The financial information on which our review was based comprised:

- for the year ended 31 December 1997: draft financial statements for each of the base hospitals, and a set of draft combined financial statements for AMINCH for the year. Audited financial statements for this year were not available at the time of our review.

- for the period to 31 August 1998: unaudited management accounts of AMINCH.

Because our work has not comprised an audit, we can give no assurance as to the completeness or accuracy of the financial results for the periods under review. In consequence, the management accounts at 31 August 1998 may not identify all liabilities of the Hospital at that date.

1.1.5 FORECASTS

Insofar as our work has included a review of projections, we have reviewed their compilation to assess whether they have been prepared on the basis of the underlying assumptions. The assumptions on which they are based are the responsibility of the Hospital. We have commented on those assumptions but accept no responsibility for them or the ultimate accuracy or realisation of the projections. Furthermore, you should note that there will usually be differences between projections and actual outturn because events and circumstances frequently do not occur as expected and such differences may be material

1.1.6 POST DATED EVENTS

This report covers matters identified by us and drawn to our attention up to the date of signature. We have no responsibility to update this report for events and circumstances occurring after the date of this report.

1.1.7 ACKNOWLEDGEMENTS

We wish to acknowledge the considerable assistance received from the Board, management and staff of the Hospital and officials of the DOH&C in the preparation of this report.

SECTION 2
BACKGROUND

2.1 ORIGINS OF THE HOSPITAL

The Adelaide and Meath Hospital (Dublin) incorporating the National Children's Hospital (AMINCH) is a body corporate established to provide hospital services under Statutory Instrument 228/96 The Health Act, 1970 (Section 76) (Adelaide and Meath Hospital, Dublin, Incorporating The National Children's Hospital) Order 1996. The Hospital is a public voluntary teaching hospital, primarily funded by the DOH&C, incorporating the former Adelaide, Meath and National Children's Hospitals and will include certain services transferring from St Loman's Psychiatric Hospital.

The base hospitals have a long history of providing hospital services in Dublin. The Meath Hospital was founded in 1753. The National Children's Hospital was founded as a hospital for sick children in 1821. The Adelaide Hospital has its origins in the Adelaide Institution and Protestant Hospital founded in 1839. The Adelaide Hospital proper was established in Dublin in 1858.

Although AMINCH'S Charter did not take legal effect until 1996, the base hospitals had a history of co-operation as part of the MANCH group of hospitals. An Interim Board comprising representatives of the base hospitals was established in 1996, prior to the formal establishment of the AMINCH Board under the Charter.

2.2 THE CHARTER

The Charter of the Adelaide and Meath Hospital, Dublin, incorporating the National Children's Hospital, which took legal effect on 1 August 1996, was the result of extensive amendments to the charter of the Adelaide Hospital, Dublin. The text of the amendments emanated from detailed discussions undertaken in a Working Party established by the Minister for Health in 1990. Heads of Agreement produced by this Working Party were agreed by the Boards of the three base hospitals in May 1993. A draft text of the Charter was approved by the Boards of these hospitals in August 1995. The final text, based on this draft text as advised by the Attorney General, was amended by an Order passed by both Houses of the Oireachtas in July 1996.

The objects, inter alia, for which the Hospital is established and incorporated are:

(i) To operate the Hospital premises that are to be built by the Tallaght Hospital Board at Tallaght, County Dublin, as a public voluntary teaching hospital and, in particular, to carry on at those premises, when the building of them is completed and, pending such completion, at the respective premises of the hospitals hereafter mentioned in this provision, the activities carried on by the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital immediately before commencement of the Health Act 1970 (Section 76) (Adelaide and Meath Hospital, Dublin, Incorporating the National Children's Hospital) Order 1996 (referred to as "the transfer day"), and for those purposes, to assume responsibility for the hospital services and equipment provided and held by each of the said hospitals immediately before the transfer day.

(ii) On or after such day or days as may be determined by the Minister for Health, to perform the functions conferred on and assume the responsibilities and liabilities of the Tallaght Hospital Board established by the Tallaght Hospital Board (Establishment) Order 1980, and to perform the functions performed in respect of the Adelaide Hospital, the Meath Hospital and the National Children's Hospital carried out by the Central Council of the Federated Dublin Voluntary Hospitals under the Hospitals Federated and Amalgamation Act, 1961.

(iii) To promote and secure the availability, as a matter between the patient and his/her doctor, of such medical and surgical procedures as may lawfully be provided within the State. The charter stipulates that the Hospital shall ensure the availability of an adequate range of staff to enable this objective to be achieved, but not so as to prejudice the rights of conscience of individual members of staff of the Hospital.

(iv) To provide for the treatment of diseases and illnesses requiring medical and surgical relief for persons, whether adult or children.

(v) To provide as far as possible for the health, happiness and welfare of children and adults accepted as patients.

(vi) To manage the Hospital premises and services provided by it in the interests of patients.

(vii) To provide and maintain instruction in medicine and surgery in connection with the treatment of diseases and illnesses and the promotion of health, and undertake and promote medical research in education at both undergraduate and postgraduate levels.

(viii) To establish and support a faculty of health sciences, including a College of Nursing and a School of Postgraduate Medical Studies.

(ix) To act as an institution for the training of medical personnel.

(x) To maintain the fundamental principle from which the Adelaide Hospital Dublin was established, namely that it should be essentially a religious and Protestant institution, while maintaining the Hospital as a focus for Protestant participation in the health services and thereby preserving its particular denominational ethos. While maintaining its focus and preserving this denominational ethos, freedom of conscience and the free profession and practice of religion by all within the establishments operated by the Hospital are equally affirmed and guaranteed. The Hospital will therefore have a multi-denominational and pluralistic character.

(xi) To employ or hire by means of contracts of service or contracts for services such persons as may be required to enable the objects of the Hospital to be achieved.

(xii) To develop the tradition of voluntary support groups for the activities of the Hospital.

(xiii) To continue close co-operation with the Health Board and other Health Agencies.

(xiv) To promote and develop paediatric medicine and surgery in the State.

(xv) To maintain and develop sick children's nursing within the College of Nursing and to associate such sick children's nursing with the name of the National Children's Hospital.

(xvi) To promote preventative medicine, health education and healthcare.

Under the Charter, the Board of the Hospital is responsible for the management of the activities of the Hospital and the services provided by it. The Board consists of 23 members, 6 of whom are appointed by the Adelaide Hospital Society, 6 by the Meath Hospital, 3 by the National Children's Hospital, 6 by the Minister from among persons nominated by the President, and 2 further by the Minister, one of whom shall have been nominated by the Eastern Health Board, the other by the Board of Trinity College, Dublin. One of each of the appointees of the Adelaide Hospital Society, Meath Hospital and National Children's Hospital shall at the time of appointment hold a consultant medical post with the Hospital.

The President of the Hospital shall be the person, who for the time being, is the Church of Ireland Archbishop of Dublin.

Each Board member shall hold office for a period of three years.

The Board may establish one or more committees for such purposes as it may determine.

The Charter also provides for the establishment of a Medical Board of the Hospital, the members of which shall be the members for the time being of the consultant medical staff of the Hospital. There shall also be a Paediatric Committee of the Hospital.

2.3 THE HOSPITAL

The Hospital incorporates the activities of the former Adelaide, Meath and National Children's Hospitals and will include certain services transferring from St Loman's Psychiatric Hospital. As such it brings together three very different traditions of medical and nursing care.

A summary of relevant statistics for the base hospitals is shown below:

	No of Beds	*1997 Allocation IR£m*	*1997 In patient discharges*	*1997 Day cases*	*1997 Out Patients*	*1997 A&E Attendances*
Meath Hospital	288	25.52	9,053	6,793	39,746	43,542
Adelaide Hospital	180	16.92	4,721	4,011	40,678	-
NCH	66	7.54	4,209	4,100	19,815	21,853
Total	534	49.98	17,983	14,904	100,239	63,395

The numbers employed in the base hospitals amounted in aggregate to c.1600 WTE's at 31 December 1997.

The Hospital opened in Tallaght on 21 June 1998, having relocated from an inner city catchment area. The base hospitals were very old buildings on three different sites. The new facility in Tallaght is a major, modern new hospital. The Hospital provides child-health, adult and age related healthcare on one site. It will serve areas of Tallaght, Firhouse, Rathfarnham, Terenure, Templeogue, West Wicklow and parts of Co Kildare. Its specialties, which have transferred from the base hospitals, are:

- medicine
- surgery
- intensive and coronary care
- out-patients
- accident and emergency
- urology
- gynaecology

- cardiology
- gastroenterology
- psychiatric unit
- age-related healthcare
- neurology
- nephrology
- orthopaedics
- trauma
- pathology
- child health services, including haemophilia.

Additional facilities have been built to allow further services to be brought on stream in the future. These include:

- one additional theatre and theatre reception areas
- Four bay high intensity recovery room
- Two additional ICU beds
- an age-related day hospital
- Seven additional radiology rooms
- Cardiac catheterisation laboratory
- Expanded cardiac rehab unit
- Ten observation beds in Adult A&E
- Six observation beds in children's A&E
- Hydrotherapy pool
- Ophthalmology suite
- Dental suite
- Endoscopy suite
- Education centre
- Paediatric high dependency unit
- Seven dialysis stations
- Pharmacy manufacture system
- Enlarged Physiotherapy Department.

There are currently 462 beds available in the hospital. A further 16 beds are available within the Accident & Emergency Observation area, if required.

The Hospital currently has access to an inner-city 35 bed Eastern Health Board facility to cater for patients who would otherwise inappropriately occupy acute beds in the Hospital. The current total bed complement, including those provided by the Eastern Health Board, is 513.

In addition, 56 psychiatric beds will be opened on the site once the necessary agreements are finalised with the Eastern Health Board. This will result in the transfer of certain psychiatric services from St Loman's Psychiatric Hospital to the new purpose built unit at Tallaght, which is planned for late 1998.

The Hospital plans to develop private and semi-private facilities providing 76 additional beds. It is expected that the private wing will be available in late 1999 or early 2000. It is the responsibility of the Board of the Hospital to develop the private block. The Hospital has secured VHI approval for the bed complement in the new private wing.

The Hospital has its own laboratory facility. Previously, the base hospitals referred the bulk of its laboratory tests to St James Hospital.

The Hospital is a major teaching institution and formal links have been established with Trinity College which is proposing to construct an on-site health sciences facility to support existing education facilities. This facility is being funded as to approximately IR£3.5m

through Trinity College and the private resources of the Adelaide Society, the National Children's Hospital, and the Meath Foundation. These are separate legal entities established, inter alia, to fund certain future activities of the Hospital.

2.4 PLANNING AND CONSTRUCTION OF THE HOSPITAL

The Tallaght Regional Hospital Board (TRHB), established under the Tallaght Hospital Board (Establishment) Order 1980, was responsible for the planning, building, equipping and furnishing of the Hospital. The Board of the Hospital included representatives from the Board of the base hospitals (and latterly of AMINCH), management and staff (medical and administrative) of the base hospitals, and the DOH&C. It is chaired by Professor Richard Conroy.

The Hospital at Tallaght was designed in accordance with the requirements of a Planning Brief prepared by the Tallaght Hospital Board Planning Group. The Planning Group included Board members (which included 8 hospital medical consultants), the Matrons and Secretary/Managers of the Meath, Adelaide and National Children's Hospital, with input from department heads of the base hospitals.

The Planning Brief, completed in March 1984, contained a detailed statement of the requirements of the new hospital, and how it would operate. It included descriptions of the overall and inter-departmental operational policies to apply to the Hospital, a description of each department including, a detailed schedule of accommodation.

Planning of the Hospital in accordance with the Planning Brief was completed in September 1990, following an architectural competition for the project in 1984/85.

Following a review, concluded in May 1992, of the functions, scope and scale of the proposed Tallaght Hospital by the Dublin Hospital Advisory Group ("Kennedy Group"), planning revisions were made to the tender documentation completed in September 1990 to reflect this group's recommendations. The revisions included inter alia a reduction in bed numbers. The plan provided for a distributed administration function. The report was not provided to the Boards of the base hospitals however, the Kennedy Group included representation from the base hospitals. The tender documentation was approved and tenders were invited in June 1993. Tenders for the revised project were received in September 1993, and construction commenced on site on October 1993.

The planning of the Hospital through its years of detailed development by the design team was overseen by a project team, which reported through the Project Director to the TRHB. The TRHB took final possession of the main hospital building at the end of May 1997.

Since June 1998, the Hospital has been held by AMINCH on a 150 year lease at a peppercorn rent from the Minister.

The transfer of the functions to and the assumption of responsibilities and liabilities of the Tallaght Hospital Board by AMINCH for which provision is made clause 5b of the Charter has yet to take place. This is because the Board of AMINCH wished to have amending legislation considered in relation to the transfer, as well as clarification on the nature and extent of liabilities being assumed.

2.5 INDUSTRIAL RELATIONS

Industrial relations issues relating to the transfer of services to the new Hospital in Tallaght fall within the framework of an Industrial Relations Protocol for the transfer of services to, and the opening of Tallaght Hospital, agreed between management, the DOH&C and the trade unions representing staff employed in the base hospitals. The application of an Industrial Relations Protocol is established in Clause 19(3) of the Charter.

The Protocol covered issues such as:

- best industrial relations/personnel practice
- security of tenure
- agreed procedures
- recruitment and promotion

A Co-operation Agreement, involving the Hospital, the DOH&C, the unions and the HSEA, was finalised in December 1997, and covered issues relating to the transfer of staff to the Tallaght site. The Co-operation Agreement covered arrangements in relation to procedures for consultation, transfer arrangements and remuneration. The remuneration element of the Co-Operation Agreement, estimated at IR£1.7m, was the subject of binding arbitration following representations from the parties.

2.6 THE ENVIRONMENT FOR VOLUNTARY HOSPITALS

The following are key features of the environment in which AMINCH operates, and its relationship with the DOH&C, and are relevant to the context in which this review takes place.

2.6.1 HEALTH STRATEGY

The Department of Health's strategy "Shaping a Healthier Future" sets out the strategy for the provision of health services and emphasises the underlying principles of equity, quality of service and accountability in the provision of public and voluntary health services in the State. It sets out the future organisational and management structures for the delivery of health services, and specifies the role of the Department of Health, future regional health authorities and the role of the voluntary sector.

The strategy recognises that the voluntary sector plays an integral role in the provision of health and personal social services in Ireland. It also recognises that one of the strengths of the Irish healthcare system is the existence of a strong voluntary sector, one which is an integral part of the public system without foregoing the benefits of independence and flexibility.

The strategy states that, in the future, voluntary agencies will receive funding from the health authorities to whom they will be accountable for the public funds they have received. This will be a statutory framework designed to create between the health authorities and the voluntary agencies involved, specific recognition of the role and responsibilities of both parties. It is recognised that the independent identity of the voluntary agency will be fully respected under any new structure and that they will retain operational autonomy, while at the same time being fully accountable for the public funds they receive.

Larger voluntary agencies, in common with all agency providers in the Health system, will be required to enter into service agreements with health authorities which will link the funding by the authorities to agreed levels of service to be provided by those agencies. It is envisaged that these agreements will be for a term of a number of years.

AMINCH currently receives its public funding directly from the DOH&C. It is envisaged that in the future the Hospital, in common with other voluntary agencies in the ERHA region, will enter into service agreements with that Authority in respect of its funding. These agreements will set general parameters in relation to the level of funding and associated service requirements over a period of years, as the amount of funding that will be available in any one year cannot be guaranteed in advance. The precise funding levels in each year will fall to be determined annually between the ERHA and the relevant agency.

2.6.2 ACCOUNTABILITY LEGISLATION

The Health (Amendment) (No 3) Act, 1996, which became fully operational on 1 January 1998, sets out in legislation the responsibilities of health boards in relation to use of public resources, and their accountability for expenditures made. This legislation does not apply to voluntary agencies, but the DOH&C made it clear to AMINCH in their Letter of Determination of 4 December 1997 (as they did to other voluntary agencies) that they intend to apply, in an administrative way, any terms of the legislation that are relevant to the DOH&C's dealings with voluntary agencies. This would include:

(i) The requirement for each voluntary agency within a stipulated period of between 21 and 42 days on receipt of its determination, as the Minister may direct, to adopt a service plan specifying the services to be provided by the agency within the financial limits determined by the Minister.

(ii) The requirement for the agency to monitor expenditure to ensure that it does not exceed the amounts set by the Minister.

(iii) The requirement for the agency to work within a maximum amount of indebtedness as determined by the Minister in any year.

(iv) An arrangement whereby any excess of expenditure over determination that arises in any year will be come a first charge against the determination of the following year.

2.6.3 LETTER OF DETERMINATION

The process under which the DOH&C fund Health Boards and voluntary agencies has changed as a consequence of both the Health (Amendment) (No 3) Act, 1996, and changes introduced in relation to the Government estimates and budget procedures. The budget cycle has been changed so that both estimates and the Budget for the ensuing year are settled during the autumn. As such, expenditure required to further develop existing policies or to introduce new policies will normally be reflected in the budget provisions.

The Letters of Determination, (such as that sent to AMINCH on 4 December 1997, and included in Appendix I) which was issued by the DOH&C to health agencies to advise them of the amount of their 1998 funding, outlined these changes and indicated, as a consequence, that the DOH&C would, in the normal course, endeavour to incorporate all aspects of approved expenditure in the initial Letter of Determination.

This has meant a significant change in relation to supplementary funding. In the letter of Determination, it was recorded that the Minister wished to draw specific attention to the policy that will apply from 1998 onwards in relation to supplementary funding. In the context of the overall expenditure planning framework and the need to adhere strictly to agreed budgetary criteria, the DOH&C has agreed with the Minister for Finance that in relation to 1998 and subsequent years, supplementary estimates for the health services will be granted only on an exceptional basis and only then in relation to specific categories of expenditure.

In the case of 1998, the items which have been identified which may qualify for additional funding are:

- demand led schemes (applicable to health boards only)
- superannuation
- medical indemnity
- PRSI

The Letter of Determination issued by the DOH&C on 4 December 1997 is explicit in stating that categories of expenditure that had been the subject of supplementary funding in recent years must be provided by the relevant voluntary agency in its service plan for 1998 within the agreed determination for that year. The amount of provision to be made should be based on recent experience and an assessment of the relevant agency's ability to avoid exposure in these and similar areas.

The Letter requires each agency to adopt and submit a service plan to the DOH&C no later than 42 days from receipt. It states that the service plan will be the benchmark against which expenditure, output, and progress will be assessed during the year. The Letter states that it is the responsibility of the agency's management to ensure that the amount of net expenditure of the agency does not exceed the amount of the Determination.

2.6.4 PROMPT PAYMENTS LEGISLATION

The Prompt Payment of Accounts Act 1997 came into operation on 2 January 1998. Health agencies, including AMINCH, are required to adhere strictly to the terms of this legislation.

2.6.5 OTHER RELEVANT LEGISLATION

The provisions of the Accounting Standards for Voluntary Hospitals, and of the Comptroller and Auditor General (Amendment) Act 1993 are also of relevance to the environment in which voluntary agencies operate. Where more than 50% of the funding of any agency derives from public finances, the C&AG has the power to examine that agency. The C&AG is also responsible for carrying out value for money studies, and as such has the ability to assess voluntary agencies in respect of such matters.

2.6.6 THE MOVE AND THE MERGER OF THE BASE HOSPITALS

The terms of reference of the study require this review to be carried out in the context of the recent merger of the base hospitals and the move to the new hospital in Tallaght. An overview of these issues is provided below.

The TRHB were responsible for the planning, building, equipping and furnishing of the Hospital. The planning was undertaken in close consultation with the Hospital. The Hospital is the largest single capital investment in the history of the health services. The base hospitals received a total of IR£3.7m in 1996 and 1997 in revenue resources to meet expenditures relating to the new Hospital. The DOH&C also approved a capital budget for IT of IR£4m for the project.

THE MOVE TO TALLAGHT

The move to Tallaght was a very major operational and logistical task, one which involved staff at all levels in the base hospitals to a high degree in its planning and execution. It involved significant co-operation and support from the DOH&C and other agencies, including the Eastern Health Board, other hospitals, and local GP's.

The decision to move the base hospitals to Tallaght was effectively made when DOH&C gave the go ahead for the construction of the new hospital in 1993. Significant resources were

made available by DOH&C in 1996 and 1997 to facilitate all the necessary planning for the move.

Detailed operational plans for all clinical and non-clinical areas were drawn up and responsibilities assigned to individuals to oversee the execution of the move to Tallaght. A structured approach to identifying and carrying out critical tasks was undertaken, a process in which management were assisted by external management consultants.

Planning and executing the move was a complex and time consuming activity, and placed significant demands on management, who, understandably, had little prior experience in such matters. Most of the team had come from the base hospitals. Each of these hospitals were considerably smaller than the new Hospital, and operated with the form of traditional management systems commonly found in agencies of their size in the Irish health system. Particularly in the months immediately prior to the move, a range of critical issues had to be resolved within tight timeframes. Management were involved in running full clinical services in the base hospitals as well being required to commission their respective areas of the Hospital. Many issues arose of out the commissioning process which necessitated the establishment of an operations group, a sub committee of the management team, that had to deal with a wide range of issues in the lead up to 21 June 1998, for example:

- Issues associated with the building programme, for example the resolution of difficulties with the Out Patients Department, HSSD requirements, plans to develop a private wing, and a long list of commissioning issues.
- Issues relating to the equipping of the Hospital.
- Issues associated with recruitment of staff required in the new Hospital
- The development of plans for service reduction prior to the move.
- Involvement in industrial relations issues associated with the move.
- Timing overruns in relation to IT systems
- Accommodation issues for administration staff.

During the time in which the move was being planned, activities in the three base hospitals, which were continuing at full capacity, were being managed by the same management team. Management has indicated that activity levels in these hospitals were 14% ahead of service plan in the period to April 1998. Management adopted the approach of providing patient care in all base hospitals to the latest possible date to secure the safe transfer of both adult and children. This was accomplished on 21 June 1998.

The challenges posed did not cease on 21 June 1998. Management had to set about completing the commissioning process and have the Hospital operational. This period posed a series of new challenges unique to the opening of a new hospital.

The physical move to Tallaght, and the logistical issues associated with it, can be regarded as a success. There were undoubtedly aspects of the move that might have been planned or organised better and earlier, and as such these are likely to have contributed to the need for management to deal with a large number of issues in a short timeframe in the period preceding the move. In the final analysis, the move to Tallaght on 21 June 1998 happened on time and it is widely held that patient care was not compromised at the time of, or after the move to the new facility, a major achievement. Credit is due to the management team and staff in overcoming the challenges posed by the move.

THE MERGER

The objective of the merger was to create one organisation before the move to Tallaght from the three base hospitals operating from the sites of the Adelaide, Meath and National Children's Hospital.

A significant amount of planned effort went into the merger process. In practice, many of the events associated with merging the base hospitals were integrated into the change processes associated with the move. It is clear that the move itself was used as an integrating force.

The CEO has indicated that the following strategies, which began in 1996 and progressed through 1997, were adopted in merging the base hospitals:

(i) A Board drawn primarily from the base hospitals in line with the requirements of the Charter became operational in 1996. An Interim Board had operated from early 1996.

(ii) A Board sub-committee system was established to ensure that each constituency was well represented.

(iii) A mission statement was agreed by the Hospital.

(iv) A new organisational structure was designed and communicated to staff. The structure was quite different from the form of organisation structure in place in any of the base hospitals.

(v) A senior management team was formed which for the most part comprised personnel chosen by internal competition from each of the base hospitals.

(vi) A staff communications programme was implemented using internal newsletters/bulletins such as "Le Cheile" and "Pulses", and a series of open meetings were held at which concerns could be raised. Board members were kept informed of the issues raised at such meetings. Meetings were also held with the union leadership to ensure that they were informed of issues during the transitional phase.

(vii) Staff in certain areas were transferred between the base hospitals in advance of the move so that they could work with each other principally in the commissioning of the new hospital.

(viii) A process of communicating with clinicians and members of the Medical Board was undertaken.

(ix) An open and fair process of recruitment was undertaken, and front line staff were given the opportunity to be part of interview teams for management positions.

The above merger strategies appear to have been successful in merging the cultures of the base hospitals. Indeed there is a strong sense of commitment to the new organisation among the Board, management and staff. The merger process is however incomplete in a number of important respects:

- Better integration and organisation of certain administrative and support services functions, (for example, personnel, technical services and finance) is required. A particular concern is the continuing use of the financial systems from the base hospitals and the failure as yet to consolidate the payroll/personnel systems. This has to a significant degree adversely affected the production of reliable management information on a timely basis in the new hospital. This is an important matter, which is dealt with in more detail elsewhere in this report.

- The organisation structure at senior management level, a product of the merger process, is not suited to the effective management of the Hospital.

- There is a lack of standardisation in operational policies.

- Paediatric services, previously carried out by the National Children's Hospital, have yet to be satisfactorily integrated into the structures of the new hospital.

The move to Tallaght and the merger process involved significant effort at all levels of the base Hospitals during a period of major change.

It is important to record the very considerable support and assistance given by the DOH&C to the Tallaght Hospital project. This included the establishment within the DOH&C of a dedicated project team (to ensure the opening of the hospital on schedule) and participation on the Board of the TRHB, and on committees associated with the project. It is evident also that the Secretary General of the DOH&C took a personal interest in the project. Both the DOH&C and the Hospital also acknowledge the co-operation from the unions in effecting the move to Tallaght.

SECTION 3
MANAGEMENT REPORTING AND CONTROL

3.1 INTRODUCTION

This section of the report reviews the processes for management reporting and control using a methodology developed by Deloitte & Touche for this purpose. It starts with a brief overview of principles and criteria against which we have benchmarked the Hospital. This is followed by an assessment of the Hospital's processes in the following areas:

- Strategic Planning
- Performance Measurement
- Accountability Process including Budgetary Control
- Costing
- Management Organisation
- Information Systems

The section ends with a summary of our conclusions in relation to the effectiveness of the above processes and our recommendations for improving management reporting and control within the Hospital. Within each area we identify and comment on the issues. Our views have been determined based on best practice and the interview programme with the management team. In arriving at our conclusions, we have been cognisant of the fact that the Hospital had been operating from the new location in Tallaght for only 15 weeks prior to commencement of this review.

The section generally provides an insight into the reporting and control environment in place in the Hospital, in the period after the move.

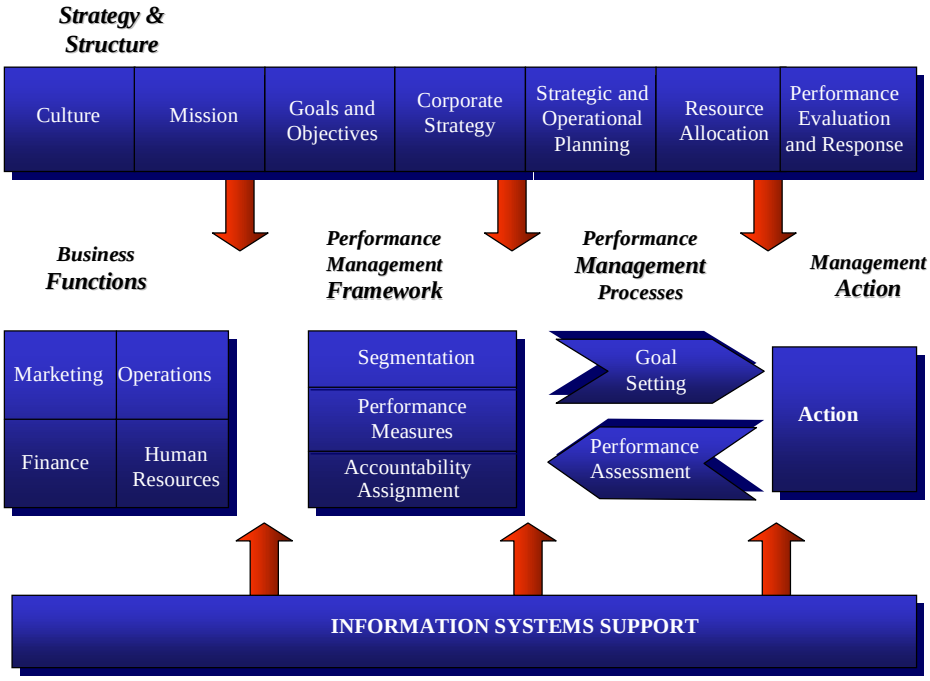
3.2 PRINCIPLES

Management reporting and control is a key component of the overall management process of any organisation. Management reporting and control systems and processes must be consistent with the requirements for effective management and decision making. Whilst within the health care delivery sector the primacy of patient care is a strong overriding factor, it must be mirrored by systems to procure such care in the most effective and efficient manner. This adds to the need for appropriate management reporting and control mechanisms.

Figure 1 overleaf, presents an overview of an integrated business management process which applies to any organisation. The process has six major components:

- Strategy and structure
- Business functions
- Performance management framework
- Performance management processes
- Management action
- Information system support

Figure 1 – Integrated Business Management Processes



The following paragraphs discuss each component briefly.

STRATEGY AND STRUCTURE

Strategy and structure provide direction and organisation for management of an enterprise. Strategy is rooted in the culture of the organisation – the values, beliefs and attitudes that shape its operating philosophy. The key elements are:

- The establishment of the enterprise's mission
- Definition of the corporate goals and objectives
- Development of strategies to achieve the goals and objectives
- The development of the strategic and operational plans
- Establishment of organisational structures and processes
- Allocation of the resources and definition of accountability for results
- Revision of strategies and plans based on performance

Strategy and structure provides the top-level integration for the management process. It provides direction to the organisation by identifying and communicating priorities, making these priorities to the organisational structure and operating processes and adjusting direction in response to performance.

BUSINESS FUNCTION

There are four major functions that are integral to all enterprises. They are:

- Operations
- Finance
- Human Resources
- Marketing (in a healthcare context, this focuses on identifying the needs of the community served, and other stakeholders)

Each function deals with a critical aspect of an enterprise and has its own structure and systems. However, all functions are, or should be, closely inter linked. This integration is achieved through an effective management process and the support of appropriate information systems.

PERFORMANCE MANAGEMENT FRAMEWORK

For the overall management process to be effective, it is essential that accountability for performance is clearly assigned and that there are benchmarks against which performance can be evaluated. The performance management framework illustrated in figure 1 provides the mechanism for this process.

The first element for the performance management framework is the definition of the segments of the enterprise for which accountability is to be assigned and performances assessed. A segment may be any dimension an enterprise where there is a focus for management decision making.

The second element of the framework is the establishment of the measures against which performance can be evaluated. For control purposes, these measures are normally determined through the planning process and usually include specific financial targets for each responsibility/cost centre.

The final element of the framework is the assignment of accountability for performance results to specific managers. For control purposes, accountability will generally be assigned along the lines of the responsibility centre structure of the organisation.

PERFORMANCE MANAGEMENT PROCESSES

Performance Management Processes are a crucial element of the overall strategic management framework. As illustrated in figure 1, these processes create the link between the organisation, it's business functions, and the accountability framework and actions carried out by management. The processes include:

- Establishing objectives, goals and programmes that are linked with strategic plans
- Providing focused feedback on performance
- Identifying exceptions that require management's attention

Effective performance management processes include a goal setting and budgeting process and a management reporting system. The goal setting and budgeting process must tie together corporate objectives, the strategies and programmes developed to meet these objectives and the organisation that must achieve them. The organisation's management reporting system must provide accurate and relevant information to ensure that operational and strategic performance can be measured analysed and controlled.

MANAGEMENT ACTION

This component of the management process incorporates activities that are directed to business operations, among these activities are:

- Day to day direction of activities
- Deployment of resources
- Interaction with other managers
- Response to performance standards and results

- Corrective action (when necessary)

INFORMATION SYSTEMS

All enterprises and all management processes require timely, accurate and relevant information to assess performance and support decision making. While information technology has emerged as a key internal function in its own right, it is important to remember that information systems support the business functions of the enterprise. Therefore, effective information support systems require a clear definition of the information requirements of the enterprise as a whole and of each of its functions and technology segments. Once information needs have been identified, the appropriate platforms and delivery mechanisms may be selected.

In complex enterprises, there is a requirement to classify and report on data in multiple dimensions. This complexity occurs because of overlaps between the information required to manage the organisation from a control perspective and the information necessary to measure performance of programmes, units and service sectors from a tactical or strategic perspective. This multi-dimensional requirements means that systems have flexibility to classify data along multiple dimensions to provide information for both performance measurement and reporting.

3.3 MANAGEMENT ORGANISATION

BACKGROUND

AMINCH is a public voluntary teaching hospital, a successor to three voluntary hospitals merged under the Charter.

It is not possible to discuss the management team and organisation without reference to AMINCH's board of management and the board committee structure.

The Board of Management of AMINCH is appointed by the following:

	No. of Members
Adelaide Hospital Society	6
Meath Hospital Foundation	6
National Children's Hospital Foundation	3
Minister for Health & Children from persons nominated by	
President of the Hospital (Church of Ireland Archbishop of Dublin)	6
Eastern Health Board	1
Trinity College, Dublin	1

In all there are 23 members of the Board of Management. The Hospital Charter, legally constituted in both Houses of the Oireachtas in 1996, provides for the Board of Management and specifies that the function of the Board "shall be to manage the activities of the Hospital and the services provided by it". It is important to note the use of the word "manage", rather than governance, which might be considered a more normal remit for a Board. This remit and the general enthusiasm of what is a voluntary board are reflected in an operational approach of the Board to the running of the Hospital.

The Board is supported by a committee structure which includes the following committees:

- National Children's Hospital Committee
- Resources Committee (of which there is a HR sub committee)
- Strategic Planning & Communications Committee
- Foundations Committee
- Academic Research & Development Committee
- Nursing Committee
- Patient Care Committee
- Pastoral Care Committee

These committees were established in 1997, and there is a standard framework by which they operate. Typically each committee has four Board members, a management team representative, a medical staff representative, a staff member, a community member, with the Chairman of the Board and CEO as ex officio members. It would appear that the Board is highly motivated and has gelled well together as a group.

The CEO and his management team support the Board of Management. The CEO was recruited in 1996, with a clear brief to manage the merger of the base hospitals and manage the move to Tallaght. He was chosen by the Board because of his experience and in particular because of his open participative management style. This was seen as important in managing the merger of the base hospitals as all had different cultures. The individual management team members are directors with responsibility for certain portfolios. In all there are nine portfolios:

- Medical
- Clinical Services
- Nursing
- Organisation Development and Co-ordinator of Education & Research
- Programmes
- Environmental Services
- Human Resources
- Information Technology
- Finance & Administration

In addition to these nine portfolio directors, the head of pharmacy is also a member of the management team. This team, with the exception of the Director of Finance, was in place in early 1997. This management team meets formally every week.

The CEO is of the view that he was constrained in that the Board had decided that he should initially seek to fill all his management team positions internally from the base hospitals. Criteria were established against which candidates were evaluated. No internal candidate satisfied the criteria for Director of Finance. As a result, the position was advertised externally, and because of difficulties in the recruitment process, of which the DOH&C were informed, the appointment was not made until mid-September 1997.

3.3.2 CORE ISSUES

(i) Governance versus Management

The Boards of the base hospitals had a participative approach to the running of the hospitals, and were clearly involved in management and operational functions. There is evidence that this approach has continued into the new Hospital. The focus should be on governance and not management. It is our view that the Board devotes a

disproportionate amount of time to operational activity instead of strategy and policy development.

(ii) Relationship between Hospital and DOH&C

The relationship between the Hospital and the DOH&C is strained at present. There are tensions as to the current financial situation, the adequacy of funding, and the future development of the Hospital. There have been different interpretations placed on matters written and spoken, which have aggravated the situation.

Given the sizeable investment in the facility by the State, to enhance accountability for public funds, and to achieve the common objective of maximising the benefit of the Hospital to the community and developing it as a modern centre of excellence in healthcare, it is essential that the relationship between the parties is rebased. The following would help:

- agreeing in principle an overall strategy for the Hospital, including a medium term development plan in service and funding terms.

- the development of a service plan for 1999 within Determination. Ideally in-depth discussions between the parties should take place on what can be achieved in service and funding terms before the Determination is set. Time is short to achieve this in the current year. This may vary from the norm, but the current circumstances, which follow the opening of a new Hospital and significant financial overruns, are not normal. The service plan for 1999 must be prepared within Determination; a prior consultation process would enable this to happen, and minimise the risk of any misunderstanding between the parties.

- the Hospital should ensure compliance with IMR requirements and reporting requirements as specified in the Letter of Determination.

- The establishment of clearer less diverse lines of communication in both directions between AMINCH and the DOH&C. A structured process through the CEO is required from the Hospital's perspective.

(iii) Committee Structure

The committee structure reflects certain elements of the Charter and is supported enormously by the voluntary board members. However, the focus of the committee structure has been too operational. The development of the committee structure was appropriate given the size of the Board. It is clear however that the number of committees and their operational focus places a strain on the resources of the management team. The committees also provide an ambiguity for the management team in terms of where accountability lies e.g. is the committee accountable or is the relevant portfolio director accountable. This is a particular problem given the inexperience of some of the portfolio directors.

(iv) Management Team

At present, the management team do not operate as a cohesive unit. A number of factors, outlined below, have influenced the lack of progress here. In particular the delay in the opening of the hospital has resulted in the team effectively operating in commissioning mode rather than in operational and strategic planning mode, for a much longer period. Furthermore, the CEO was required, by a Board decision to

recruit a large element of his team by internal competition, and as such has a team whose experiences are founded to a large degree in smaller hospitals which did not require the form of organisation, systems and structures now required in the larger, more complex facility in Tallaght. The management skills required in the team are therefore understandably lacking.

There are a number of current issues relevant to the management team and its effectiveness:

- ***Span of Control***

  With 10 direct reports, the CEO's span of control is far too wide. Best practice would suggest a maximum management team size of six. The appointment of a Director of Operations / Deputy CEO would help to reduce the span of control.

- ***Not working as a Team***

  There are clear tensions within the management team. To a large extent, this is a group of people who operate individually; they do not operate as a team. There is a lack of trust and respect between certain members of the management team.

  Communication amongst the management team is mixed. The weekly management team meeting seems to provide the main access for team members to meet each other. A significant basis for communication outside of this forum appears to be by letter, the formality of which is not helpful in terms of team building, as one of the primary roles of this form of communication is to protect the individual's interest by providing an audit trail. This policy is bureaucratic and archaic and does not belong in a vibrant new team environment. This policy adds enormous delay to the decision making process. There is an e-mail system in the Hospital, but not all members of the management team had access to this. There is little evidence of the use of e-mail in the organisation. As noted earlier, there is also concern amongst some members of the management team with the Board/Committees of the hospital over the extent of their involvement in operational matters.

- ***Decision Making Process***

  Decision making at the management team meetings appears to have been based on seeking consensus, in keeping with the style of the CEO. This is not effective, impairs accountability and clarity of purpose. The management team meetings occur weekly, and are too long (4-6 hrs has not been abnormal). The management team themselves believe that too often decisions are not reached because of the consensus approach.

  It appears that some of the team have adjudged it better to opt out of these discussions in the hope that it would facilitate quicker decision making, and shorter meetings.

  In the environment of moving to a large hospital complex in Tallaght, this was an inadequate approach to decision making. This was recognised and led to the setting up of the operations room in the run up to the move. Setting up the operations room was necessary, but it did not address the real problems

i.e. having the appropriate information to make decisions. As a result many decisions were made without understanding the impact on the resources of the organisation. It also had the negative effect of excluding members of the management team from the decision making process and thus built on the team problems.

Managerial decision making falls broadly into two areas; planning, where managers set a course of action and performance, where managers review the actual results.

Within AMINCH there is evidence of planning in certain areas, although this has primarily related to the vision for the organisation, managing the move to Tallaght, and merging of the base hospitals. As far as performance measurement is concerned, there is little evidence of the availability of crisp, timely information to: facilitate decision making; assess performance; or measure performance. There is limited discussion for the need for any of this in management team minutes. The lack of this information also impacted on individual portfolio directors making decisions, forcing all decisions to be made at management team level.

- ***Training***

  The DOH&C has identified the need for management development in the health sector and is supporting initiatives throughout the system to improve management skills. The management team in the Hospital has emerged from smaller base hospitals in the system. In common with other hospitals of their size, these base hospitals neither provided, nor arguably required, their managers to have formal training in management. The Hospital poses new challenges for the management team; management development programmes are required to address these. A training needs assessment of management is required, and a plan should be developed to meet these needs. The specific training requirements of each team member should be assessed.

  The following points are relevant:

  - Management training will help harness the commitment of the management team.

  - We are aware that a number of the members of the management team are pursuing various Masters degree programmes. Whilst this in the longer term will no-doubt be beneficial to the individuals and the organisation, it needs to be complemented with practical training in areas such as: interpersonal skills, conflict resolution, team working, communication, problem solving and decision making.

  - Training will be imperative in management responsibilities for budget holding and accountability. Generally, a culture of financial awareness and responsibility is required, enforced by an appropriate budgetary control system in the Hospital.

We are aware that there is an overall objective to change the management structure to one based on programmes. This will require the overall management structure and organisation to be addressed.

(v) CEO Style and Role

We have commented elsewhere on the successes achieved in moving the base Hospitals to Tallaght, and to the achievements in merging the cultures of the three separate entities from which the Hospital has come. The open and participative style of the CEO undoubtedly assisted both the move and the merger. There is also an acceptance amongst staff that this openness is refreshing.

One downside of this approach is that the CEO is seen more as a facilitator than "commander-in-chief'. His approach is consistent with helping to build openness and participation, which we would regard as being in keeping with the Charter and with a smooth merger of the cultures of the base hospitals. However, a less consensual, more decisive approach to decision making is required in the future, a matter that will be facilitated by having a smaller senior management team. The following key components are also required:

- Devolved budgets for portfolios, and accountability for that budget by the portfolio director.
- A management team that has the willingness to move forward and work as a team. Teamwork will only develop out of respect.
- An appropriate decision making process consistent with devolved budgets i.e. the majority of the issues addressed at the management team meetings should have been resolved outside of that forum.

(vi) Recruitment Process

The recruitment process being used in the Hospital is also based on openness and fairness. This is appropriate, however the process has been overly complex, cumbersome and time consuming. We fully understand the objective in trying to foster openness, and recommend an open recruitment process, whereby the process delivers the most suitable person for the given position without bias. This however can be achieved in a less complex and time consuming way.

(vii) Dual role of Director of Environmental Services

The dual role of the Environment Services Director, being on AMINCH's management team and also being the TRHB Project Director, merits comment. It is unacceptable in terms of good business practice that this director could place orders on behalf of both organisations using the order books of both organisations. This has lead to the disagreements in terms of whose budget certain expenditure should come from. Orders for equipment amounting to c.IR£0.5m were placed by this individual using an AMINCH order book outside the proscribed materials management system. There was no prior discussion on these orders with the Director of Finance and no specific budget available within AMINCH for this expenditure. The expenditure was made when it became apparent that the Equipping budget in the TRHB was fully utilised, for which, as Project Director of TRHB, the same individual was responsible. This created a conflict of interest for the individual concerned, one, which he handled in an unsatisfactory manner. The Board of AMINCH should not have entertained this duality of roles. If the TRHB had been dissolved in April, this dual role difficulty and the issues of a lack of a clear separation between the two organisations would have been greatly reduced.

(viii) Accommodation

There are severe office accommodation difficulties for administration staff at the new Hospital. Insufficient space was provided in the design. The fact that this was not realised until very late in the commissioning process reflects a serious lack of planning in the non-clinical areas.

(ix) Location of the role of Purchasing

The location of the role of purchasing/materials management within the organisation has created a number of difficulties. The role initially reported to the Director of Environmental Services, which because of the dual role referred to above, was not good practice. There were also delays in the implementation of the Materials Management system for the Hospital. In recognition of this difficulty the Finance Director sought and was given responsibility for the materials management function in February 1998. This is probably the right place for now, and particularly until the financial situation stabilises, but not an appropriate choice for the long-term. It is important that the function operates centrally, and is not fragmented into devolved departmental ordering/purchasing units, which we understand has been called for in certain support service areas. Centralisation increases control and optimises purchasing power.

3.4 STRATEGIC PLANNING

3.4.1 BACKGROUND

A strategy provides direction and organisation for management. It should reflect the culture of the organisation in terms of its values, beliefs and attitudes.

- A mission statement has been developed for the Hospital, together with a draft Vision statement and a Statement of Values.
- An ISIT strategy for the Hospital was developed in 1995 and finalised in 1996 including a change management programme.
- SDC Consulting were employed in early 1997 to conduct a high level organisational, service and resource review prior to their facilitation of a 3 day retreat for the management team in April 1997. This reflected the desire of the CEO to begin a process of longer term strategic thinking at an early juncture.
- A Strategic Planning & Communications committee of the Board was established in June 1997, with the CEO and the Director for Organisation Development & Education as the management team representatives. This committee commissioned a strategic plan for the hospital, a process which is still underway at the time of this report.
- Medical services plans were developed.

In addition to the above, a management retreat was planned for October 1998 to review a range of strategic, operational and organisational issues identified as part of a management audit being undertaken by CEO and the management team. The CEO of the Hospital decided to defer this retreat because of this review.

The Hospital as part of its strategic management process has developed a mission statement, which reflects the Charter, ethos and values of the base hospitals. This mission statement was in existence prior to the management team three-day retreat in April 1997.

The retreat was primarily a strategic planning exercise looking at:

- the current position of the base hospitals;
- the mission for the future;
- the values of the organisation;
- the priorities for development, and
- the development of action plans.

The objective of this retreat, facilitated by SDC Consulting, was to:

- develop a common agreed understanding of where the organisation was starting from;
- develop some critical success factors for the management team for the new organisation
- develop the basis for initial action plans around these Critical Success Factors
- promote team building amongst the management team

The 10 Critical Success Factors (CSF's) developed were both strategic and pragmatic. Whilst they did not specifically reflect the mission statement of the Hospital, they were viewed as priority areas for action which must be done well if progress towards the mission was to be achieved. The CSF's developed were:

- deliver a usable hospital facility
- agree a clinical service plan for the new hospital
- development and implementation of financial strategy
- development and implementation of human resources strategy
- development and implementation of performance management arrangements
- development and implementation of a communications strategy
- development of effective working relationships within the hospital
- development of a strategic service investment plan
- demonstrate completion of organisation merger
- develop and implement plan for clinical programme structure

Responsibilities were assigned to individual team members for the majority of these CSF's although timing for delivery of the above was not clearly established. Priority was given to the first of these CSF's, namely the requirement to deliver a usable hospital facility, as this was recognised as the principal task. The management team were assisted in this process by external management consultants. At the time these CSF's were developed, the process for the merging of the base hospitals had commenced, and the move to Tallaght was due before the end of the year. In retrospect, it is reasonable to conclude, given the effort and disruption that could have been anticipated by both the merger and the move, that achievement of all these tasks would have been unrealistic, even by this time. However, ownership of these CSF's amongst the management team is still poor and delivery of the strategies and action plans is limited. Some of the CSF's have been delivered to a degree others not at all, the non-delivery of some impacting on the ability to deliver others. The major areas not adequately delivered to date are primarily in the non-clinical areas of:

- Human Resources strategy
- Financial Strategy (we recognise that the Financial Director was not recruited until the latter half of 1997)

- Performance management arrangements
- Clinical programme structure
- The completion of the merger
- A strategic service investment plan

The setting up of the Strategic Planning & Communications Committee in June 1997 reflected the importance given to strategic planning by the Board. Having reviewed the minutes of this committee it is clear that much of its time was preoccupied with the communications aspect of the committee's brief. The committee did recognise the need for a strategic plan, and requested that a plan be commissioned. The broad objective was to have a 3-5 yr. plan in place in 1998 that would have a bearing on the 1999 financial year. It was agreed in October 97 that a working group should be established to develop the strategic plan. To date an extensive process of consultation and meetings has taken place as part of this process, and a number of studies to support the working group have been commissioned. These studies have focused on clinical service developments, and the different demographic requirements of the Hospital's new location. An incomplete draft plan has been prepared, and it is recognised that further work is required to complete it, in particular it has not been issued or reviewed by the management team, and there is no assessment of the financial implications of the strategy prepared. This strategic plan was initially due for Easter 98.

It is clear that a rigorous co-ordinated process for strategic planning is not in place, despite the well-intentioned efforts of the Board. Furthermore, there is a danger with the current approach that departmental expectations will not be managed. We have not identified any mechanism for prioritising service developments. When people are consulted on what they need there is an inherent expectation that they will get something. Given the limited financial resources of the organisation, expectations need to be managed. The hospital needs a phased development plan – it will not be able to provide "best-in-class" service in all areas from day one.

3.4.2 CHANGE MANAGEMENT

In conjunction with the ISIT project a major programme of change management was planned. Change management was identified in the IS/IT strategy as a crucial element in the successful delivery of information systems for hospital opening in order to ensure systems alignment with business processes in the Hospital. Consultants were engaged to assist in this programme. The aim was to successfully implement effective and efficient applications and processes and to ensure that people were adequately trained and informed. The objectives of the change management project were to:

- Co-ordinate and control the design of the new business processes in relation to the new applications, ensuring that they are efficient and effective.

- Ensure that the communications are in place to fully inform staff of the planned change to the new applications/processes.

- Co-ordinate and manage the training requirements for both user and technical staff to ensure successful implementation of the new applications and processes and

- Involve staff in the design of the new processes to encourage user ownership of the applications and processes.

Change management planning is key to the successful implementation of new systems and reengineered processes. The importance of this can not be understated particularly in the context of the merger of the three base hospitals. There is a view within AMINCH that this

was inadequately funded and has resulted in some of the initial problems within the new Hospital. The DOH&C refute this, stating that adequate resources were made available.

3.4.3 CORE ISSUES

(i) Committee Structure

Our overriding concern about committees is that their focus has been operational rather than policy driven. As such the committees are limited in the support they can give to strategic planning.

(ii) Strategic Planning at Management Team level

Apart from the management team's involvement in the April 97 retreat, there has been limited involvement in strategic planning at management level. We recognise that a further retreat was to happen in October 1998, which was deferred because of this review. At present, the management team does not have a clearly defined role for strategic planning. Whilst the director of Organisation Development & Education is chairing the working party to deliver the strategic plan, and one of the CEO's goals for 1998/99 is the finalisation and implementation of the strategic plan, the management team have not yet had any real input into the process.

(iii) Lack of 'buy-in' by Management Team

Given the significant number of the 10 CSF's yet to be addressed, it is essential that the management team takes ownership of the strategic plan and takes responsibility for delivering the strategy. Furthermore, this year's service plan was seen as a Finance Department exercise and was not bought into by the management team. The management team must be empowered and accountable for the delivery of service and strategic plans. Some members of the management team are thinking strategically about their own portfolios. Care needs to be taken to ensure that the plans developed in individual portfolio areas will be consistent with the long-term strategy of the Hospital (difficult in the absence of an overall strategic plan for the Hospital)

(iv) Service Planning & Strategic Planning

We are of the view that the service plan should in fact be the operating plan of the first year of a rolling 3-5 yr. strategic plan. Given that only an incomplete draft of the strategic plan is available today, it is difficult to see how this will support and integrate with next year's service plan, which is due before the end of January 1999.

(v) Structure & Process for Planning

The process for strategic planning is inadequate. Roles and responsibilities are not clearly defined (there is a Board committee, a work group, the CEO the Director of Organisation Development & Education who are involved). The guidelines for the development of the strategy are not clear. Objectives need to be set within the constraints of available funding and the real needs of patients in the area served by the Hospital. A mechanism for prioritising these needs must be established. There is insufficient detail regarding revenue and cost implications. There are inadequate controls and performance measures for the process. Key to the success of any strategic planning process is the requirement to develop operational responses to deliver the strategy. We would have concerns that the current process will lead to

unrealistic expectations, which in the long term could cause increased conflict in a battle for limited resources.

(vi) Strategy & Finance not linked

Given the current circumstances, it is inconceivable that the strategic plan is being developed without an assessment of the financial implications of the strategy. We have been assured that this will happen. The Director of Finance should play a central role in the strategic planning process, to ensure plans are realistic in relation to available resources.

(vii) Implementation Planning

Implementation planning for the strategy is the more difficult aspect of the strategic planning process. It is evident that considerable planning effort went into the move from the base hospitals to Tallaght. However it is unclear if there is a sufficient project management discipline to ensure plans are implemented on schedule. Generally, management are tied up with day to day operation. There is no evidence of a structured follow up of the CSF plans in the management team meetings.

(viii) Change Management

We are of the view that the change management process was not effective, and that this adversely affected aspects of planning the move, the merger and the implementation of new systems and procedures at the Hospital.

3.5 PERFORMANCE MEASUREMENT

3.5.1 BACKGROUND

Integrated enterprise wide management processes of the type described above are required for an organisation to meet its objectives. Frequently, organisations fail to consistently achieve their desired results not as a result of inadequate planning but because of deficiencies in management. Management failure frequently occurs because processes are not integrated and managers do not understand how their actions effect planned results and corporate objectives. Managers often do not have formal mechanisms to link their goals and programs to operational processes and results. Measuring performance is central to achieving this objective.

Performance measurement is specifically required by the Letter of Determination, which requires that “a comprehensive set of performance indicators” be included in the service plan, which should reflect the indicators in use, or proposed to be used by the relevant agency.

We believe it is the objective of AMINCH to establish and maintain an integrated enterprise management process along the lines described already.

We have considered the performance management dimension of the management process under three headings:

- Information
- Control
- Measurement

INFORMATION

Information is a currency of the management accountability process. Information should be relevant, timely and sufficiently accurate to provide reasonable support for management decision making and action

There are a number of areas in which the provision of accurate, regular, and timely information has been lacking in AMINCH in the period since the move. Furthermore, managers are not sufficiently used to specifying information requirements, nor using information to manage. The AMINCH management team needs to define the set of information it requires for decision making. This set will include a combination of financial and non-financial information. The requirements of managers need to be clearly identified and the information systems put in place to meet these requirements.

The performance measurement systems used up to 21 June 1998, the date of the move, were those in operation in the base hospitals. At the time the new Hospital opened, new systems in Patients Management and Materials Management were implemented. The payroll/personnel systems from the base hospitals have continued to be used, and the financial system in use at AMINCH is one from the base hospitals.

There have been delays in getting reliable activity data to managers, principally because of difficulties with the use of the new Patient Information Management Systems. Reliable activity data using the PIMS system was not produced until late September, but is now produced on a daily, weekly and monthly basis. The provision of relevant activity data to managers on a timely basis is essential.

The Materials Management system, whilst not yet integrated with the General Ledger, has been used to produce reports on consumables usage since the move. It provides the capability to report at various levels of the organisation, for example programme, directorate, or specialty level if required. These systems, however, do not currently operate as part of an integrated information systems environment, but will do so when the remaining financial applications are implemented.

The personnel/payroll systems in use since the move continue to be the three separate systems taken from the base hospitals (each in itself is an integrated personnel and payroll system) The personnel system has not been updated to reflect staffing at service/department level at the Hospital. The three separate financial systems from the base hospitals were used to produce the June and July 1998 management accounts. These continued to be used because of the late implementation of the materials management system, because of the deficiencies in personnel systems, and to ensure continuity in areas such as accounts payable and receivable. These systems are not integrated with one another, nor is the General Ledger system integrated with either the new PIMS or Material Management systems mentioned above. The systems and procedures used in the base hospitals were also different, a further complicating factor. We have been informed that the full financial system including the new General Ledger system, already acquired, is now planned to be implemented by management by January 1999. A coding system for materials management compatible with the new General Ledger has already been implemented. We understand that no plan regarding implementation of the financial systems in this timeframe has been put to the IS/IT Steering Committee.

Payroll costs represent circa 70% of healthcare agency costs; AMINCH is no different. There are complexities in the health service in managing pay, such as those associated with multiple shift types, multiple pay rates, variations in hours and agency staffing. The Hospital's current system does not meet management's needs in providing WTE analysis by cost centre. This has been known for some time, but not addressed. The personnel system is discussed in greater detail in Section 8.5 of this report.

The personnel systems are not integrated and present difficulties in preparing key manpower data such as:

- Number of staff by grade by department
- Number of staff by contract type etc
- Overtime by staff
- Absenteeism by Staff

The Hospital has recently carried out a review of the utility of the 1995 decision to purchase the Perfast system, its personnel system.

The position described above is unsatisfactory and has resulted in an environment in which the pay cost of the Hospital is not being actively managed and controlled by the management team. However complex some of the pay variables may be, they are capable of being managed. The deficiencies were particularly exposed in the period immediately prior to and after the move. Whatever the system difficulties, it is inconceivable that an organisation whose costs are primarily payroll cannot readily determine its staff complement, assess the impact of joiners and leavers or temporary staff. It is clear from Resource Committee Meetings and management meetings that this information has been requested frequently, though it has not been delivered. This can only represent a serious failing on the part of the management, and the Human Resources department in particular, to provide such information. It is not a difficult exercise to carry out a census and to set up a database of the results. Once the base line figure is established, controlling starters and leavers on a weekly basis is a relatively simple exercise. It is clear however that adequate controls were not in place to manage the Hospital's pay costs, in terms of controlling increases in staff (particularly relative to the Hospital's own service plan) and overtime payments.

On a general level, we are of the view that, within AMINCH, there are deficiencies in the provision of relevant, timely and accurate information to managers. It is true that some of these are being resolved. Because of the deficiencies in the provision and use of information, individual Portfolio Directors are not held accountable, and some are inexperienced managers and as such do not understand or have a need for information that allows them to effectively manage their portfolios. The information which is provided is of limited use to portfolio directors in controlling their pay and costs, because they do not own budgets for their respective portfolios.

CONTROL

Management information is used in two fundamentally different ways:

- To control business activities
- To measure performance segments in order to better understand the performance of the overall business.

In conceptual terms it is important to recognise the difference between control and measurement but that both are important in providing information for the management of the enterprise. The purpose of control is to ensure the achievement of results and to identify situations where expected results may differ from actual results. Control processes are normally initiated after actual results as reported vary significantly from plans and forecasts. The principal objective of control is to make the enterprise's financial performance predictable. Therefore, control forms an important element of the overall management framework. However, it does not provide a mechanism to fully assess the effectiveness with which the enterprise is being managed.

The Hospital suffered from inadequate controls in a number of areas including in the immediate aftermath of the move, as evidenced by:

- Staff numbers were inadequately controlled, as was the process of releasing commissioning staff after the move.

- Significant levels of overtime were incurred without the appropriate level of prior approval.

- Material levels of expenditure were incurred by AMINCH in respect of building alterations and equipping in July and August 1998. These orders were processed outside the materials management function.

- There was a lack of clarity on precisely what service contracts had been signed on behalf of the Hospital, and what their financial implications were.

- Because the patient administration system was by default implemented to treated all inpatients as public patients and due to the lack of appropriate procedures being put in place, no private patients were recognised in the Hospital for a period of approximately five weeks after the opening, with the result that income relating to private patients was not recorded. Procedures have changed to avoid a recurrence of the problem, and the Hospital is seeking to recover the income concerned.

In a memorandum to all members of the management team on 21 September, the Director Finance reiterated a number of financial policies and procedures to be applied in the Hospital. This memorandum was issued in view of his concern that these procedures were being ignored or because certain staff may have, for whatever reason, believed them to have changed. Given the circumstances, it is understandable that he would want to do this. Cost control will however only be fully effective when a devolved budgetary control mechanism is implemented, where budget holders are made accountable for controlling their respective budgets.

While it appears that an attempt has been made to tighten financial control procedures**,** it is now important that:

- A review be carried out of internal control procedures in the Hospital to assess their adequacy and operation in the new environment.

- A financial procedures manual be drawn up.

- The current vacancy in the Internal Audit function be filled as soon as possible, and a comprehensive programme of internal audit work be drawn up. We would expect this programme to address not only financial controls and systems, but also performance measurement and value for money issues.

- Staff briefings take place on the manner in which financial control procedures are to apply in the new Hospital.

PERFORMANCE MEASUREMENT

Measurement is essential for gaining insight into how different aspects or dimensions of an enterprise are operating (such as programmes, directorates or specialties) that may be difficult to influence or control directly. Measurement is an informative rather than controlling

activity; accuracy is a key issue in this area. Measurements not only provides snap shots of a point in time, they also provide a view of changes and trends over time.

AMINCH has been reporting performance measures to the DOH&C in the format required under the Information Monitoring Report (IMR). These reports have not always been submitted on a timely basis and DOH&C stated that they were not always accurate or complete.

The management team in AMINCH does not have the set of information it requires to make reliable key business decisions. The existing management information systems are an assembly of systems commissioned for the new Hospital and others brought from the base hospitals. These systems are not integrated and reflect requirements specified by different managers at different points in time. The information available, although voluminous lacks an overall conceptual framework and is not action oriented. With increasing organisational complexity, the data and information collected by the old systems do not address managers needs. Management information is now required to provide financial information for strategic business units, key programmes, major patient groups and critical business functions in addition to the tradition departmental and operational dimensions.

It was recognised at the management retreat in April 1997, that there was a need for improved performance measurement. It formed one of the CSF's; it has not yet been delivered.

CORE ISSUES

(i) Processes are not integrated

Processes are not integrated and managers do not understand how their actions effect planned results and corporate objectives.

(ii) Accountability

Individual Portfolio Directors who comprise the Management Team are not held accountable.

(iii) Information

Within AMINCH there is a requirement for relevant, timely and accurate information.

(iv) Manpower information

It is extremely surprising that a process has not been put in place to allow control of manpower within each department. We have been advised that the software supplier of the personnel/payroll system was requested to merge the three systems as far back as December 1997/January 1998. This exercise was not carried out. We recognise that the three separate payrolls had different coding structures, which is a complication, but not a reason why, now nine months later, there is no one system in the Hospital to determine numbers of staff by grade, by contract type, by department. It is not possible to readily identify those staff taken on for commissioning or task force purposes. This is a major failing of the management team and in particular the HR department.

(v) Performance Measurement

Performance Measurement is limited, though plans to develop it exist.

(vi) Financial Systems

The existing management information systems are an assembly of sub systems that have been developed at different points in time by different managers. A modern integrated financial system is specified in the ISIT strategy, was acquired in October 1996, but has not yet been implemented with the exception of the materials management system. Implementation is scheduled for January 1999.

3.6 ACCOUNTABILITY PROCESS INCLUDING BUDGETARY CONTROL

3.6.1 Background

The Letter of Determination states clearly that the DOH&C intends to apply the terms of the Health (Amendment) (No 3)Act 1996 (commonly referred to as "the Accountability Legislation") in an administrative way to voluntary agencies such as AMINCH. The legislation applies to members of Health Boards and their Chief Executive Officers. The issue of accountability is central to this legislation, and includes provisions to plan within Determination, and monitor expenditure to ensure that it does not exceed the amount set in the Determination. In our view, the application of this legislation to voluntary agencies, even in an administrative sense, places clear responsibility on Boards and CEO's of agencies, such as AMINCH, to be accountable for public funds.

At management level, a major element of accountability concerns adherence to the Hospital's budget. This in turn should be consistent with the financial plan included in the service plan. A comprehensive budgetary control system is required to achieve this.

Budgetary Control is an essential element in planning and measuring financial performance, in initiating corrective action, and assigning responsibility and accountability for performance to departments and managers in an organisation.

1998 was the first year a consolidated budget was prepared for the Hospital. This budget reflected the operation of the three base hospitals until 21 June 1998, the date of opening of the new Hospital, and the operations of the new Hospital for the remainder of the year. The budget for the year is set out in the Hospital's service plan of 9 April 1998. This reflects a projected net expenditure of IR£59.5m, some IR£5.9m in excess of the amount provided in the Letter of Determination. The Hospital has based its plan on providing the same level and scope of clinical services as in the base hospitals, which it regards as an entitlement deriving directly from Clause 5(a) of the Charter, set out in Section 2.2 of this report.

Based on our discussions with Hospital management, it is evident that the budgetary control systems and the financial systems to support them, in the base hospitals were centralised, a not uncommon feature of smaller organisations in the health sector. Budgets were set for the hospital as a whole and were managed at a high level in the organisation, primarily by the Secretary Manager and the Financial Controller of the base hospital. In general, managers were not accustomed to having specific budget responsibilities, nor the associated accountability for management against budget.

Based on the process for the preparation and management of the 1998 budget, the budgetary control systems in place in the new Hospital suffer from a number of significant deficiencies.

(i) Budgets are set for the Hospital as a whole and have not been broken into appropriate service/departmental cost centres. Given that the move had yet to happen and the organisation structure had yet to be finalised, we recognise that there were some practical difficulties in budget segregation in 1998. However, for future years, it will

not be possible to operate and manage a budget centrally for an organisation as large as the new Hospital. The financial systems selected in 1996 and being implemented will support, as planned, the devolution of budgets to managers.

(ii) Budget setting is carried out centrally for the Hospital as a whole, primarily by the Director of Finance, with limited input only from senior managers in the Hospital. The Director of Finance did develop a strategy for the preparation of a detailed 1998 budget at individual directorate level, which was intended to involve Departmental managers in its preparation. Implementation of this strategy was not effective.

(iii) Managers throughout the Hospital are not involved in a budget setting process, and do not hold budgets for their portfolios or areas of responsibility. This applies at all levels of senior and middle management, and across clinical and non-clinical areas.

Because of this lack of budget holding responsibility, there is a lack of awareness throughout the organisation of the financial implications of spending decisions. Furthermore, no formal process exists to make managers accountable for the financial implications of decisions they are making.

3.6.2 CORE ISSUES

The centralised and relatively basic budgetary control system, which operates in the new Hospital, is inadequate. A budgetary control system is required which:

(i) Assigns responsibility and accountability for the achievement of certain objectives to specific departmental cost centres. It is essential that the Hospital develop a comprehensive budgetary control system, which divides the overall budget for the Hospital into an appropriate and sufficiently detailed number of individual cost centres. This will enable the performance of individual budget holders to be evaluated against budget on a monthly basis, thus ensuring a match of responsibility and accountability within the management structure of the Hospital. In addition to this, a structured approach to variance reporting and analysis is required to ensure, as a matter of routine, that variances above a given materiality level are critically examined.

(ii) Involves budget holders in the budget setting process within overall financial parameters. This will assist in increasing the awareness of the importance of managing and controlling expenditure at lower levels of the Hospital, and should improve the capacity of the senior management team to manage the Hospital budget in overall terms within Determination.

(iii) Properly profiles the annual budget on a monthly basis to reflect any seasonal changes in activity/service provision. A build up of experience of activity levels/service requirements in the new environment in Tallaght will be required over a period of years.

(iv) Develops the annual budget within the context of the medium term financial plans for the Hospital.

(v) In time, forms part of an activity based management system i.e. one which provides integrated financial and service/activity information. Budgets will be drawn up having regard to both financial and activity drivers i.e. activity based budgets.

(vi) Ensure the budgets are finalised on a timely basis in advance of the commencement of the financial year to which they relate. This was not achieved in 1998 for reasons

associated with the opening of the new Hospital and related exceptional circumstances, but is something which should be achieved in the future. This should enable the Hospital to better plan its activities in line with the Determination from the DOH&C.

A significant amount work will need to be done to develop a budgetary control system in line with the above criteria. In particular, care will be required to ensure that the structure of the budgetary control system is consistent with the management structure of the Hospital, and is segmented into appropriate cost centres and sub-cost centres.

We are aware that the Hospital intends to introduce a programme structure in the future. This structure is a way of empowering clinical directorates to manage and make decisions at the closest point to the patient, with the overall objective of improving patient care. The greater devolution of decision making responsibility to clinicians within the programme structure will require major changes in the structure and operation of budgetary control systems, to ensure that financial accountability is appropriately assigned to clinical directorates. Great care will be required in the development of appropriate budget structures as the Hospital moves towards a programme structure of management. It will be particularly necessary to ensure that those involved in clinical areas obtain the necessary training in the discipline of budgetary control, in the interpretation and use of financial information, and that there is a full recognition within clinical directorates of the prime responsibility to manage their activities within a given financial budget.

3.7 COSTING

Costing is under-developed in the Hospital. Management have pointed out that a Service Planning Unit was in place in the Meath Hospital which had commenced work on an Activity Based Costing initiative, but that this unit had to be closed because of funding constraints. DOH&C stated that this unit was intended to be self financing based on submissions received from the hospital. It is important that the Hospital develops its systems to provide costing information at various levels, for example in relation to departments, specialities, clinicians, procedures etc. We recognise that information systems will need to be developed and integrated to support the creation of a sophisticated costing environment, and this will take time; it is however important that in a modern hospital of this type, there is a clear objective to develop appropriate activity based management systems. In particular, we believe that a focus on activity based costing will bring enhancements in the areas of:

- budgeting and control;
- cost analysis and reduction;
- performance measurement;
- understanding cost behaviour;

Activity based costing will also enable the Hospital to better understand the relationships between activity and financial data and will enhance accountability for decision making at budget holder level.

3.8 INFORMATION SYSTEMS

3.8.1 BACKGROUND

IT support, both systems and people, was provided to the base hospitals by the FDVH.

As early as 1994, an ISIT Steering Committee was established within the TRHB to oversee the development and implementation of the IT programme for the Hospital. Responsibility for the Committee passed to AMINCH in early 1997. In line with planning for the new Hospital, an Information Systems Assessment was carried out in the base hospitals in 1995 with assistance from Ernst & Young. This exercise and the ensuing development of an IS/IT strategy by early 1996 were commissioned by the FDVH on behalf of the TRHB. On completion of the strategy study, a detailed evaluation and selection process was undertaken to identify "best of breed" systems for the new Hospital. Once this process was complete, an IT budget was drawn up, and the DOH&C committed to provide a IR£4m capital budget towards IT developments in the new Hospital. An IT Manager has been in place since early 1996 to implement the systems.

Some of the findings of the initial assessment are set out below:

- The SMS Financials were are not acceptable to users
    - The main reasons for this are their inflexibility, lack of suitable reporting facilities and the cumbersome interface which they present.
- The SMS PAS (Patient Administration System) was generally not acceptable to users due to the lack of an effective interface with other applications.
- The lack of integration of applications was a serious problem.
- The lack of report generation facilities was a general problem.
- Documentation of applications was poor throughout.
- The range of data stores was extensive.
- Data stores were not integrated. This leads to several problems including the following.
    - Data is not current in some data sources e.g. patient demographics.
    - The integrity of data across systems is impossible to determine.
    - The redundancy inherent in storing data in more than one location.

The findings of the study clearly indicated the need to replace the existing Patient Master Index (PMI), Patient Management Systems (i.e. ADT, OPD, Waiting List and Chart Tracking), Accident & Emergency System and Financial suite, including Supplies Management. The need for the integration of systems, which would reduce duplication and ensure consistency, was also highlighted. The strategy was finalised in early 1996 and its implementation was overseen by a steering committee chaired by the chairman of the Board of the FDVH.

The study indicated user satisfaction with certain departmental systems e.g. Pharmacy and Radiology. It was proposed to move these systems to the new hospital in the interim. The longer term viability of these systems and their ability to interface with the PMI and Order Communications system were to be investigated as a separate project.

The study also identified that the new hospital would be providing Laboratory services in-house and as such a computerised laboratory system would be required. The need for Order Communication as a further development was identified. It was proposed to introduce Order Communications for Laboratory service in phase one of the plan. Standard office systems were also to be provided for the new hospital. An exploration of the feasibility of a hospital wide electronic mail system was also to be undertaken in phase one.

The main areas covered by the first phase of the strategy were:

- Patient Information Management Systems (PIMS)
- Enhancements to the A&E system purchased for Tallaght but also installed in the Meath and National Children's Hospital, with registrations taking place on the PIMS system, because of urgent requirements in those hospitals.
- Radiology systems with links to Patient Master Index and PACS
- PACS, the first hospital wide Picture Archiving & Communications System implemented in Ireland
- Laboratory systems to manage test results, again linked to the Patient Master Index and with plans to link to the Order Communication Module (OCM)
- Materials Management Systems
- Financial Management Systems
- Order Communication Module

Key to this strategy was the requirement to effectively interface all these systems in order to allow a "once and once only collection of patient information". The initial project plan looked at an implementation in 1997 in line with the projected opening date of the hospital. Detailed project plans and charters were set out for each element of the ISIT programme. These plans included change management and identification of risks. There was extensive consultation with user groups during this process, but at the time of developing the strategy the management team would not have been in place.

The proposed Financial Systems were to be integrated and capable of interfacing to the Payroll and Patient Billing systems. Some of the key issues associated with this project were identified as follows:

- The Financial Systems must be flexible enough to support the accounting practices envisaged for the new hospital.

- The Financial Systems and Supplies System must be completely integrated, the links between the Supplies, Creditors and General Ledger Systems being of particular importance.

- The Systems must be capable of providing meaningful standard and ad-hoc reports.

- The ability of the Financial and Supplies Systems to integrate with the Order Communications, Patient Management Systems and Payroll System is important to the success of the Information Systems Strategy.

The time scale allowed to specify, select and implement the Financial, Supplies and Office Systems was short (this assumed an opening date for the Hospital of August 1997). It was critical that the implementation plan be strictly adhered to, if these systems were to be in place for the opening of the Hospital. A number of factors were determined as critical to the success of this project, including availability of the project team from Jan 1996, and Management sponsorship and commitment. Despite the delay in opening the Hospital until June 1998, implementation of systems has not been fully achieved.

PROJECT TIMING

An overview of the project timing is set out below:

(i) Specify the requirements for the new Financial and Supplies Management Systems by 31 May 1996.

(ii) Specify the requirements for interfacing to the Order Communications system, Patient Management Systems, Payroll System and other relevant departmental systems by 31 May 1996.

(iii) Select packages based on the above requirements by 27 Sept. 1996.

(iv) Install the Financial Systems in conference room pilot by 25 Nov. 1996.

(v) Install the Supplies Management System in conference room pilot by 6 Jan. 1997.

(vi) Design a communications plan and change management approach by 11 Apr. 1997.

(vii) Install the packages and implement the new processes by Hospital August 1997, the then planned opening day.

IMPLEMENTATION

Implementation of systems has been undertaken progressively over the past 18 months or so. By opening, the following systems had been implemented:

- Patient Information Management system
- A&E System
- Radiology systems linked to Patient Master Index and PACS
- PACS
- Materials Management
- Laboratory information system
- Pharmacy

Major system integration was achieved in the implementation of these systems. An integrated engine to ensure the linking of all other systems had been implemented by opening date. The systems not fully implemented at opening were the financial systems and order communications.

The need to implement an integrated financial management system was identified in the planning stage. However, to date, important aspects of the plan, including the implementation of the new General Ledger system, have not been implemented. Whilst the new Materials Management system (Cedar Data), is operational, it does so on a stand alone basis. The Creditors system being used is the SMS system from the base hospitals. The General Ledger system is Pegasus, again from the base hospitals. None of these three systems are integrated, with the result that duplication of effort in inputting data to the systems arises.

The principal reasons given for the fact that the original plan to have the new financial systems implemented at opening has not been met are as follows:

- Cost centres could not be decided until bed allocations were agreed in May 1998.
- Inadequacies in personnel system, which were not updated to reflect staffing arrangements in the new Hospital. The three base hospital systems have continued in use, with staff being coded and designated as in the base entities.
- The final batch of PIMS was not delivered until May 1998.
- Delays in the final implementation of the materials management system.

The delay in the implementation of materials management system was a major reason for the inability to implement the new financial system in full by opening date. Up until February 1998, Materials Management was the responsibility of the Director of Environmental Services. From October 1997, the Purchasing and Materials Manager, whose prime responsibility had been to set up an operational integrated materials management system, had become seconded to the TRHB because of the heavy workload in ordering equipment and other equipping matters for the Hospital. This reflected the fact that at that stage he was reporting to the Director of Environmental Services who was also Project Director of the TRHB. By late 1997, the Purchasing and Materials Manager had raised concerns about the slippage in the schedule for materials management. In January 1998, he again raised concerns with the Director of Human Resources regarding the delayed recruitment of suitably qualified staff for the function, and sought temporary staff for immediate engagement to progress work in the materials management function. Some temporary staff were subsequently provided.

In February 1998, discussions with the DOH&C were ongoing on the appropriate numbers and grading of staff in the function. On 19 March 1998, the Purchasing and Materials Manager wrote to the Director of Finance (who had recently taken over responsibility for materials management) indicating that the biggest difficulty he was having was the lack of resources and the lack of agreement from the DOH&C on staff structure in the function. He indicated that the "plans for implementing an integrated Materials Management Structure within the timescales drawn up are not on line" and that there remained a "considerable amount of work to be undertaken to have Materials Management ready for opening". The DOH&C stated that by the end of January 1998, approval had been given for five key positions in Materials Management in addition to the existing 13 positions in the base hospitals. However, it had considerable difficulty with the aggregate number (30) and grading levels sought by the hospital for the function. The DOH&C informed the hospital by fax on 8 April 1998 that the overall level of staffing should not exceed 22 posts and outlined its views on the organisational structure. DOH&C received a response to this fax on 17 June 1998 indicating a revised total of 27 posts for the function. The DOH&C confirmed in writing on 23 June 1998 its approval for a structure, which totalled 22 posts. The DOH&C confirmed that it was not prepared to approve an increased ceiling or additional funding as it believes that scope exists to redeploy staff into the function.

There were also difficulties in inputting all the required product details onto the Materials Management system because of the relatively short period of time between the stores area of the Hospital becoming available and the opening of the Hospital. Product/pricing data was downloaded from the Meath Hospital (used as the base hospital for this purpose) to ease the backlog. These prices had to be verified as they were not all up to date, and all products for the laboratory had to be set up ab initio and as such no facility existed in the base hospitals.

The result of the above was that the Materials Management function was in place with approximately 30% of products entered just in time for opening. However, because it had not been tested sufficiently prior to going live, particularly as regards its integrity as a direct source of postings to an integrated General Ledger, the Director of Finance was of the

opinion that it would neither be correct or prudent to use the materials management system as a direct posting medium in these circumstances, until he was assured of the completeness and accuracy of data from the Materials Management function. He decided to defer the implementation of the full new financial system until the materials management system was operating satisfactorily. In the circumstances, it is difficult to question this decision; the situation would be considerably worse if financial information for the Hospital was not available or deficient, and the current difficulties had not been identified. At least, even using a financial system from the base hospitals, the Hospital has been able to produce monthly management accounts on a timely basis. However, to meet the information needs of a large hospital and to support devolved decision making, the new financial system needs to be implemented as soon as possible.

We understand the materials management system is now operating satisfactorily and that implementation of the financial systems will now be undertaken by January 1999. The Director of Finance plans to parallel run the new system over the coming months. A key matter which requires to be resolved is the updating of the personnel/payroll system to reflect current staffing locations in the Hospital, and the subsequent interfacing of the personnel/payroll system with the General ledger.

It is not clear why the project plan for materials management and financial systems implementation were not progressed in accordance with the planned project timing during 1997. Whatever the reason, the implementation of these systems was not being sufficiently driven in this year, with the result that by the end of 1997 a significant amount of work remained outstanding. In 1998, the delays were exacerbated by the delayed implementation of materials management, and the knock on effect on the financial systems. It is not clear that the project plan for implementation of these systems was systematically revised to take account of the delays, and to establish new target dates. Furthermore, it is clear that the information on financial systems implementation being presented to the ISIT Steering Committee indicated, even in the weeks prior to opening, that these systems were on schedule to be implemented in advance of opening date. This is significantly at variance with the reality of what was happening on the ground.

3.8.2 CORE ISSUES

Many of the information system issues have been referred to already in the previous sections. To summarise:

- Lack of timely information for decision making and control. Information requirements of users need to be defined.
- The time delay in the opening of the Hospital, and in implementing systems. This has meant that ISIT commissioning resources have been in place considerably longer than planned.
- Delays in the implementation of the financial systems, now planned for January 1999. This is at variance with information being given to the ISIT Committee that implementation was on schedule.
- Initial difficulties in the use of new systems, particularly in the use of the PIMS system. Inadequate staff training may account for part of the difficulty here; a lack of operational policies in respect of the new systems has also been a contributory factor.

- The running of three separate personnel/payroll systems. The Hospital is also currently running a series of stand alone systems for General Ledger, Creditors, payroll and Materials Management. The PIMS system also operates in isolation of the present financial systems. It is not possible to exercise effective financial management

in this environment. Implementation of the new integrated financial system is urgently required.

3.9 OVERALL CONCLUSIONS & RECOMMENDATIONS

PROCESSES

The Management reporting and control systems and processes in AMINCH need to be enhanced to meet the requirements for effective business management and decision making**. In our view, the requirements could have been identified at an earlier stage, and had this aspect of the merger been better planned, the development and implementation of the type of management reporting and control environment required in the Hospital could have been further advanced by this stage. The delayed implementation of financial systems, and lack of integration of the current systems, are barriers to progress here.**

As a matter of urgency, the Hospital's requirements in respect of management reporting and control need to be carefully defined. Thereafter it is necessary to ensure that the systems meet these requirements, and a comprehensive strategy for implementation needs to be developed, with practical and detailed implementation action plans. For the overall management process to be effective, it is essential that accountability for performance is clearly assigned and that there are benchmarks against which performance can be evaluated. Individual management team members are currently not held accountable for their respective portfolios.

Limited strategic planning has been carried out to date. **A strategic plan is necessary to give direction to the organisation. The planning process must be rigorous and co-ordinated and must involve a significant input from the Director of Finance.** We believe that the 1999 Service plan should in fact be the operating plan of the first year of a rolling 3-5 yr. strategic plan.

It is important that management reporting and control processes are integrated so that the managers understand how their actions affect planned results and corporate objectives. Manpower planning and reporting is a key element of this. Given the significance of payroll costs to the organisation it is of major concern that a process has not been put in place to allow control of manpower within each department. There are no systems in place to determine numbers of staff by grade, by contract type, by department. It is impossible to identify those staff taken on for commissioning or task force purposes. This is a major failing of the management team and in particular the HR department. **It is vital that one personnel/payroll system is put in place for the Hospital, and that procedures are established to manage payroll costs on a timely basis, covering recruitment, temporary staff control, overtime and other allowances.**

The budgetary control system in operation in the Hospital is underdeveloped and inappropriate for such a complex and large organisation. **A devolved budgetary control system needs to be developed and implemented. It is essential that managers throughout the Hospital are more closely involved in the budget setting process, and that they take ownership of budgets. This process needs to be implemented urgently.**

We recognise that the structure of the budget and responsibility for management of budgets will change as and when the programme structure is implemented. This may take some years to develop and implement. Under no circumstances should the necessary changes in the requirements for the budgetary control system in the Hospital be deferred until that programme structure is implemented.

Activity based costing is also required to enable the Hospital to better understand the relationships between activity and financial data and to enhance accountability for decision making at budget holder level.

MANAGEMENT ORGANISATION

The committee structure reflects certain elements of the Charter, and requires significant commitment from voluntary board members. In our view, the committees have been too greatly focussed on operational matters, most of which should be handled by the management team. This approach originates in the base hospitals where governance and management were inextricably linked at Board level. In a Hospital as large and as complex as Tallaght, it is essential that the Board and its committees are structured to focus on strategic and policy matters. **As such, there is a need to clearly define the roles and responsibilities of the Board, its Committees, the CEO and his management team.** In conjunction with this the relationships between these newly defined roles and the DOH&C needs to be clearly defined.

The current management team is transitionary, and whilst there is an overall objective to move to a programme structure of management, there are a number of issues relating to the management team and its effectiveness. The team with 10 members is much too large. The appointment of a Director of Operations/Deputy CEO reporting directly to the CEO would help reduce the span of control. **An organisation study at senior management level is required to define more precisely the organisation structure and reporting relationships to the CEO. This study will need to take into account the planned move to a programme structure.**

The senior management group is not operating effectively as a team at present. Communication between team members is formal and bureaucratic; the interaction at the lengthy weekly management team meetings is ineffective. The individual team members are clearly committed to the organisation, but many lack the management training required to manage in the new environment. **Practical management training needs to be made available to the management team as required.**

Within the management team the decision making process is cumbersome and ineffective. Managers have limited information on which to make decisions. The CEO has encouraged a consensus approach to decision making. This style of openness and participation should be maintained but in a structure, which empowers managers to be accountable and make decisions in their areas of responsibility. **A crisper decision making structure, with clear accountability is needed.**

The delayed implementation of integrated financial systems and the lack of a single personnel/payroll system has greatly hindered the ability of the management team to take effective decisions. **It is essential that the new financial system, is implemented in the new Hospital to ensure the provision of reliable and meaningful information to managers throughout the organisation on a timely basis. In addition the consolidation of the personnel/payroll systems into one is critical. It is important that any systems implemented are integrated with other core systems.**

SECTION 4
THE 1998 SERVICE PLAN

4.1 INTRODUCTION

In this section, we review the AMINCH Service Plan for 1998. The section includes a summary of the Letter of Determination from the DOH&C, a chronology of relevant events in relation to this service plan, and a review of the constituent elements of the plan as submitted to the DOH&C on 8 April 1998.

The service plan covers the period of the move of the hospitals to Tallaght, and the continuing merger of the base hospitals. As far as AMINCH was concerned, it was prepared in the context of its understanding of Clause 5(a) of the Charter, which, as outlined in Section 3.6.1 above, it interpreted as giving it an entitlement to carry on the same level and type of services as in the base hospitals.

4.2 LETTER OF DETERMINATION

The DOH&C advised the CEO of their Determination of health expenditure for 1998 for AMINCH in a letter of 4 December 1997. The letter advised that the approved expenditure level for 1998 in respect of non-capital expenditure (i.e. gross expenditure less minor income) determined for AMINCH was IR£53.659m. A detailed breakdown of this determination is included in Appendix I and is summarised below.

	IR£m
Revised allocation for 1997	49.973
Less once-off funding for 1997	(2.813)
Adjustments for 1998	2.499
Developments for 1998	4.000
Determination of net health expenditure	53.659

The once-off funding for 1997 relates primarily to payments made by the DOH&C to the Meath Hospital of IR£1.3m and to the Tallaght Hospital project of IR£0.9m. AMINCH has indicated to us that the payment to the Meath hospital was required to deal with service pressures, and contends that this reflected an underfunding being carried from 1993, and that as a consequence these amounts should have been carried forward into the 1998 base allocation. The DOH&C has stated that, in their view, the deficit arose because services over approved levels were undertaken; their decision to provide this funding was to avoid having a deficit carried forward into 1998, the year of the move.

The adjustments for 1998 of IR£2.499m relate principally to Partnership 2000 and other payroll increments, nurse education, waiting lists initiative payments and inflation.

An additional amount of IR£4m was provided towards "the costs of essential developments related to the integration of the services in the base hospitals in advance of the opening of the new hospital at Tallaght, to the transfer of services, and the anticipated additional costs arising subsequent to the opening of the hospital". In particular, this funding was designed to

meet "additional staffing and related transitional costs, including approved consultant posts and pathology laboratory staffing." The base level of funding from 1997 already included IR£1.9m in respect of these matters, which was carried forward into 1998, bringing the total funding available for these matters to IR£5.8m.

In their Letter of Determination, the DOH&C stated that whilst the Health (Amendment) (No.3) Act 1996 does not apply to AMINCH, it intended in an administrative way to apply any terms of the legislation that are relevant in the DOH&C's dealings with the agency. In this regard, relevant sections would include:

Section 6 – which requires the relevant agency to adopt the service plan specifying the services to be provided by it within the financial limits determined by the Minister within a period of 21 to 42 days of receipt of their determination.

Section 7 – which requires members of the Board to monitor expenditure to ensure that it does not exceed the amounts set by the Minister.

Section 9 – which requires the Chief Executive Officer to ensure that the net expenditure and indebtedness do not exceed the amounts determined by the Minister. Where the Chief Executive Officer forms an opinion that a decision or a proposed decision of the Board will result in net expenditure or indebtedness exceeding the amounts so determined, he or she is required to inform the Minister and the Board.

Section 10 – which provides that if expenditure is greater than authorised in any year, the excess expenditure becomes a first charge on the following year's determination.

Section 11 – which requires the adoption of annual financial statements on or before the 1 April in the year following the year to which they relate (this assumes a 31 December year end).

Section 15 – which requires the preparation and publication of an annual report.

The Letter of Determination also made clear a number of important changes which have been introduced in relation to the Government's estimates and budget procedures. The determination letter stipulated that estimates were now being prepared and considered on a multi-annual basis. The budget cycle now changed to the Autumn will enable the DOH&C and Health Agencies plan more effectively for the future.

The letter indicated that the DOH&C would in the normal course endeavour to incorporate all aspects of approved expenditure in the initial Letter of Determination. The letter specifically drew attention to the policy which will apply from 1998 onwards in relation to supplementary funding and specified that supplementary estimates for the health services would only be granted on an exceptional basis in 1998 and in subsequent years. For 1998, the items that have been identified which may qualify for additional funding were demand led schemes (Health Boards only) superannuation, medical indemnity and PRSI.

THE LETTER OF DETERMINATION

- required that all of the categories of expenditure that have been the subject of supplementary funding in prior years must be provided by the agency in its service plan.

- drew attention to the Prompt Payment of Accounts Act 1997 which came into operation on 2 January 1998 and indicated that health agencies are required to adhere strictly to the terms of this legislation.

- specifically required the adoption and submission of a service plan to the DOH&C which would be the benchmark against which expenditure, output and progress would be assessed during the year. The letter indicated that it will be necessary to complete all matters relating to AMINCH service and financial plans no later than 42 days after the date of receipt of the Letter of Determination.

Section 7 of the Letter of Determination sets out criteria in respect of service plans, and states they should have the following characteristics:

- a clear and distinct statement of priority objectives having regard to the overall strategy of the relevant agency;

- a description of the appropriate quantification of the core level of services to be provided in the coming year having regard to the level of resources contained in the Determination;

- the shifts in services being brought about in the coming year as compared to current previous years;

- the resources (pay, and income) being allocated to various services in the coming year at an appropriate level aggregation;

- the amount of developments planned in 1998, the extent of those developments, the funding arrangements and the subsequent year costs of those developments;

- the extent to which service difficulties experienced in 1997 are catered for within the plans and the specific effects of any corrective measures;

- the arrangements for monitoring and management of the service plan on an ongoing basis. These include the reporting arrangements to the Chief Executive Officer, the Board of Management, arrangements for value for money, and those being developed to measure the impact of services and to improve customer service.

The letter of Determination stipulated that it was the responsibility of the agency to ensure that the amount of net expenditure did not exceed the amount of the Determination, and suggests that particular attention be given to the involvement of relevant senior professional staff in the development of the service plans and the agreement of target hospital outputs for 1998. As part of the service and financial plan, the Letter states that arrangements must be put in place to alert management at an early juncture to any departure from the plan and to instigate any necessary steps to immediately rectify the matter.

The Letter of Determination also requests that adequate provision for pay costs is made having regard to present and projected numbers employed. It emphasises that the attainment of better value for money through effective and efficient use of resources remains critical for all the Health Agencies.

4.3 CHRONOLOGY OF EVENTS

A Chronology of relevant events is set out below. It is based on correspondence, AMINCH Board and Board sub-committee minutes, and notes of meetings. The notes of meetings are from the separate files of the DOH&C and AMINCH, and as such do not represent minutes/notes agreed between the parties.

14 FEBRUARY 1997

Letter from the Secretary General of the Department to CEO of AMINCH

This letter was issued, following discussions in 1996, to provide guidance to the CEO and the Board of AMINCH on the parameters in relation to services, non capital funding and employment ceiling with respect to the first full year of operation at Tallaght. This letter indicated that with the exception of the new pathology laboratory and psychiatric unit, services and funding at Tallaght should be made available from the existing service and funding base of the constituent AMINCH hospitals. The letter indicated that the proposed full year approved level of expenditure for AMINCH would be IR£49.018m for 1998, calculated on the basis of the current approved levels of expenditure, and IR£2m for additional costs arising from the operation from the new site. The amount did not include the psychiatric unit and pathology services, and stated that the approved level of expenditure would be adjusted when these matters were agreed with the DOH&C. The amount of IR£49.018m also included IR£3.3m in respect of the FDVH (an entity whose responsibilities are to be assumed by AMINCH under the Charter).

The letter also indicated that new service needs arising from the new location in Tallaght would require either the redirecting of existing resources or prior agreement of additional funding with the funding agency, currently the DOH&C, and that funding in relation to proposed developments would, of necessity, normally be phased in over a number of years on a basis to be agreed between the Hospital and the DOH&C. The letter indicated a proposed employment ceiling of 1543.4 WTE posts, which included 11 posts approved in relation to pathology. It was acknowledged that the ceiling may fall to be adjusted when discussions on pathology and the psychiatric unit are finalised and approved by the Department.

The letter acknowledges that an incremental approach to service provision and funding was being adopted as being the most appropriate in the circumstances, and that any enhancements would be regarded as developmental, and thus would require Departmental agreement and approval.

28 AUGUST 1997

Letter from Chairman of AMINCH to Minister

This stated that the Board now considers it will be unable to open the hospital by the date planned, i.e. 24 January 1998.

12 SEPTEMBER 1997

Letter from DOH&C to AMINCH

This concerned the setting up of a meeting to discuss the financial situation in the Meath Hospital for 1997.

13 OCTOBER 1997

Letter from DOH&C to CEO of AMINCH

This letter referred to an earlier letter from the CEO of 25 August 1997 in which the DOH&C indicated that the first task of the Director of Finance would be to develop the commissioning budget and the first cut at the 1998/99 base budget. The letter indicated that as the DOH&C

were finalising its 1997 spending, it was essential that final details regarding 1997 be submitted, as well as "the additional 1998 revenue costs" without delay.

14 OCTOBER 1997

Letter from Minister to Chairman of AMINCH

Letter stated that he was concerned that the "new hospital should open as soon as possible. A massive investment of public funds has already taken place and the people of Tallaght and the catchment area deserve to avail of these facilities at the earliest opportunity" In the letter, the Minister expressed his concern that AMINCH might not be able to open all the hospital in 1998, and asked that a phased opening of the majority of services by the beginning of May 1998 be considered. He particularly asked that the St Loman's service be transferred as soon as possible.

14 OCTOBER 1997

Letter from Director of Finance AMINCH to DOH&C

This letter set out details of projected 1997 out turn for base hospitals, and details of additional statutory costs. The letter projected that a shortfall of IR£1.3m would arise in the Meath Hospital in 1997 after anticipated funding of IR£0.5m, primarily in relation to statutory costs. Tallaght related expenditure of IR£0.47m was also projected.

17 OCTOBER 1997

Letter from Director of Finance AMINCH to DOH&C

Further letter clarifying details of projected funding requirement for 1997 in the base hospitals.

23 OCTOBER 1997

Meeting between representatives of AMINCH and the DOH&C

This was a meeting to review progress on the project under a wide range of headings, principally focused on reasons for the delay in opening the hospital as scheduled on 24 January 1998. A document tabled at the meeting indicated an opening date of 1 August 1998. A representative of the DOH&C indicated that if the tabled document became known more widely in the DOH&C, the revenue earmarked for 1998 would disappear in 24 hours.

(extracts from DOH&C notes of meeting)

23 OCTOBER 1997

Letter from Chairman of AMINCH to Minister

This letter, in response to the Minister's letter of 14 October 1997, stated "on reviewing the current estimated timescales for the availability of basic crucial services such as Laboratory on site services, adequate OPD facilities, Radiology services, and a completed equipping programme, we do not anticipate being able to transfer the majority of our services until August 1998"

18 NOVEMBER 1997

Letter from DOH&C to Director of Human Resources of AMINCH

This letter concerned the staffing of the new hospital. It referred to an earlier letter of 10 September 1997 from the DOH&C to AMINCH which had stated that it would be "very difficult to proceed towards opening in the absence of an integrated overall manpower plan and on the basis of submissions which appear to take no account of the employment control ceiling" The letter went on to state that the DOH&C were seriously concerned that expectations at all levels of the hospital concerning employment at Tallaght were unrealistic. The letter ended with a request that an overall manpower plan be submitted without delay.

27 NOVEMBER 1997

Letter from Chairman of AMINCH to Minister

This letter informed the Minister that following an in-depth analysis by management of all issues related to the opening of the hospital, the Board has accepted the management team's recommendations to open the hospital on 21 June 1998.

1 DECEMBER 1997

Letter from Director of Finance of AMINCH to Finance Unit of DOH&C

This letter enclosed draft 1998 budget proposals. The proposals were presented as three options, and were described as a "corporate overview" of the budgetary requirements for 1998. The letter stated that a detailed budgetary analysis would be forwarded on 5 December 1997.

The three options presented were:

Option 1: Net Expenditure for year IR£55.956m

This option was based on current pay, non-pay and income levels projected to year end, no adjustment having been made for any incremental increases or changes in service profiles.

Option 2: Net Expenditure for year IR£61.318m

The pay element of this proposal is as in Option 1; non-pay is adjusted to reflect those of a "comparable institution in Ireland".

Option 3: Net Expenditure for year IR£66.954m

This proposal attempted to identify the expenditure levels for the base hospitals remaining in situ for the first half of 1998, and that of a similar institution for the latter half of the year. The combination of both these elements gives option 3.

None of the options included costs associated with developments or commissioning which may occur in 1998. In the letter, the Director of Finance states that "the enclosed budget options are inclusive of IR£1.2m of the IR£3.7m expenditure incurred for commissioning for 1997. In the light of increased activity for commissioning, I believe it would be prudent to provide for a similar figure for 1998, i.e. IR£4m."

2 DECEMBER 1997

Based on minutes of Resource Committee meeting of AMINCH

Discussion on budgetary strategy for 1998 deferred until next meeting (we are advised that this decision was taken because Letter of Determination was imminent)

3 DECEMBER 1997

Letter from Tallaght Project team of DOH&C to CEO of AMINCH

This letter confirmed funding of IR£1.9m was being made available to cover approved costs relating to Tallaght Hospital.

4 DECEMBER 1997

Letter of Determination of Health Expenditure for 1998 from Secretary General of DOH&C to CEO of AMINCH

This is the letter of Determination for AMINCH for 1998, which is dealt with in Section 4.2 above.

9 DECEMBER 1997

Meeting between the DOH&C, the Tallaght Hospital Project Team and AMINCH

DOH&C representatives stressed that the Service Plan must be submitted within 42 days and emphasised that the areas in which a supplementary estimate could be sought were very limited. It was emphasised that while the Meath hospital end of year deficit had been wiped out, this would not happen again. Department officials also indicated that the additional IR£4m allocated was the most that could be secured on the basis of a June opening of the Hospital.

(Extracts from DOH&C's notes of meeting)

10 DECEMBER 1997

Based on minutes of Executive Committee of AMINCH

It was noted that a letter had been received from the DOH&C dated 4 December 1997 regarding finance which was being analysed and a report was to be made available to the Board at the next meeting. It was also noted that a change in the method of funding of hospitals was being applied by the DOH&C. It was noted that the base budget should be correct and one with flexibility taking into account staff requirements.

17 DECEMBER 1997

Based on minutes of Board meeting of AMINCH

The Board was advised that the budget for 1998 had been received from the DOH&C. The Board noted that for 1998, the budgets for the three base hospitals were being consolidated and that there was a separate provision for commissioning.

22 DECEMBER 1997

Letter from the Finance Unit of DOH&C to CEO of AMINCH

This advised of a minor increase in the determination in net health expenditure to IR£53.674m relating to pay awards to pensioners made after the Determination was set.

23 DECEMBER 1997

Letter from AMINCH to DOH&C

This letter submitted the draft manpower plan for the Hospital, and sought approval for 2578.5 posts.

9 JANUARY 1998

Letter from DOH&C to AMINCH

This letter responded to the letter of 23 December 1997 relating to the draft manpower submission. It stated that the number of posts sought was totally unacceptable, and that no cognisance had been taken of the incremental approach set out in the Secretary General's letter of 14 February 1997. The letter emphasised that the final plan must be in line with the net Determination notified to the Hospital on 4 December 1997. The letter stated that the DOH&C expected the final manpower plan by 16 January 1998.

13 JANUARY 1998

Meeting of Tallaght Hospital Project Team of DOH&C and AMINCH

A discussion took place on the draft manpower plan (received by DOH&C on 5 January 1998, and responded to on 9 January 1998). The Department stressed that the 1998 Letter of Determination sets the parameters for 1998. The Department emphasised that the draft plan was totally unrealistic as it sought approval for 2578 posts. The CEO of the Hospital indicated that the management team were reviewing this figure. The Director of Finance indicated that staffing would be put in a service planning context and that the Service Plan to be submitted to the DOH&C on 24 January would be based on existing services.

(extracts from DOH&C notes of meeting)

15 JANUARY 1998

Letter from Chairman of AMINCH to Secretary General of DOH&C

This stated "that vital issues such as staffing levels, budget and the development of our service plan are well in hand and are being progressed……"

19 JANUARY 1998

Letter from Finance Unit of DOH&C to CEO of AMINCH

This reiterated the Department's requirements for a Service Plan to be submitted within 42 days following receipt of Letter of Determination. This letter requested that the Hospital submit as a matter of urgency a Service Plan in accordance with the Letter of Determination.

26 JANUARY 1998

Letter from CEO of the Hospital to Secretary General of DOH&C

This letter set out the Hospital's formal reply to the Letter of Determination. The letter stated that the 1998 service plan was based on 1997 activities and indicated that "if one assumes similar funding is required in 1998 as in 1997 an underfunding in our base allocation of IR£897,000" was apparent. [Note: We have been advised by AMINCH that the signed version of the letter held by the CEO did not contain this statement. As such, AMINCH has stated that the version held by the DOH&C was not the final version, and that as such this was submitted in error. Copies of this letter on AMINCH's files sighted by us do omit this paragraph and effectively show a breakeven position.]

The letter made the following points:

(i) Changes in Estimates and Budget Procedures

The letter acknowledged the changes outlined in the Letter of Determination but pointed to the exceptional environment in which the AMINCH hospitals were presently operating, i.e. the operation of three indigenous hospitals combined with the opening of one of the largest acute hospitals in the State. For this reason, the letter stated that it may not be possible to foresee and quantify all possible eventualities. It indicated that the Hospital had initiated a management process which should reduce to a minimum any unknown variables which may impact upon the Hospital's budgetary situation. The letter stated that the Director of Finance was in the process of initiating a budgetary control system to control both the expenditures of the combined base hospitals and non recurring costs related to the commissioning of the new hospital. The letter suggested that a formal process of review to be agreed and implemented between the DOH&C and the Director of Finance at the Hospital to review exceptional items arising on a quarterly basis.

(ii) Service Plan

The letter states that the core basis of the Service Plan was to ensure that the same level and quality of services provided in the base hospitals during 1997 would continue in 1998, including the period after which services had been transferred to the new Hospital at Tallaght.

The letter states that an analysis of the 1998 allocation would indicate that 1997 base funding has not been carried over into 1998, and states that it remained the intention of the Board of Management of AMINCH to maintain the level and standard of services which was provided for our patients in 1997, assuming comparable funding is available.

(iii) Developments/Commissioning Priorities

Details of developments, commissioning processes, their associated costs and the management's team priorities were included in the letter. The letter states that the list included was not exhaustive but did include significant development/commissioning expenses presently known. These amounted in total to IR£6.7m; the letter also indicated that projected development and commissioning expenditure in a number of areas was still awaiting final quantification at the time of submission of this letter. The letter states that "initially the cost of these developments will be funded by the once-off allocation of IR£5.853m for the year".

(iv) Enhanced Facilities

The letter confirms that where additional facilities are to be provided in the new Hospital's infrastructure to allow increased or enhanced service provision, they will not be utilised. The letter states that this approach was being taken to comply with the objectives of the letter of 4 December 1997 i.e. the Letter of Determination. The letter indicates that such developments will only be implemented following agreement with the DOH&C on their funding.

(v) Non-clinical Support/Staffing Levels

The letter indicates that other areas which may fall under the heading of developments such as increased staffing in maintenance, portering, household and materials management had not been included in the budget as they were the subject of separate negotiations with the personnel unit of the Tallaght project group.

(vi) Accident and Emergency

The letter indicated that the accurate forecasting of A&E utilisation in the new Hospital was extremely difficult, because of the new catchment area and demographics of the suburban area of Tallaght

(vii) Employment Control Ceiling

The letter indicated that as part of the analysis of the 1998 budget, the Director of Finance in collaboration with the Director of Human Resources was reconciling the approved employment levels to agree with the Department of Health records. The letter states that this was a once off opportunity to agree not just funding but the basis of funding for a green field site.

(viii) Conclusion

The letter concludes by stating that the objective of the CEO and the Board was to achieve a breakeven outcome for 1998. The letter states that the CEO had directed the various directorates to ensure 1998 activities remain in line with 1997 activities, and that the Director of Finance would be monitoring expenditure on an ongoing basis to ensure expenditure remains within allocation. The letter ends by stating that the opening of a new hospital affects one's ability to project activity with the same level of confidence, but that the CEO expected that the proposed quarterly meetings would reduce to a minimum any surprises that would occur.

28 JANUARY 1998

Based on minutes of Board meeting of AMINCH

The CEO advised that DOH&C had not agreed to the staffing requirements submitted in the draft Manpower Plan, and that it was necessary to take an incremental approach with regard to additional staffing requirements. The CEO informed the Board that it is possible that a priority rating will need to be developed with regard to future appointments being made. The Board also heard that the reply to the Determination Letter from the DOH&C would be submitted on 1 February, which matter was being progressed through the Resources Committee. It was noted that the level of activity will be the same as in 1997, and that a request to be exempted from the casemix system will be made.

30 JANUARY 1998

Letter from Finance Unit of DOH&C to AMINCH

This confirmed that the revised determination was in fact IR£53.762m, as there was a minor error in the letter of 22 December 1997.

3 FEBRUARY 1998

Based on minutes of Resource Committee meeting of AMINCH

The reply to the Letter of Determination, of 26 January 1998, was discussed. The Director of Finance outlined, the main contents and noted that the allocation for the combined hospitals was IR£53.65m, of which IR£5.8m related to service developments and commissioning cost. It was noted that the allocation was comparable to 1997, but that the base allocation was insufficient as it was based on 1993 activity amended for service developments in 1994.

It was also noted that the IR£1.6m one off assistance received in 1997 would not be repeated. It was recognised that no additional services were included in the Letter of Determination. The Director of Finance proposed that service developments or enhancements be the subject of a separate submission to the DOH&C.

11 FEBRUARY 1998

Based on minutes of Executive Committee of AMINCH

It was noted that a meeting was planned on 13 February 1998 with DOH&C regarding the Service Plan.

13 FEBRUARY 1998

Meeting between DOH&C and AMINCH

The purpose of this meeting was to review the AMINCH Service Plan for 1998 and the out-turn for 1997.

The DOH&C reiterated:

- the reasons for the stringent budgetary controls;
- the fact that virtually all monies had been allocated upfront for 1998 and that no supplementary funding was available apart from items listed in Letter of Determination;
- that it was essential that Health Agencies plan and manage their activities within budget.

The AMINCH representatives indicated that they would seek to maintain activity at 1997 levels whilst indicating concerns at predicting A&E levels in the Hospital after the move to Tallaght. They also outlined areas in which development and commissioning costs would arise, although did not have any quantification of same.

The DOH&C representatives explained that AMINCH could not expect minor capital funding of the nature provided in 1997 (IR£1.3m and IR£0.5m, both once off). The DOH&C stressed

that if activity exceeded Determination, immediate remedial action would be required, and reiterated that no funding was available for exceptional expenditure. The DOH&C expressed serious concerns that the commissioning costs were only indicative, were in fact above budget and had not been prioritised. Concerns were also raised by the DOH&C that the laboratory commissioning costs were high compared to available budget and that the staff numbers appeared to be above the approved staff complement.

On conclusion at the meeting, it was agreed that AMINCH would get back to the DOH&C as quickly as possible with a revised Service Plan within determination for:

(i) Tallaght, and
(ii) each of the three hospitals until 21 June, the day of transfer to the new facilities.

(taken from DOH&C notes of the meeting)

16 FEBRUARY 1998

Letter from Finance Unit of DOH&C to AMINCH

This outlined cash and working capital limits for 1998 associated with Letter of Determination of 4 December 1997.

20 FEBRUARY 1998

Letter from DOH&C to CEO of AMINCH

This reiterated the requirement for a revised Service Plan within Determination as quickly as possible for:

(i) the period to 21 June 1998, the date of opening of the new facility, and
(ii) for the new facility in Tallaght and emphasising the need to submit that plan without delay.

3 MARCH 1998

Based on minutes of Resource Committee meeting of AMINCH

It was noted that the 1998 budget was still under discussion with the DOH&C. It was also noted that a budget of IR£5.7m had been received from the DOH&C to fund all developments planned for the Hospital. In the opinion of the Director of Finance, this was totally inadequate.

4 MARCH 1998

Letter from CEO of AMINCH to DOH&C

This letter included details of possible recurring clinical and non clinical cost increases relating to the move to Tallaght, and of projected commissioning and ISIT costs. The letter also included a projection of the cost of retaining 76 beds in the Meath Hospital until such time as the private wing of the Hospital was built (this was not subsequently pursued, as outlined in Section 10). The letter states that, following discussions between the Management team, the Board of the Hospital, and the Medical Board and clinicians, a consensus had been reached on the funding requirements for the new Hospital.

The possible clinical cost, totalling IR£5.7m, related to a number of proposed developments:

- Expansion in volume of adult A&E services, including chest pain programme, acute gynaecology - IR£1.069m.
- Expansion in volume of paediatric A&E services - IR£0.504m
- Age related day care - IR£0.385m
- Dialysis unit - IR£0.686m
- Emergency theatre/trauma, including impact of different layout and size of theatres - IR£1.396m
- Paediatric High Dependency Unit - IR£0.554m
- Additional beds in Intensive Care Unit - IR£0.414m
- Invasive cardiology - IR£0.587m

The non clinical cost increases, totalling IR£8m, included the cost of car park resurfacing (IR£0.2m), waste management (IR£0.15m), increased light and heat costs in Tallaght (IR£0.12m), increased staffing costs in HSSD (IR£0.342m), IT pay and non-pay budget (IR£2.2m), laboratory pay and non-pay costs (IR£3.2m), increased portering requirements (IR£0.3m), increased security costs (IR£0.35m), additional staff in materials management (IR£0.15m), and new consultant posts (IR£0.16m).

The costs of developments and commissioning of the Hospital for the six months to 30 June 1998 were projected at IR£5.3m (which included laboratory costs of c.IR£1.7m), which the letter notes fully utilises the notified allocation. The ISIT budget was projected at IR£2.2m, which included IR£1m for personal computers (which is more appropriately recognised as capital expenditure).

4 MARCH 1998

Meeting of Chairman and CEO of AMINCH, and Chairman and Project Director of TRHB, and Secretary General and Officials of DOH&C

This meeting was held to discuss the progress towards opening, and equipping and building issues. At the meeting, the Secretary General emphasised that the budgetary provision for equipping was sacrosanct, and repeated that no additional money would be available for capital, and that he was not prepared to disadvantage other agencies in order to give Tallaght extra capital funding for building work over and above that agreed with the DOH&C's Hospital Planning Office.

(Taken from DOH&C notes of the meeting)

6 MARCH 1998

Meeting between AMINCH and DOH&C

The purpose of the meeting was to quantify items of a development and commissioning nature outlined in the submission of 26 January 1998.A proposal to continue to operate 76 beds in the Meath Hospital was discussed. A document detailing potential clinical and non clinical costs associated with the new Hospital was circulated, as well as ISIT budgets and commissioning costs.

10 MARCH 1998

Meeting between AMINCH and Tallaght Hospital Project team of DOH&C

The purpose of the meeting was primarily to discuss critical opening day issues, and review service plan issues.

11 MARCH 1998

Based on minutes of Executive Committee of AMINCH

It was noted that an additional IR£5.7m would be required in excess of the Letter of Determination for work in IT, commissioning, laboratory, HSSD, portering services and materials management

13 MARCH 1998

Letter from CEO of AMINCH to DOH&C

This letter was set against a background of the CEO having prepared a strategy document to deal with the transfer of services to Tallaght, and assessed both financial and non financial implications of the move. The letter states that the parameters which influenced the strategy were:

- the maintenance of the quality and quantity of current patient care
- provision of the services within the allocated resources.

The letter made the following points:

(i) Whilst the funding process incorporated in the Letter of Determination provides adequate funding for the provision of services in the Service Plan, it did not adequately fund the following:

- revenue costs related to commissioning of the Hospital
- revenue costs for the pathology department
- revenue costs specific to the Tallaght site/facility
- revenue costs relating to additional approved posts
- revenue costs of the ISIT department
- additional paediatric and pharmacy costs

The letter costed these items in aggregate at IR£10.748m. AMINCH believed that once-off funding in the sum of IR£5.853m had been included in the Letter of Determination in relation to these items. Excess expenditure of IR£4.893m therefore arose of which the letter stated IR£2.4m was once-off.

The letter considered a number of proposals for funding this deficit, including:

- Requesting St James to continue to supply laboratory consumables to the Hospital for the period April to December 1998, at an estimated saving of IR£985,000 in 1998.

- Savings in various cost categories, in aggregate amounting to IR£636,000.

The letter indicated that it was not practicable to fund a final remaining deficit after savings of IR£3.272m by way of a reduction in the service activity as to do so would

require the closure of approximately 80 beds for the balance of the year. The letter also stated that capital equipment had been reviewed and that they were confident that budget would not be exceeded. The letter further states that with regard to the previously projected over run of capital and building issues, "we propose to meet this by deferring equipment purchases and increasing transfers from the base hospitals" as well as incorporating a further IR£0.5m which the DOH&C had indicated would be available in relation to health and safety issues.

13 MARCH 1998

Meeting of AMINCH and DOH&C

The DOH&C expressed their concerns that a service plan had not yet been agreed. The DOH&C acknowledged that it was difficult to gauge service pressures in the new location in Tallaght, but that both the parameters letter of 14 February 1997 and the letter of Determination recognise that there would be ongoing discussions regarding additional funding, and that a strategy for dealing with agreed deficiencies over the next few years could be agreed. The DOH&C also indicated at the meeting that it was not going to walk away from the Tallaght in terms of its needs, but its wants are a different matter. The DOH&C notes of the meeting record that they " thought that we had put enough funds aside, while it does not look like that now, the amount is set".

The CEO stated that the building had several serious deficits, some of which were incompatible with opening. He indicated that the cost of remedying these deficiencies - IR£1.3m - had been scaled back from IR£3.3m, which he regarded as IR£2m of problems for the future. The CEO nevertheless confirmed the intention to open on 21 June 1998 using the remaining equipping budget, an additional amount of IR£0.5m being provided in respect of health and safety issues, and undertook to come back with a schedule of implementation of clinical developments over time.

The DOH&C indicated at the meeting that it was very difficult to understand the quantum and the price of building issues, and expressed grave reservations over what was defined as essential. They indicated the equipping budget had been assessed on the basis of its experience, and that St James had been involved in breaking down the overall budget.

A discussion also took place on the draft service plan. The Director of Finance indicated that IR£10.748m was required to fund developments and commissioning, some IR£4.9m more than provided in the letter of Determination. Certain proposals had been identified to fund part of the deficit including a proposal to request St James's to continue to fund consumables for the Hospital laboratory for 1998, which AMINCH estimated would generate a saving of IR£1m and deferral of the transfer of St Loman's until the private facility is completed; however a final deficit of c.IR£3.3m still remained. The DOH&C indicated they could not accept the Hospital's proposal, regarding St Loman's and indicated that the St James's proposal also caused difficulty.

It was agreed that final costings with relevant narrative would be submitted by AMINCH as soon as possible to the DOH&C.

(taken from DOH&C notes of the meeting)

25 MARCH 1998

Based on minutes of Board Meeting of AMINCH

The Board heard from the CEO that three meetings had taken place with the DOH&C and representatives of the management team regarding service plans. The CEO indicated that it was his brief to ensure the same level of service in the new hospital as in the base hospitals, and the Board noted that this was a solemn agreement with the DOH&C. The CEO indicated that maintaining the same level of activity in the new hospital would require an additional allocation of approximately IR£5m.

27 MARCH 1998

Based on minutes of Special Board Meeting of AMINCH

This meeting was held to approve the service plans for 1998 prior to submission to the DOH&C. The Board noted that a Letter of Determination on health expenditure for 1998 had been received in December 1997 and responded to by the CEO in January 1998.

The Board noted that normally service plans are based on the level of the previous year's activity. However, they noted that in this case, the plan was based on the same level of activity being carried out in the new hospital as had been performed in the base hospital which is a solemn agreement with the DOH&C. They noted that on the transfer of services to the new Hospital, a deficit of c.IR£6m would be created in 1998, which arises from development and commissioning costs.

A document was tabled at this meeting to assess various strategies to bridge the funding deficit for 1998, including equipping strategy, laboratory strategy, clinical service reduction, revenue generation, move of St Loman's, and efficiency strategy. The Board agreed that a clinical service reduction strategy would not be considered.

On conclusion of this meeting, it was agreed that the current level of activity was to be maintained in a deficit situation and that the CEO was to proceed with the conclusion of the Service Plan on this basis.

27 MARCH 1998

Letter from CEO of AMINCH to DOH&C

This letter set out clinical and financial considerations in seeking to meet the DOH&C's imperative of no additional funding.

The letter stated that the financial situation indicated at earlier meetings had not changed significantly, i.e. a shortfall in funding of IR£5m, which "represents the cost of unfunded developments and commissioning" The letter states that the management team are proposing to bridge the problems with equipping, laboratory, revenue generation and efficiency strategies. The letter states that AMINCH "has been operating within the constraints of the IR Protocol and with the solemn agreement to continue our existing level of service" and that therefore there was no significant room to adjust staffing costs in the short term.

30 MARCH 1998

Meeting between DOH&C Tallaght Project Team and AMINCH

Meeting held at request of AMINCH to give assistance in relation to service plan.

31 MARCH 1998

Meeting between DOH&C Tallaght Project Team and AMINCH

The budgetary situation was discussed. DOH&C officials referred to the meeting of the previous day in the DOH&C concerning the draft Service Plan. The DOH&C suggested that the budget be examined with a view to separating out capital items. The DOH&C stressed that there was no additional revenue funds available for the year whatever about the possibility of getting some element of capital funding.

(taken from DOH&C notes of the meeting)

1 APRIL 1998

Based on minutes of Special Board Meeting of AMINCH

This was a further special meeting regarding the service plan. The Board again noted there was a gap of IR£5m between the estimate of the amount required to carry out the level of activity as provided in the base hospitals and that included in the Department's Letter of Determination. The CEO stated that officials from the Department had advised that the Minister is adamant that the provision of services must be carried out within the allocated budget.

The CEO advised that some of the items contained in the revenue overrun were not part of patient services but were essential for the opening of the Hospital. He further advised that savings of c.IR£1.6m could be achieved in certain areas which would leave some IR£4.4m of a deficit remaining.

The CEO advised that negotiations were taking place with the DOH&C to reach an agreement that the capital items shown in a document presented to the meeting, and totalling IR£4.4m, could be funded outside the Letter of Determination. The CEO stressed the importance of obtaining from the DOH&C a guarantee that all services allocated to the new Hospital will be operational in 1999; an additional IR£15m to the base budget is required to provide the full potential services.

Following discussions, the Board agreed:

- To adopt the strategy, as outlined in the documents circulated at the meeting, that negotiations should take place with the DOH&C with a view to agreeing that items in the sum of IR£4.4m included in revenue expenditure could meet capital expenditure criteria
- To strive to achieve savings of IR£1.6m
- The DOH&C must be a party to the above decisions.

3 APRIL 1998

Letter from Tallaght Hospital Project Team to CEO of AMINCH

This letter was sent for clarification purposes following the meeting of 30 March. This letter refers to discussions regarding the finding of a solution to the projected deficit of IR£5.8m in a document previously presented by AMINCH entitled "Review of Budgetary and Commissioning Strategy", effectively an earlier draft of parts of the Service Plan of the Hospital. The letter indicates that it was agreed at a meeting of 30 March 1998 that a strategy for presenting a 1998 Service Plan that would be within the level of determination to the Board of AMINCH needed to be developed to deal with the projected deficit being identified in the document entitled "Review of Budgetary and Commissioning Strategy". The letter also noted that an examination would be carried out by AMINCH to establish what element of the 1998 projected expenditure might have been inappropriately classified as being part of the Revenue Determination advised, e.g to identify capital expenditure.

The letter states that, as had been emphasised at all times in their discussions, no further funding (either revenue or capital) would be available to bridge the gap between projected expenditure levels and the amount advised in the DOH&C's Letter of Determination of 4 December 1997.

7 APRIL 1998

Based on minutes of Resource Committee meeting of AMINCH

The outcome of various meetings with the DOH&C were considered in relation to Letter of Determination. The letter from the DOH&C of 3 April 1998 was considered. It was noted that at a meeting on 31 March 1998, the DOH&C had confirmed that no additional revenue funding would be available, and that capital funding was not available at present. The DOH&C base line requirement was the production of a document which would indicate the service activity for 1998 and a related budget within Determination. The Resources Committee heard from the Director of Finance that, in his view, the budget required for 1998 was between IR£62m and IR£65m in total.

At this meeting, the Resources Committee decided to recommend that the Board adopt the Service Plan which included an excess of IR£5.9m over the amount included in the Letter of Determination.

8 APRIL 1998

Based on minutes of Special Board Meeting of AMINCH

The Board considered and approved the final version of the Service Plan for submission to the DOH&C. The Board noted that the service plan had the confidence of the consultants appointed by the DOH&C to assist the management team with the difficulties in funding which had arisen regarding the transfer of the base hospitals to Tallaght. [Note: The consultants mentioned, Leslie Buckley & Co, have indicated that their assistance to the management team was in relation to the presentation of the service plan]

8 APRIL 1998

Letter from CEO of AMINCH to Secretary General of DOH&C submitting the final Service Plan for 1998

This letter submitted the service plan approved by the Board of AMINCH. The plan showed a budget shortfall relative to the Letter of Determination of IR£5.883m. This Service Plan is examined further in Section 4.5 below.

23 APRIL 1998

Letter from Finance Unit of DOH&C to AMINCH

The subject of this letter was the late submission of Integrated Management Reports. It also stated that the service plan submitted on 8 April 1998 was not an agreed document, and that further correspondence would issue in that regard.

28 MAY 1998

Meeting between AMINCH and DOH&C

This meeting was held to discuss AMINCH results to 30 April 1998, and concerns that activity was up in all base hospitals, which was increasing costs. The minutes of the meeting note that "the service plan was rejected by the DOH&C", and that the Secretary General had confirmed that no further funding would be available. It was noted at the meeting that full year costs of commissioning were estimated at IR£8.271m against a provision of IR£5.9m, and that questions exist as to what portion of future expenditure will be of a capital nature and the role of the Tallaght Hospital Board in relation to this expenditure. The DOH&C asked the Hospital to identify staff numbers and tenure at the meeting.

29 MAY 1998

Meeting between AMINCH and DOH&C

The meeting was held to discuss activity and expenditure for the first half of the year, phasing in of the new Hospital, IT issues, capital expenditure and issues relating to 1999. The DOH&C reiterated at this meeting that there was no expectation of further funding from Government. A discussion took place on IT expenditure, and on what element of expenditure could be regarded as capital.

5 JUNE 1998

Letter from DOH&C to CEO of AMINCH

This letter was sent in preparation for a meeting on 11 June. It stated that the following were essential as a matter of urgency:

- AMINCH accounts for 1997, including details of commissioning costs incurred by the FDVH. Confirmation of the audited status of 1996 and 1997 accounts was requested.
- Financial projections to end of year
- Details of capital expenditure being funded from revenue
- A report on the system in place for reporting on the management of the service plan, with particular reference to the Executive Information System outlined in the cover letter to the service plan submission of 8 April 1998.

7 JULY 1998

Based on minutes of Resource Committee meeting of AMINCH

It was noted that the Service Plan had not been accepted by the Department of Health.

4.4 HOSPITAL'S PROCESS FOR PREPARATION AND SIGN-OFF OF SERVICE PLAN

The following points are relevant to the internal processes and sign-off arrangements which prevailed in respect of the Service Plan for 1998:

(i) The service planning requirement was seen primarily as the preparation of a financial budget by management of AMINCH in accordance with the Letter of Determination, and accordingly, this preparation was handled to a very high degree by the Director of Finance. The degree of involvement of other members of the senior management team in the preparation of the Service Plan was small and was principally limited to the estimation of staffing requirements for their areas. We are advised that the Medical Board Executive had an input into the final version of the Service Plan.

(ii) The preparation of the plan was complicated by a number of factors:

- The Director of Finance was appointed in September 1997 and as such he was new to the position when the requirement for a Service Plan arose.
- The plan covers a period during which the move to the new facility in Tallaght was planned. There was little track record on which to depend in assessing the impact of the move on pay and costs, and a significant amount of work was required to try to assess the variables in these and other areas.
- Preparation of the base position in the service plan required the consolidation of three separate entities until the time of the move to the new facility At the time of preparation of the Service Plan, there were difficulties associated with the finalisation of the 1997 accounts, a matter which continued up until the time of our review.

(iii) The draft Manpower Plan prepared by clinical and non-clinical staff in parallel with the Service Plan and submitted to the DOH&C of 23 December 1997 indicated a requirement for 2,578.5 posts in total. The DOH&C stated in their letter of 9 January 1998 that this number of posts was totally unacceptable and emphasised that any such Manpower Plan needed to be produced in line with the requirements of the Letter of Determination of 4 December 1997 so that proposals for additional staff in 1998 were included within that allocation.

Management stated that the requirement to refine this unrealistic draft Manpower Plan in consultation with relevant departments of the Hospital complicated the finalisation of the Service Plan.

(iv) Each member of the management team was asked to confirm that the resources provided in the Service Plan in respect pay, and capital was sufficient to operate the services for which they were responsible.

(v) The DOH&C provided the services of Leslie Buckley &Co to assist management in:

- Carrying out a review of all matters pertaining to the new hospital at Tallaght
- Drawing up an implementation plan and in monitoring of the plan so as to ensure completion of the planned opening of the new hospital on 21 June 1998.

As part of this brief, assistance was given to management in the presentation of the service plan.

(vi) As noted in the chronology, the Resources Committee of the Board addressed matters relevant to the Service Plan

- At their meeting on 3 February 1998, when the reply of 26 January 1998 to the Letter of Determination was discussed. Concerns were raised that the Determination was inadequate. It was recognised that no additional services were included in the Letter of Determination.

- At their meeting on 3 March 1998, when it was noted that the 1998 budget was still under discussion with the DOH&C. It was also noted that a budget of IR£5.7m had been received from the DOH&C to fund all developments planned for the Hospital. In the opinion of the Director of Finance, this was totally inadequate.

- At their meeting on 7 April 1998, when the outcome of various meetings DOH&C were considered in relation to Letter of Determination. It was noted the DOH&C had confirmed that no additional revenue funding would be available, and that capital funding was not available at present and that they required a budget within Determination. The Resources Committee heard from the Director of Finance that, in his view, the budget required for 1998 was between IR£62m and IR£65m in total.

  At this meeting, the Resources Committee decided to recommend that the Board adopt the Service Plan which included an excess of IR£5.9m over the amount included in the Letter of Determination.

- It was noted at their meeting on 2 June 1998 that the Service Plan had not been accepted by the Department of Health.

(vii) As noted in the chronology, the Executive Committee of the Board addressed matters relevant to the service plan at the following meetings:

- On 10 December 1997, when it was noted that a letter had been received from the DOH&C dated 4 December 1997 regarding finance which was being analysed and a report was to be made available to the Board at the next meeting.

- On 11 February 1998, when it was noted that a meeting was planned on 13 February 1998 with DOH&C regarding the Service Plan.

- On 11 March 1998, when it was noted that an additional IR£5.7m would be required in excess of the Letter of Determination for work in IT, commissioning, laboratory, HSSD, portering services and materials management.

(viii) The main Board of AMINCH addressed matters relating to the Service Plan as follows:

- On 17 December 1997, when the Board was advised that the budget for 1998 had been received from the DOH&C. The Board noted that for 1998, the budgets for the three base hospitals were being consolidated and that there was a separate provision for commissioning.

- At their meeting on 28 January 1998, when the CEO advised that DOH&C had not agreed to the staffing requirements submitted in the draft Manpower Plan. The Board also heard that the Determination Letter from the DOH&C would be submitted on 1 February, which matter was being progressed through the Resources Committee.

- At the meeting on 25 March 1998, when the Board heard from the CEO that three meetings had taken place with the Department of Health and representatives of the management team regarding service plans. It was noted that the plan was to provide the same level of service in the new hospital as in the base hospitals. The CEO indicated that maintaining the same level of activity in the new hospital would require an additional allocation of approximately IR£5m.

- At their meeting on 27 March 1998, held to approve the service plans for 1998 prior to submission to the DOH&C.

  On conclusion of this meeting, it was agreed that the current level of activity was to be maintained in a deficit situation and that the CEO was to proceed with the conclusion of the Service Plan on this basis.

- At their meeting on 1 April 1998, the Board again noted there was a gap of IR£5m between the amount required to carry out the level of activities as provided in the base hospitals and that included in the Department's Letter of Determination. The CEO indicated that officials from the Department had advised that the Minister is adamant that the provision of services must be carried out within the allocated budget.

  Following discussions, the Board agreed:

  - To adopt the strategy, as outlined in the documents circulated at the meeting, that negotiations should take place with the DOH&C with a view to agreeing that items in the sum of IR£4.4m included in revenue expenditure could meet capital expenditure criteria

  - To strive to achieve savings of IR£1.6m

  - The DOH&C must be a party to the above decisions.

- At their meeting of 8 April 1998, the Board considered and approved the final version of the Service Plan.

The CEO has confirmed to us:

(i) That the letter from the Secretary General of the DOH&C of 14 February 1997 (which set out inter alia the parameters for 1998 funding) was not presented to the Board, as he regarded it as the start of a process of discussion and negotiation with the DOH&C on the funding for the new Hospital, which at that stage was due to open in January 1998. The CEO was aware that a nursing study (the Cobain study) was planned, and in his view it was too early to determine staffing levels in the new Hospital at the stage of the parameters letter.

(ii) That the initial reply of the 26 January 1998 to the Letter of Determination was not put to the Board for approval, as work in finalising the plan was ongoing up to 26 January and he was anxious to meet the requirement to submit a service plan within 42 days of receipt of the Letter of Determination. The 26 of January was the 42nd day.

(iii) That the Letter of Determination was not tabled for consideration by the Board until the series of meetings in late March and early April 1998, which were part of the process leading to Board approval of the service plan on 8 April 1998. We are advised that the letter was not tabled until such time as it was obvious that no further funding would be forthcoming from the DOH&C, despite many AMINCH efforts.

During our work, we had discussions with the Chairman of the Resources Committee, a Board member, and with other members of the Board of AMINCH on the context in which the service plan was in the first instance recommended by the Resource Committee for approval by the Board, and ultimately so approved at the Board meeting of 8 April 1998. These members of the Board have stated that the decision to adopt a service plan in excess of Determination was not taken lightly, and was only done on the basis that the CEO, and certain of the members themselves, had the clear impression from discussions with representatives of the DOH&C that further funding could be obtained, and that a mechanism to achieve this was to assess the extent that expenditure, contained in the service plan under revenue, could be reclassified as capital expenditure. They have stated that they believed that the Tallaght Project Team of DOH&C had sought IR£11m additional funding for AMINCH for 1998, and that this had effectively been halved because the opening was delayed from January 1998 to June 1998. They believed that the discussions on reclassification of items as capital were a recognition on the part of the DOH&C that there were funding difficulties associated with the reduction in incremental funding from the IR£11m initially sought to the IR£5.9m ultimately obtained in the Determination for developments and commissioning. In the service plan submitted, the funding deficit of IR£5.9m in the plan is shown as being bridged by a combination of savings (IR£1.5m) and reclassification of revenue items as capital expenditure (IR£4.4m).

They have also pointed to the statement on Page 2 of the Letter of Determination that the DOH&C would, "in the normal course endeavour to incorporate all aspects of approved expenditure in the ***initial*** letter of determination." (the emphasis on "initial" is ours). For this reason also, they had the impression that further funding would be available later in the year, although not incorporated in the initial letter of determination.

We have discussed the above position with representatives of the DOH&C. It is acknowledged that the Hospital had been informed that application had been made by the Tallaght Hospital Project Team of the DOH&C to the Finance Unit of the DOH&C for additional funding of IR£11m over and above the then existing budgets of the base hospitals on the basis that the Hospital would open in January 1998. However, the Board's decision to defer the opening until 21 June 1998 resulted in a related reduction in DOH&C funding for the Hospital for 1998. It is also acknowledged that meetings took place between AMINCH and representatives of the DOH&C at which the position emerging from the draft service plan

was discussed, and that the DOH&C were aware that Leslie Buckley & Co. were, inter alia, helping management in the presentation of their service plan.

The DOH&C has further acknowledged that discussions did take place on whether items included in the draft plan for 1998 could be treated as capital. This was because the DOH&C were seeking a plan in accordance with the letter of Determination which should include revenue items only, and as such capital items should be excluded. The DOH&C has indicated that these latter discussions were undertaken at the request of AMINCH to assist the CEO and his management team develop proposals for their Board. Following a meeting of 30 March 1998, a letter dated 3 April 1998 was sent to the CEO to clarify the context of the discussions and their outcome. This letter is referred to in the chronology in Section 4.3 above, and states that it was "agreed that a strategy for presenting to your Board a 1998 service plan that would be within the level of determination…. needed to be developed to deal with the projected deficit….". It also states that the parties had agreed "that the strategy would include possible corrective action relating to approximately IR£2m revenue costs and that an examination by you of expenditure would also take place with a view to determining what element of the projected expenditure might have been inappropriately classified as being part of the Revenue Determination advised e.g. capital expenditure." The letter states "that it was emphasised at all times that no further funding (either revenue or capital) was available to bridge the gap in funding. The meeting of the 4th of March referred to in the chronology also states that no further capital funding would be forthcoming.

4.5 THE SERVICE PLAN

4.5.1 FINANCIAL OVERVIEW

The Service Plan adopted by the Board on 8 April 1998 is summarised below:

	1997 Base net Expenditure IR£m	*1998 Development Expenditure IR£m*	*1998 Commissioning Expenditure IR£m*	*Total IR£m*
Pay	39.0	3.9	1.1	44.0
Non Pay	17.5	4.0	1.7	23.2
	56.5	7.9	2.8	67.2
Income	(7.7)	-	-	(7.7)
Net Expenditure	48.8	7.9	2.8	59.5

The 1997 net expenditure was based on management accounts for the base hospitals as at 30 November 1997 together with an estimate for December 1997. This figure reflects the costs of providing the services in the three base hospitals in 1997. AMINCH considered that this was the appropriate level of activity on which to base the Service Plan for 1998

The developments included in the service plan are summarised below:

	Laboratory IR£m	*ISIT IR£m*	*New Posts IR£m*	*Site Costs – Tallaght IR£m*	*Paediatric A&E IR£m*	*Total IR£m*
Pay	2.2	0.6	0.6	0.2	0.3	3.9
Non Pay	1.3	1.0	0.3	1.4	-	4.0
	3.5	1.6	0.9	1.6	0.3	7.9

4.5.2 BASIS OF SERVICE PLAN

As part of the submission of the Service Plan to DOH&C, the Hospital made the following points, which, for the most part, were a reiteration of the points made in their submission of 26 January 1998:

(i) It may not be possible to foresee and quantify all possible eventualities, but that at the time of submission of the plan, all known liabilities and costs had been included within it.

(ii) That the plan was prepared on the basis that the Hospital would provide the same level and quality of the services as provided in the base hospitals during 1997.

(iii) That where additional facilities had been provided in the new Hospital's infrastructure to allow for increased or enhanced service provision, that these would not be utilised until funding had been provided.

(iv) That it was anticipated that capital expenditure would be fully funded by the DOH&C.

(v) That the Hospital had plans for the development of a performance measurement framework, including the implementation of an advanced information system to support the Hospital management, its clinicians and nursing staff. It also indicated its intention to implement an executive information system.

(vi) The Hospital was carrying out a review of its employment numbers and reconciling these to DOH&C approved levels. It noted that a reduction in staffing complement of 80 WTE arising from the merger process was anticipated through redeployment of staff and voluntary departures.

A request was made that a review process be put in place on a periodic basis with the DOH&C to review progress against the Service Plan to assess issues arising in the new operating environment in Tallaght.

In concluding his letter attached to the service plan, the CEO stated that it was his objective and the objective of the Board to achieve a breakeven outcome for the year. The letter states that the CEO had directed the various directorates to ensure 1998 activities remain in line with 1997 activities, and that the Director of Finance would be monitoring expenditure on an ongoing basis to ensure expenditure remains within allocation. The letter ends by stating that the opening of a new hospital affects one's ability to project activity with the same level of confidence, but that the CEO expected that the proposed quarterly meetings would reduce to a minimum any surprises that would occur.

In an introduction to the service plan, there is a description of the process followed in preparing the plan, which includes a review of budgetary and commissioning strategy carried out by the management team, and meetings with the DOH&C in March 1998 at which the strategies for dealing with the budget deficit were broadly outlined. Reference is made to the letter of 4 March 1998 from the CEO to the DOH&C in which the CEO had stated that the allocation was sufficient for providing for the base level activity undertaken in 1997 only, and did not cover the costs associated with a range of clinical and non clinical recurring costs associated with the move to Tallaght. A document prepared by AMINCH was also referred to which identified the total cost of commissioning, new posts and new support departments at IR£10.7m, for which funding of IR£5.4m had been provided.

The introduction to the plan also stated:

(i) That the funding requirement was a difficult issue to resolve, and that it was agreed with the DOH&C team and the management team of AMINCH that a document would be produced which would identify a level of service that could be provided within the agreed determination of non capital expenditure.

(ii) The position of the Board in the plan, which was that they were "of the view that an agreement exists with the Minister of Health to provide adequate funding to the Hospital to enable it achieve the historical level of service activity in the new Hospital". This position underpins the basis on which the Service Plan has been compiled.

4.5.3 ASSUMPTIONS

The principal assumptions used by AMINCH in the preparation of the 1998 Service Plan are considered below.

1998 BASE BUDGET

The 1998 base budget is based on the out-turn for 1997 in the three base hospitals adjusted for the increments and developments outlined in the Letter of Determination from DOH&C of 4 December 1997. The projected net expenditure shown for the 1998 base budget of IR£48.7m has been compiled on this basis.

This approach reflected:

(i) The calculation of net expenditure for the year for the same level of activity as in the base hospitals for 1997.

(ii) The terms of the Industrial Relations Protocol for the transfer of services to, and the opening of the new Hospital in Tallaght. The Protocol was drawn up between management, the DOH&C and the unions. Staff were given undertakings in respect of security of tenure equivalent to those prevailing in the broader health service. It was intended as a general rule that staff in the base hospitals would transfer to available posts in Tallaght. The issue of compulsory redundancy did not arise in the case of staff in the base hospitals in the context of the transfer of services

The Service Plan indicates that a reduction in the staffing complement of 80 WTE's arising from the merger process was anticipated through redeployment of staff and voluntary departures. It is not clear from the plan how this reduction is reflected in the costs for the year. We are informed by AMINCH that this estimate was based on management literature on mergers, which indicated that a 5% saving in expenses can be achieved, and that the intention was to achieve the target of 80 WTE's over two years.

The base budget similarly assumes that costs will remain in line with 1997 in the base hospitals. One would expect certain costs in the base hospitals not to recur, for example, certain maintenance, establishment and professional services costs which arose in the previous environment. We would also have expected the relocation to Tallaght to have resulted in savings in the six months ended 31 December 1998, the period after the move. This is not recognised in establishing the base budget, but is acknowledged later in the Service Plan in relation to savings which might be possible in reducing the deficit in the Service Plan.

4.5.4 LABORATORY

The Service Plan reflects the establishment of a laboratory in the new Hospital in Tallaght. The plan assumes that the majority of staff would be taken on progressively in March and April 1998 so that the laboratory would be fully staffed at the time of opening of the new Hospital.

The assumptions made in the Service Plan in relation to laboratory staff and the period of months there included in the Service Plan for 1998 is shown below.

	No of Months employed in 1998				
No of Laboratory Staff	12	9	8	6	Total
Consultants	5	-	-	1	6
Registrars	-	-	-	4	4
Chief II	1	-	-	-	1
Chief I	5	-	-	-	5
Technologists	-	10	-	-	10
Senior Medical Laboratory Technicians	-	12	-	-	12
Basic Medical Laboratory Technicians	-	-	34	-	34
Laboratory Aides	-	-	10	-	10
Porters	-	-	7	-	7
Pathology Technicians	-	-	2	-	2
Biochemists	-	-	-	2	2
Admin/Clerical	-	-	12	-	12
Totals	11	22	65	7	105

The payroll costs for laboratory staff were projected at IR£2.2m. for the year ended 31 December 1998, of which approximately one-third was projected to arise in the six months to 30 June 1998. The full year payroll cost for this level of staff in future years is IR£3.3m.

The budget for Pathology were estimated at IR£1.3m. for 1998 and IR£1.6m. in a full year.

The service plan assumes a fully staffed and functioning laboratory at the time of the opening of the Hospital. Staff recruitment was undertaken to meet this objective. The option of a phased or reduced laboratory operation for 1998 was not pursued on clinical grounds, as it was adjudged by management that the scale and type of Hospital involved, with a significant A&E presence and teaching responsibilities, required a fully functioning laboratory on opening.

A more phased introduction of laboratory services or a reduction in the level of services, whilst rejected by the Hospital on the above grounds, would have had the effect of reducing costs during 1998.

Two other points are relevant:

(i) In their letter of 18 December 1997, the DOH&C approved a total of 83 posts in the laboratory, which number excluded consultants, registrars and administrative staff. The letter indicates that this number is inclusive of existing staffing in the base hospitals of 7.5 WTE's, or an increase of 75.5 WTE's for the staffing of the new laboratory. In addition, the letter indicates that the DOH&C was prepared to approve 14 posts in relation to clerical administrative staff.

The sanction included in the letter was conditional, inter alia, on the costs involved being met from the Hospital's 1998 allocation.

(ii) The service plan includes a cost for administrative and clerical staff in the laboratory as if they were to be new staff. The payroll costs for these staff in 1998 was projected at IR£143,000.

We would have expected that support staff for the laboratory would have come wholly or substantially from existing resources as part of the merger of other support service functions from the base hospitals. Whilst this was not assumed in the plan, we have been advised by the CEO that in practice this did occur.

4.5.5 ISIT

The service plan provides for an additional 17 WTE IT staff at a cost of IR£503,000 in 1998 (IR£667,000 in a full year). This includes amounts totalling IR£159,000 respectively for 1998 for consultant contracts in respect of positions which could not be filled by suitably qualified staff on a fulltime basis. (Part of their brief was to provide training to staff in the IT department – we understand that the appointment of full time staff on standard pay scales is planned by AMINCH; the DOH&C understand this will occur by March 1999.)

Historically, IT staff servicing the base hospitals were employed by the FDVH.

The DOH&C have approved the total of 21 posts for ISIT in the new Hospital, on the basis that funding for same is provided within the 1998 determination.

The non-pay ISIT budget totals IR£992,000. This includes capital expenditure of IR£250,000 relating to the projected purchase of personal computers which could not be accommodated within the capital IT budget.

4.5.6 NEW POSTS

Service plan assumes a total of 26.5 new posts in the Hospital, with a payroll cost effect in 1998 of IR£623,000. These posts arise primarily in administration, and support services.

The increase in support services was projected to cover increased requirements in household staff, catering, theatre orderlies, ward attendants, linen clerks, which the plan indicates would be impacted directly by the increased size of the Tallaght complex and the geographical spread of the various patient care locations.

Non-pay costs at IR£326,000 are projected to arise in relation to these new posts. The plan does not specify the basis on how such costs are estimated, nor is the plan explicit in identifying the manner in which support service staff in the base hospital would be deployed. As a full evaluation of the effect of merging support services had not been carried out at the time of the plan, the estimates contained therein for additional support service staff could be regarded as somewhat tentative. For the most part, these additional posts were not approved by the DOH&C.

4.5.7 SITE COSTS – TALLAGHT

These relate to costs associated with operating the Hospital from the new location in Tallaght. They breakdown into pay costs of IR£217,000 and non-pay costs of IR£1.422m for 1998.

Pay costs relate to an additional sixteen porters projected to be required and twelve additional technical services staff to service the new building.

Non-pay costs relate to the following:

	IR£,0000
Waste management	218
Energy	354
Security	700
Technical services	150
	1,422

Waste management was projected to increase because the Adelaide Hospital had used an incinerator for disposal of waste material, a system not planned for use in the new Hospital.

Energy and other technical services costs reflected experience of these costs in operating the Hospital in Tallaght prior to opening.

The plan states that security costs were based on an evaluation of security requirements carried out by the Hospital and submitted to the DOH&C during 1997.

4.5.8 PAEDIATRIC A&E

The costs included in the Service Plan relate to 24 members of staff in respect of this facility for six months, i.e. from 1 July 1998. The full year cost is IR£545,000.

4.5.9 COMMISSIONING COSTS

Commissioning costs, that is the cost associated with getting the Hospital up and running, were projected at IR£2.9m in the Service Plan, IR£1.1m of which related to pay and IR£1.8m. to non-pay.

Pay costs relate to 112 personnel across a wide range of disciplines in the Hospital and a further 10 staff involved in ISIT commissioning. The assumption incorporated in the plan is that commissioning work would cease on the opening of the new Hospital.

Non-pay commissioning costs of IR£1.1m include legal and professional fees associated with the opening of the Hospital, a training budget of IR£400,000, provision for removal expenses from the base hospitals of IR£500,000 and the cost of new uniforms of IR£180,000.

The commissioning budget was calculated up to 21 June 1998, the date of opening of the Hospital. No provision was made in the Service Plan for the possible continuation of commissioning staff beyond that date.

4.6 EVALUATION OF SERVICE PLANNING PROCESS

The preparation and submission of a comprehensive service plan to the DOH&C is central to the relationship between the DOH&C and the relevant agency being funded by it. Service planning is required in the broader context of the health strategy, ”Shaping a Healthier Future” to enable the DOH&C focus on a national basis on improving health status and in providing the most appropriate care throughout the health system. Service planning is also intended to facilitate improved decision making and greater accountability at all levels of the health service, and to enhance measurement of performance. Service planning assists in setting parameters in relation to funding and the associated service requirements, not only for

the immediately ensuring year, but over a period of years. Particularly as regard voluntary agencies, the agreement of service plans, with relevant funding agency, is essential to link the funding by those voluntary bodies to agreed levels of service as part of the integration of those services into the wider provision of health and personal social services throughout the country.

It is important to recognise that the preparation of a service plan for AMINCH for 1998 was undertaken in the unusual circumstances of the merging of the three base hospitals and a move to a new facility in Tallaght. These factors complicated the service planning process in 1998 for a number of reasons, including:

- This was the first year that a consolidated financial budget was being agreed for the AMINCH hospitals.

- The management team for the new Hospital had only recently been established in early 1997.

- There were a range of significant factors which rendered the preparation of a financial budget difficult, largely associated with the commissioning and opening of the new Hospital and the transfer of services from the base hospitals. The ability to rely on historical trends in these areas, a feature of all service planning, was not possible in the preparation of the 1998 service plan for AMINCH.

While it is acknowledged that these unusual circumstances prevailed in 1998, there are lessons to be learnt for future service planning:

(i) the 1998 service plan was regarded primarily as the preparation of a financial budget for DOH&C funding purposes. Indeed, it is almost certain that a service plan would not have been prepared had the DOH&C not required it under the Letter of Determination.

In future years, it is essential that service planning is an integral part of the management of the Hospital and is set in a strategic framework. This means that the Service Plan should include a strategic review of the position of the Hospital, the needs of its catchment area and the impact of shifts in service provisions. Service and activity data by specialty is required. The service plan should be a more broadly based document which informs the reader of strategic, operational and financial matters relevant to the ensuing year. The 1998 plan comes nowhere near the form of plan required. Fundamentally, the plan must operate within the Determination of the DOH&C.

The service plan should derive from and be consistent with an overall medium term strategic plan for the Hospital.

(ii) The preparation of the Service Plan should be an inclusive process involving management and clinicians throughout the Hospital, a process suggested in the Letter of Determination. The extent of the involvement of management and clinicians in the 1998 service plan was limited. The 1998 Service Plan is weak in relation to service planning at specialty level. Particularly in the context of the Hospital's plan to move to a programme structure, it would be essential that the Service Plan is built up through programmes to identify strategic objective, policies and plans for each programme.

(iii) The expenditure and plan should be split across the range of services, identifying the areas in which resources are being consumed. This was not done in the 1998 Service Plan.

(iv) Service issues need to be specified, including the shifts occurring within services relative to prior years.

It is imperative that the Hospital approaches the preparation of Service Plans in line with the above criteria. This will not only improve the quality of the Service Plan submitted to the DOH&C on an annual basis in response to the Letter of Determination, but importantly, form an integral part of the longer term strategic planning of the Hospital. The service plan should, within the parameters of funding available from the DOH&C, be for the first year, of a medium term plan for the Hospital.

4.7 THE CORE ISSUES ON SERVICE PLANNING

4.7.1 THE PRIMACY OF THE LETTER OF DETERMINATION

The Service Plan underpins the relationship between the Hospital and the DOH&C in relation to services being provided and related funding. The primacy of the Letter of Determination in setting the basis for this relationship should not be understated. The Letter of Determination of 4 December 1997 is unambiguous in relation to the basis on which funding is provided and the requirements in relation to service planning, reporting, employment control, the attainment of value for money and the delivery of better quality health services. The problems associated with the funding of the Hospital for 1998 must in no way undermine the primacy of the Letter of Determination in future years.

There are a number of references in the chronology to the Hospital pursuing negotiations with the DOH&C on funding, on separate submissions on funding being made, on ongoing discussions etc. There is also reference to AMINCH regarding it as an initial letter of Determination. We are of the view that the letter of Determination is clear on the areas in which supplementary funding would be available, and that it could not reasonably be interpreted that the process allowed for further funding outside of the areas specified for supplementary funding. It is important to note that the Determination process does not provide for any such processes. The DOH&C refute the suggestion that they were involved in negotiations on funding, and that they had consistently made the position clear that no further funding, capital or revenue, would be available.

4.7.2 GOVERNANCE

In the final analysis, on 8 April 1998, the Board of AMINCH adopted a Service Plan which reflected net expenditure some IR£5.9m in excess of the amount included in the Letter of Determination. There was at that stage no definitive source of funding for that excess. The minutes of the Board meeting of 27 March 1998 acknowledge that the plan was to reflect the current level of activity in a deficit situation and that the CEO was to proceed with the conclusion of the Service Plan on this basis. The minutes of the Board meeting of 1 April 1998 state that the CEO indicated that officials from the Department had advised that the Minister is adamant that the provision of services must be carried out within the allocated budget. The Resource Committee meeting of 7 April 1998 concludes with a recommendation that the Board adopt the Service Plan which included an excess of IR£5.9m over the amount included in the Letter of Determination. The minutes of Board meeting of 8 April 1998 also

record that the CEO advised that negotiations were taking place with the DOH&C to seek to reach an agreement that this amount could be funded outside the Letter of Determination.

As we have noted earlier, members of the Board have stated to us that the decision to adopt a service plan in excess of Determination was not taken lightly and that the Board were aware of their legal responsibilities in this regard. They have stated that the decision was made only on the basis that the CEO, and certain of the members themselves, had an indication from discussions with representatives of the DOH&C that a way to fund the deficit could be found, and that a mechanism to achieve this was to assess the extent that expenditure, contained in the service plan under revenue, could be reclassified as capital expenditure. The service plan reflects such an approach and reflects a reclassification of certain items as capital, amounting to c.IR£4.9m. For the most part, these were costs associated with the commissioning of the Hospital and pre opening costs relating to new developments, and could not, in strict terms, be regarded as capital expenditure.

It is evident from minutes of meetings and correspondence that discussions did take place on capital expenditure. As noted earlier, the minutes of the meeting of 31 March refer to no additional revenue funds being available, "whatever about the possibility of getting some element of capital funding", and suggest that the budget be examined with a view to separating out capital items. In other places, there are references to no additional capital funding being available (for example the meeting of 4 March 1998). The CEO of the Hospital has stated to us that, based on discussions with DOH&C representatives, he had the distinct impression that while there was no funding available at this time, that funding, particularly of a capital nature, would likely be provided by the end of the year. The DOH&C letter of 3 April 1998, the last correspondence on the matter before adoption of the service plan is very clear on the matter, stating that no further funding (either revenue or capital), would be available to bridge the gap between projected expenditure levels and the amount advised in the DOH&C's Letter of Determination of 4 December 1997. The approach taken in the plan is at variance with the letter of 3 April 1998

The Guide to Governance and Management of the Hospital issued in September 1998 sets out the responsibilities of the Board of Management. These include a requirement "to manage the property and finances of the Hospital in accordance with the powers set out in the Charter" and to "implement, evaluate and review appropriate management systems".

We are of the view that the adoption of a service plan some IR£6m in excess of Determination without certainty on how the excess would be funded does not meet the standard of good governance, whatever the circumstances and the perceived inadequacy of the Determination. We are of the view that the Board of AMINCH should not have adopted the service plan on governance grounds.

There appears to have been a view that some agreement could have been reached with the DOH&C on additional funding given the circumstances of the move; again whatever the basis for this, it was not an appropriate basis on which to adopt the service plan.

We are also bound to express concerns at the fact that the Board did not have the service plan of 26 January 1998 presented to it for approval, nor did it have the Letter of Determination presented to it until late March 1998. We are advised that the letter was not tabled until such time as it was obvious that no further funding would be forthcoming from the DOH&C, despite many AMINCH efforts. As noted above, the letter of Determination is not negotiable. In our view, the letter of Determination should have been presented to and fully discussed by the Board at its 17 December 1997 Board meeting, and that the service plan of 26 January 1998 should not have been presented to the DOH&C unless it had been Board approved.

4.7.3 THE HANDLING OF SERVICE PLAN IN EXCESS OF DETERMINATION

It is evident from the chronology that the DOH&C had emphasised to AMINCH that a service plan within Determination was required and that no further funding was available. Following receipt of the AMINCH service plan on 26 January 1998, the DOH&C, at their meeting on 13 February 1998 reiterated that no further funding would be available and requested a revised service plan within Determination. Between 13 February 1998 and 8 April 1998 (date of submission of approved service plan by AMINCH board) there were numerous meetings at which these points were again emphasised. In the letter from DOH&C on 3 April 1998, it again stated that no further funding would be available to bridge the gap between projected expenditure levels and the amount advised in the Letter of Determination.

On 8 April 1998, the DOH&C received the board approved service plan from AMINCH, which indicated an excess over Determination of IR£5.9m. A letter issued from the DOH&C to one of the accountants in the hospital's finance department on 23 April 1998 in response to an earlier letter from him stating that the service plan was not an agreed document. The DOH&C have also stated to us that they clearly indicated that the service plan as submitted was unacceptable during meetings subsequent to 8 April 1998 with representatives of AMINCH. This was interpreted by AMINCH as the service plan being rejected and was recorded as such in the minutes of the meeting of 28 May 1998.

We accept that on many occasions the DOH&C made its position abundantly clear to AMINCH on the need for a service plan within Determination and in emphasising that no further funding was available. However, we would have expected the DOH&C to have issued a formal written response to the CEO of AMINCH rejecting the service plan submitted on 8 April 1998 because it did not plan within Determination and requesting the CEO to bring this matter to the attention of the Board who had approved the plan. No such formal written response issued. We are of the view that a formal written rejection of the service plan should have been sent to AMINCH particularly as we would have seen it as a natural consequence of the DOH&C applying the terms of the Accountability Legislation in an administrative way to AMINCH as stated in the Letter of Determination

This approach may have been taken by the DOH&C out of recognition of the significant workload and pressures falling on the Board and management at the time the service plan was submitted in April 1998, associated with the planning of the move and the opening of the Hospital on 21 June 1998, a date which was then only some ten weeks away. It is not possible to gauge whether a more formal rejection of the service plan by the DOH&C would have encouraged the Hospital to pursue a cost minimisation approach to expenditure in the Hospital; it could not have detracted from it.

4.7.4 APPROPRIATENESS OF USING THE DETERMINATION PROCESS IN THIS CASE

We recognise that the system to fund the revenue expenditures of Hospitals is that provided in the Determination process. There is no other system. However, it is reasonable to examine if this system is well suited to the opening of a major Hospital.

The complex element of the AMINCH Determination concerned development and commissioning expenditures, and the estimation of costs, which would arise in the new Hospital. This was also the area of the service plan, which exceeded Determination. In arriving at the Determination for 1998, the DOH&C would have had to estimate in late 1997 the impact on the base hospitals' budget of development and commission expenditures for a hospital due to open on 21 June 1998. An amount of IR£4m was included in the Letter of Determination in this regard, which, together with an amount of IR£1.9m (including IR£0.4m in respect of FDVH) included in the base allocation for prior years, rendered the total figure

of IR£5.9m towards the costs of essential developments relating to the integration of the services in the base hospitals in advance of the opening of the new Hospital at Tallaght, to the transfer of those services and the anticipated costs arising from approved consultant's posts and pathology laboratory staffing.

While the DOH&C provided an amount in the Determination for these matters, it would have been extremely difficult for it to estimate the requirements with any degree of precision at the time they were required to do so, particularly as the Hospital had itself not projected the requirements. By their nature, costs associated with developments in and transition of organisations are more difficult to predict, particularly as the ability to draw on historical experience is limited. The Determination in respect of developments and commissioning was therefore a relatively blunt instrument.

We have concluded that the Determination process does not lend itself well to a situation of major change, such as the opening of a major new hospital. We are informed that prior to the letter of 14 February 1997, the DOH&C carried out an exercise on the potential funding requirements for the new hospital in Tallaght on a number of scenarios, including; one based on casemix, one by reference to a comparable hospital and one on an incremental approach. The last of these was chosen. The decision to base the 1998 Determination on the cost structure of the three base hospitals plus certain additional monies was inappropriate. The difficulty this approach created was that no fundamental review of the likely cost profile of the Hospital was ever undertaken. Comparisons are now being made with the consolidated cost base of the base hospitals rather than with an expected cost profile for the Hospital itself. In our view, this is not appropriate. Our comments are not intended in any way to undermine the Determination process, but rather to recognise that its effectiveness in controlling healthcare costs is suited best to existing, more stable entities.

This raises the question as to how best to approach such a situation. What should have happened is that based on the design configuration of the Hospital, the number of beds, the anticipated levels of activity and discharges, a detailed operating profile for the Hospital should have been created by AMINCH. This would have detailed the numbers and type (category) of people including consultants, junior doctors, nurses, porters, support, administration etc. required to support the activity levels. This in turn would have produced a detailed pay cost and profile for the Hospital. Non-pay costs could be similarly assessed, profiled and costed based on the given activity levels. There are a number of comparable hospitals within the Irish healthcare system and appropriate benchmarks could have been established against which the cost and activity profile of the Hospital could have been compared and determined. This process would have to have been driven by the Hospital.

Once developed, the profile and the related cost structures would form the basis for departmental budgets and would have driven the process by which people, materials and equipment were transferred from the base hospitals and defined their roles and duties within the Hospital. Any gaps in staff, shortfall in numbers or any temporary staff needed to manage the transfer and integration process would have been readily identified. Department heads would have immediately been required to compare actual outturn, costs etc. with the budgeted profiles and would have been obliged to seek to manage their departments against the agreed budgets.

The adoption of this approach would also have helped identify the absolute need for efficient and effective information systems as a pre-requisite of any budget based management approach.

In our view, this detailed 'bottom up' financial plan for the move and for the operation of the new Hospital should have been prepared no later than mid 1997, well in advance of the Determination process, and would have required the development of a financial plan for the

issues concerning the move, the commissioning of the Hospital, and for each department of the Hospital, based on realistic staffing levels and grades, and identifying associated pay and non-pay costs in each area. The financial model produced would be subject to review, challenge and refinement prior to finalisation, including input from the DOH&C to assess the assumptions and their reasonableness. A contingency allowance would be also be included to recognise the fact that unexpected matters will arise in any financial planning exercise of this nature. The intention would be to generate a financial plan which all parties would accept as a reasonable basis for projecting the move and the new Hospital's operations. In terms of the relationship with the DOH&C, it would have meant that a realistic and informed cost profile of the Hospital would have provided the basis for discussion in relation to the Letter of Determination. The financial plan would itself underpin all other planning for the move and the operations in the new Hospital, thus linking future actions back to the level of funding which was available.

Many aspects of the new Hospital were subject to detailed planning; plans were developed, inter alia for building, equipping, the logistics of the move, the merger of the base hospitals etc. It is surprising that a detailed financial plan for commissioning, the move and the operations of the new Hospital had not been prepared by AMINCH. The first time the issues associated with such a plan could be focussed on was early 1998, when the service plan was being prepared. By then, it was too late to realise the benefits which earlier financial planning would have reaped.

4.7.5 PLANNING WITHIN DETERMINATION

Undoubtedly, the most contentious aspect of the 1998 Service Plan is that it did not meet the requirement of the Letter of Determination, i.e. that it did not plan the activities of AMINCH for 1998 within the level of funding available under the Determination.

There are a number of points of relevance in this regard:

- ***Activity***

  The letter of determination requires a plan to be prepared within the given level of resources. It does not specify any level of service. The decision to plan for a similar level of services as in the base Hospital for 1997 was the Hospital's. As we have indicated elsewhere, the Board of AMINCH regard the Charter as the basis on which the new Hospital is entitled to carry on the same level and type of services as in the base hospitals. Clause 5 of the Charter states that the new Hospital shall carry on the activities previously carried on by the Adelaide Hospital, Dublin, the Meath Hospital and the National Children's Hospital and that the new Hospital shall assume responsibility for the hospital services and equipment provided and held by each of the base hospitals immediately before the transfer day. The Charter, however, is not explicit on level of service, nor do we believe it could be, as the level of service to be provided by any agency will vary one year with the next, and particularly as the concept of service agreements, which would include specifying a level of service for a given level of funding on an annual basis, is at the heart of the Health Strategy "Shaping a Healthier Future".

  In its service plan, the Hospital indicates that it would have to close 290 beds for the period July to December 1998 to achieve a saving of IR£2.5m, which it regarded as an unrealistic proposition. Whether this is accurate or not, it does reflect the fact that a significant element of cost in any Hospital of a relatively fixed nature, and that security of tenure (to which staff in AMINCH were entitled) limits the scope for pay cost reduction.

In our view, a strategy of service reduction, however undesirable AMINCH may have regarded it, was open to the Hospital, although it would in all probability only have partially reduced the planned excess of expenditure over Determination.

- ***Savings***

One would ordinarily expect that in merging three like entities that significant synergies would arise. In the case of AMINCH, the ability to achieve savings in pay would clearly have had to relate largely to the redeployment of staff, given the protocols agreed with the unions over security of tenure of staff in the base hospitals. However, the Hospital had not planned the integration of functions in a systematic way and thus the scope for redeployment of staff was not well understood at the time of preparation of the Service Plan, particularly in relation to the reorganisation of support services staff in the new Hospital. The considerable deficiencies in personnel systems in the base hospitals referred to elsewhere in this report, did not help in planning the process of integrating support service staff. It is probable that reductions in temporary and commissioning staff could have been achieved had the integration of the base hospital support service functions been better planned.

As far as efficiencies in non-pay are concerned, we would have expected some savings to arise from the funding of the base hospitals, for example, in relation to the non recurrence of certain maintenance and professional fees.

The service plan does not build savings into the budget for the year, but acknowledges the potential for savings of IR£1.5m in seeking to bridge the gap between budget and determination.

- ***The Laboratory***

The total costs projected for the laboratory in 1998 are IR£3.6m. Of this, pay costs account for IR£2.2m. The Hospital is strongly of the view that it would not have been appropriate on clinical grounds to open the new facility in Tallaght, unless it had the laboratory, fully staffed in line with DOH&C approval, in operation at the time of the opening. The DOH&C refute this view, and have stated that this position is not confirmed by the clinical advice it has received. The DOH&C's position on laboratory staffing is clear from their letter of 18 December 1997, i.e. that approval was given provided the development was carried out within Determination.

The question arises as to whether the phased introduction of the laboratory would have made a difference to the ability of the Hospital to come within Determination. We have already outlined the Hospital's views that this was not appropriate on clinical grounds. From a financial perspective, it appears to us that a phased introduction of the laboratory, which would have resulted in savings in pay and non-pay, would have reduced but not eliminated the extent of any excess expenditure in the year.

The next option to consider is whether the Board could have decided not to open the laboratory at all during 1998. It appears to us that any such decision would have to have been made in early 1998 for it to have achieved a significant cost saving in 1998. By April, when the service plan had come to the Board for final approval, it was getting too late to make this decision, even if it was considered the appropriate thing to do.

The Hospital took the view that the laboratory was approved, and proceeded to put it in place. The Department position is laid out in its letter of 18 December 1997, i.e.

approval was conditional on the costs being met from the Determination. Once a decision to proceed with the laboratory was taken, it was most unlikely, given the nature of the other developments and commissioning involved, that AMINCH could have prepared a Service Plan in 1998 which was within the amount provided in the Letter of Determination.

It should be noted that at a meeting between DOH&C and AMINCH on 13 March 1998, following discussions on the parameters for funding (including the Secretary General's letter of 14 February 1997), the difficulties being faced by AMINCH appear to have been recognised: the minutes of the meeting record the DOH&C stating that it appreciated that it was very difficult for the Hospital to gauge service pressures in the new Hospital but that it is recognised that there would be ongoing discussions concerning additional funding and that this would be sought over a number of years. It was however emphasised that despite these difficulties, the parameters letter of 14 February 1997 set out the basis on which planning should take place. The DOH&C stated that it "was not going to walk away from Tallaght in terms of its needs but its wants were a different matter" and also added that they "thought they had put enough aside, while it does not look like that now, the amount is set."

We have formed the following views:

- The fact that the Letter of Determination and service plan were not presented to the Board until late March 1998 limited the options open to the Board to plan within Determination. By the time the Board came to approve the service plan in April 1998, the opening was approaching, and decisions had been taken which committed AMINCH to courses of action and related expenditures. Implementation of the plan by management to open the laboratory was very advanced, with significant recruitment in hand or having already taken place.

- We have stated that, in our view, the Board of AMINCH should not have adopted the service plan in April 1998. We recognise that this would have been a continuing source of difficulty with the DOH&C. Because it took until April to approve the service plan, the Board had, by that stage, reduced its operational options to plan within Determination. It may well be that, by that stage, the only option was not to open the Hospital on 21 June 1998.

- It was clearly the responsibility of AMINCH to prepare and submit a service plan within Determination and which would take account of the policies and objectives of the Minister for Health & Children and of the Government. It may well have been possible to prepare a service plan within the Determination, however, in our view, in order to achieve this, a detailed planning process would need to have been commenced by AMINCH by mid 1997 at the latest. This would have allowed AMINCH, on receipt of the Determination of IR£53.6m, to readily access the profile of Hospital in Tallaght which could be operated from within the Determination amount. No such process was put in place. The Determination process imposes the obligation on every agency to prepare a service plan within the amount of Determination and this in turn dictates the profile of the hospital in terms of services, staffing and activity.

  In the service plan dated 8 April 1998, AMINCH set out its intentions for the Hospital for 1998: the profile of the Hospital presented reflected a level of service consistent with the base hospitals (a matter stated in the plan) and the costs associated with; a fully functioning laboratory at the time of opening employing c.100 employees, IT

group, commissioning the hospital and costs arising from operating at the new site in Tallaght. This plan which was IR£5.9m in excess of Determination and as such did not meet the requirement to plan within Determination. In our view, for this profile of hospital, the non-capital Determination for 1998 was never going to be sufficient to fund the intentions of the Hospital as set out in its service plan, for an opening date of 21 June 1998.

Had the Hospital been in a position to prepare its service plan in advance of the setting of the Determination for 1998, it could have been used to inform that process. Had this been the case, the Service Plan could have been used as a basis to seek to justify at the very most a need for further funding of c.IR£4m (i.e. after allowing for the savings in the cost base which were identified by the Hospital in its plan). We acknowledge that the DOH&C might not have accepted this and this may have required AMINCH to plan and operate a different profile of Hospital and thus reduce the funding requirement for the year. This amount of IR£4m is materially at variance with the level of non-capital expenditure now expected to be incurred in 1998 as outlined in section 10. Our opinion therefore that the Determination was never going to be sufficient to fund the intentions of the Hospital as set out in its service plan, should not in any way be taken as justifying the level of non-capital expenditure actually incurred.

It is also important to note that any perceived insufficiency in the Determination which the Hospital may have considered to exist did not in practice curtail actual expenditure incurred by the Hospital. For this reason there would be no justification for suggesting that any lack of funding or the perceived insufficiency of the Determination itself, caused or contributed to the deficiencies in the Hospital's management, reporting and control referred to elsewhere in this report.

- The Hospital's service plan projected that an additional IR£5.9m was required over Determination. Whether this amount was accurate or not, it is evident that this excess is significantly at variance with the actual excess of revenue expenditure over Determination projected for 1998 of IR£12.8m. The service plan therefore was not the basis of any actual plan against which actual events were measured nor was it used as the basis for staffing and other decisions; had it been used as the yardstick for performance since April, it would have caused spending decisions to be challenged before expenditures were incurred.

4.7.6 IMPROVEMENTS IN FUTURE SERVICE PLANNING

There is room for significant improvement in the quality and content of the Hospital Service Plan in future years and in the process in which it is prepared. Most importantly, it needs to be set in a wider strategic context and not be predominantly an exercise in financial budgeting.

SECTION 5
CAPITAL EXPENDITURE

5.1 INTRODUCTION

The responsibility for the planning, building, equipping and furnishing of the Hospital, within budget, lay with the TRHB. It may be asked, then, why should capital expenditure form part of this review. The reason is that significant costs of a capital or quasi-capital nature have arisen in recent months, which AMINCH, having regarded as necessary, commissioned. These costs are regarded as unattributed between the TRHB and AMINCH. These arise primarily in respect of building alteration work and the purchase of certain equipment perceived as necessary by management, to open the Hospital.

This chapter of the report reviews all aspects of capital expenditure. It has been based on discussions with the Project Director of the TRHB, the DOH&C and representatives of AMINCH and St James Hospital. An examination of the TRHB was outside our terms of reference, and as such the analysis presented in this section on the building and equipping issues which came to our attention may not be complete.

The key areas covered are; the processes by which Capital Expenditure was budgeted for and controlled; a financial summary of costs and commitments; and an overview of the future costs and developments. The section ends with a summary of the issues identified and the conclusions reached in relation to the effectiveness of the above processes.

The focus of this capital expenditure section is on the equipping costs. The actual building costs, and settlement of any final accounts with the contractor are outside the scope of this review. Commentary on the design or building processes is included as appropriate in setting the contextual background.

The construction of the Hospital has been carried out under the direction of the Tallaght Regional Hospital Board. It was planned to open the new Hospital in August 1997, this was ultimately delayed until 21 June 1998. The TRHB took possession on a phased basis from June 1996. The final handover of the main hospital building took place at the end of May 1997. Following a submission from TRHB/AMINCH for additional funding of IR£18m, additional capital funding of IR£4.1m for improvements principally in the following areas was sanctioned in March 1997:

- OPD – alterations and extension
- Intensive Care Unit
- Theatre Recovery area
- X-Ray Department Alterations
- Extension to HSSD.

Since then, funding for the following areas was also considered but no additional funding was approved.

- The need for additional office space for administration. The only explanation given other than lack of planning, for the sudden increased demand for office space stems from an operational brief written by the TRHB that certain management and

associated staff would be distributed across the organisation, and not centralised in administration areas.

- The need for additional space for medical records, which has subsequently led to use of hospital facilities originally designated for other purposes, e.g. hydrotherapy
- Additional Car parking (the car parking provision meets the Local Authority's car parking requirements and as such the additional requirements were considered unnecessary by the DOH&C)

The total capital cost provisionally approved by the DOH&C is approximately IR£133m, with an ERDF funding commitment of 30% of the total cost subject to a maximum of 39.37m ECUs. Additional facilities, as outlined in section 2, are provided in the construction of the Hospital. These are planned to come onstream in 1999.

In March 1997, the DOH&C agreed to the Hospital's proposals, subject to conditions, to develop private and semi-private facilities providing 76 additional beds. The development of this facility is the responsibility of the Board of the Hospital. The hospital management is currently finalising its arrangements to proceed with construction of a Private Wing. Construction is due to commence in November 1998, with a completion date of late 1999/early 2000.

The buildings and sites of the three transferring voluntary hospitals, which are owned by the hospitals or their successor bodies, will be closed and sold. An agreement has been reached for a contribution of IR£3.5m over 10 years to be committed to specific programmes at Tallaght. These programmes will require the prior approval of the Minister for Health & Children, the Hospital Board and the Foundations.

5.2 CAPITAL EXPENDITURE PROCESSES

5.2.1 BACKGROUND

The new Hospital was designed in accordance with the requirements of a Planning Brief, prepared by the TRHB and its planning group. An overview of the timing is set out below:

- Initial planning brief was completed in March 1984
- An architectural competition for the project was held in 1984/85
- Planning in accordance with the Planning Brief was completed in September 1990
- The function, scope and scale of the new Hospital was reviewed by the 'Kennedy group' in May 1992
- Following the Kennedy report, revisions were made by the TRHB to the initial plans. These were subsequently approved by the Minister for Health in March 1993, allowing approval to go to tender in June 1993
- Tenders were received in September 1993, the contract was awarded to Laing Paul, and construction commenced in October 1993.
- The final phase of the Hospital was handed over to the TRHB in May 1997

A number of changes/alterations have been made to the original design/contract agreed with Laing Paul. In the majority of cases the alterations did not reflect significant construction work. These however have been necessary due to changes in medical practices, procedures, technology, and health & safety. The most significant change is the major expansion of the OPD.

Since the 21 June 1998 the Hospital is held by AMINCH on a 150-year lease at a peppercorn rent from the Minister. An agreement for lease already existed to facilitate the development

of the multi-storey car park. The commencement of the lease was due to coincide with the transfer of functions from the TRHB to AMINCH on the 1 May 1998, but this has yet to happen

The Charter provides for the transfer of the responsibilities and liabilities of the TRHB to AMINCH at a time to be determined by the Minister. In September 1997, the Chairman wrote to the Minister formally requesting that a date be determined upon which the functions and responsibilities would be assumed by the Board of AMINCH. The Chairman stated that "the need for a single authority and tight control by our Board and its staff is the single most important step in achieving the earliest and most effective date to open the Hospital". In his reply, the Minister stated that this would take place no later than 30 April 1998. This did not occur as intended because the Board of AMINCH required a blanket indemnity from the Minister in respect of liabilities to be assumed and compensation in respect of faults in the buildings and the equipment of the new Hospital. The transfer has yet to take place. The Department has referred the matter to the Chief State Solicitor's Office and the Attorney General's Office and has written to the Board of AMINCH outlining the difficulties in complying with this request. Subsequent to this a delay has resulted from The Board's request for amending legislation, which it has been advised is necessary to vest the assets and liabilities of the TRHB to AMINCH.

It is not within the remit of this study to comment on the effectiveness of the design. Much comment has been made about the level of involvement of users in the planning, this was co-ordinated by the TRHB's nurse planning officer. Whilst the active participation of users is vital, it is unlikely that they would have had any training in how to read plans, which can prohibit users from critically assessing design issues. DOH&C stated that it expected that the role of Nurse Planning Officer was designed to overcome this problem.

5.2.2 PROJECT ORGANISATION

The design, planning, build, equipment, and furnishing of the Hospital was overseen by a Project team, which reported to the TRHB through the Project Director. The management of the project was by external project management consultants who reported to the Project Director.

In terms of equipping the Hospital the team included medical representation from all the base hospitals. Plans of departments were discussed and agreed with users. A Nurse Planning Officer was used to identify areas for change, and report to the project team. The key elements of the project organisation are set out below:

- ***User Groups***

  The purpose of these groups was to define user requirements, develop detailed briefs, and schedule and specify requirements. Part of their brief was to look at operational policies and manpower planning for the new hospital. It was planned that the chairman of the working groups would be the TRHB project director, though it would have been unrealistic for him to chair all these groups. It appears that in practice the project management consultants were chairing these meetings. The user groups did not hold budgets. Users groups comprised, on an as required basis, clinicians nursing officers, equipment specialists, the Information Services Officer, the Personnel officer, the Technical Services Manager, project managers and members of the Design Team. These user groups reported formally to the Project Team of the TRHB In the early stages much of the discussion at the user groups related to the building rather than the equipment requirement.

- ***Equipping Steering Committee***

  The purpose of this group was to review project strategy and implementation. This equipping steering committee was planned to include the equipping manager, the commissioning manager, the manpower resources manager, the IS officer, the Nurse planner (who was also the User Group Co-ordinator) the programme manager, representatives of the DOHC and the Finance officer. Some of these positions were not being filled and ultimately were not represented in this group. Individuals who are now on AMINCH's management team filled a number of the roles of this group. This group ultimately reported to the TRHB project team.

- ***Equipping Joint Sub-Committee of the TRHB and AMINCH;***

  This committee was set up late in 1997, in response to growing concerns that the equipping process was not being carried out in a timely fashion. It was set up as a driving committee to ensure that the hospital would be equipped in time to facilitate opening the hospital. It was chaired by the Chairman of the TRHB and its membership included both the Chairman and CEO of AMINCH, the Project Director of the TRHB, representatives from the DOH&C and representatives of the Project Management Consultants.

- ***External consultants***

  The above user groups and Equipping Steering Committee were managed by external project management consultants.

5.2.3 PROCESSES

The overall equipment budget for the Hospital is provisionally IR£24.9m; this excludes the ISIT IR£4m capital budget (held by the FDVH) and any equipment being transferred from the base hospitals. The IR£24.9m includes c.IR£2m provisionally approved expenditure relating to sterilisation of hospital instruments and procedures in pharmacy, which arose as a consequence of changes in EU Directives. In addition, the Hospital has installed a filmless radiology system (PACS) at a cost of c.IR£2.9m. The equipment budget covers a maximum of IR£975,000 for this system, which is the approximate cost of an alternative "wet" system, as originally specified. However, the DOH&C has not approved this amount; it contends that based on the received tenders the amount approved should be of the order of IR£675,000. The Hospital plans to arrange borrowings of c.IR£1.9m to fund the difference over what they understand to be in the budget of IR£975,000. The DOH&C consented to the investment in PACS on the basis that the future operational savings, which will arise from the use of this new technology, will finance the debt requirements.

The equipment budget was set in the context of the movement from the base hospitals. The initial budget at IR£23m Budget was set by the DOH&C. Some analysis was carried out by the project management consultants, who prepared a schedule in February 1996 which gave a breakdown of estimated equipping costs by department against a budget. This showed a potential overrun of IR£3.77m, which was balanced to the original IR£23m by increasing the budget on transferable items from IR£1.2m to IR£3.7m. This balancing is questionable especially as there was not an asset register in place.

The budget was broken down into departments using the 'model room concept'. This was an equipping software package, which was developed by CHL and the DOH&C. The original basis for the budget was that it would fully equip the Hospital. It was however understood that

a certain amount of equipment was to be transferred, thus providing some flexibility in the equipment budget.

The "model room" concept sets out for any type of hospital room what the particular equipment needs should be. This approach is based on a software package, which was operated by St James, who keep it up to date with the latest price information which they have as a result of their equipping consulting. Effectively this software holds a capital equipment log for each model room. Against each piece of equipment held on this log is the purchase price of that piece of equipment, based on the last time that equipment was purchased. The model rooms for the new Hospital were agreed with DOH&C. This approach gives a good representation of what equipment is required to equip a hospital.

The model room concept requires constant updating, particularly for changes in technology and statutory requirements. In the case of the Hospital, such changes particularly impacted on HSSD and the equipment requirements for the theatres.

As discussed earlier, budgets were determined at department level. However departmental budgets were never issued to users. In effect the original allocation was made on a departmental basis, but thereafter budgetary responsibility was not given to departments. St James' were not involved in project managing the equipping of the Hospital, they provided technical assistance to the equipment group on an as required basis. The also assisted the Hospital in recruiting and training staff. In 1994 they presented a process and plan for how to equip a major hospital, based on their considerable experience. This set out the organisational structure that would be required of an equipping function, and the individual roles of user groups etc. This was accepted by the TRHB at the time, but was not fully adopted, in particular how the user groups were established and utilised (though this is refuted by the Project Director of the TRHB).

A decision was made by the TRHB, that the users would not see the cost figures generated by the equipping software. In order to communicate the equipment as presented in the 'model room' an extract was created in a 'word processing' package which excluded the equipment costs. From that point on it was this document that got updated, rather than the equipping software, which then prohibited timely and appropriate reporting of cost information against budget as held on the equipping software. This also explains the disconnect between packages as sent out for tender and the 'model room' and thus department requirements.

Furthermore this equipment budget of IR£23m which was set in 1993, related to equipment much of which was not purchased until 1998. We are informed that the budget included a provision of IR£1m for changes in currency and an allowance for inflation up to August 1997. Given the five year timeframe which spanned the period from initial determination of the budget and final equipping, it would have been difficult to predict the impact of changes in technology (and thus the costs), inflation and foreign exchange variations.

User groups were involved in agreeing the equipment from the model rooms. Certain changes reflecting changes to procedures and technology would have been taken on board and agreed by the DOH&C, e.g. the HSSD procedural changes.

The Equipping process was hindered by a lack of agreed operational policies(at a hospital and departmental level). Once the equipment requirements were agreed, they were aggregated into particular packages to support the selected tendering process. Responsibility was then given to people to manage equipment packages. Budgets were allocated to packages, (though it is unclear as to how visible these budgets were or how accountable people were for delivering against the budget). As such each department did not understand its equipment budget. There was no audit trail from a particular package to a Department. All reporting was done at package level. The budget holder was the equipment steering committee, the various

equipment user-groups then came with requests for the equipment they required. There was insufficient management information provided to allow reconciliation of the base hospital assets with the net requirements for equipping the new hospital. According to AMINCH enquiries as to what was going into each room were not answered.

A selected tender process was used. Hence, any company tendering should have had the capability to deliver against the required specification. Provided the tenders submitted conformed to the specification, then the most economically advantageous tender should be chosen. Tendering was as per EU regulations. There was an elaborate tendering process in place, including how and when tenders were to be opened and thereafter evaluated. The evaluation process comprised a financial evaluation based on 'whole life' costs and a technical assessment carried out by the equipment group, and MPBE in consultation with the user. This was a time consuming process and there was a feeling by users that user involvement in the assessment process was happening too late and that earlier involvement could help speed up the process. Users also expressed the view that they were frequently given insufficient time to make an assessment. On the other hand, the Equipping Steering Committee felt that the users were being unresponsive.

External Consultants were employed to project manage the equipping and commissioning processes, and to manage the transfers from the base hospital. The TRHB delegated authority for these processes to these project managers and the equipment steering committee, on the basis that they stay within budget. As project managers for this project, they prepared a detailed project handbook setting out the project organisation, the resources and the control processes. The TRHB and the DOH&C had input into this Handbook. This was a dynamic document, and whilst it has been indicated that all parties had significant input to it and agreed to this handbook, there is no indication that it was ever signed off by the respective parties. The project managers had a dual role in terms of project managing equipping and commissioning of plant. They were also responsible for co-ordinating all activities to deliver the hospital on time and within budget. They were responsible for chairing the users groups, which were drawn from the base hospitals, but which have been described by the TRHB and the DOH&C as being too large, unfocused and unwieldy (despite being set up by the TRHB). Too much time was required to be spent chairing user groups rather than getting on with the executive tasks of equipping the Hospital.

There was concern on behalf of all parties (AMINCH, TRHB and the DOH&C) that the service provided by the external project managers was unsatisfactory and did not meet the terms set out in their engagement. Project managing a job of this nature is highly specialised. We are informed that, at the time of their appointment, the project managers had nominated one of their consultants with expertise in hospital equipping. This key individual left the firm of consultants prior to commencing this assignment. The DOH&C are of the view that a satisfactory replacement was not found until late in the process, and that the process was not adequately driven or controlled until then. From our understanding of the situation we would conclude that TRHB Project Director did not adequately manage these project managers. As a result there were timing delays in purchasing equipment. The net result was the setting up of the joint equipping sup committee to facilitate the perceived equipping crisis, such that the hospital could be equipped prior to its opening in June.

We understand that when the DOH&C made their concerns known to the external consultants, they were informed that the TRHB was their client and not the DOH&C. A number of representations were made by the TRHB to the firm of project managers, the impact of which appears to have resulted in a change in personnel at the end of 1997, which was at a very late stage in the process – the ordering of equipment was due for completion in

January 1998. The project director is also of the view that he was further constrained by:

- Lack of timely responses
- Lack of clear sign off by user groups
- Lack of operational policies for the hospital

This may have reflected the reality of what was going on, but it is clear that the processes for managing the equipping of the Hospital were weak and poorly managed. A major complaint of the Hospital is that the user groups were not listened to. Under the project handbook the Project Director was to be the chairman of the user groups. These user groups were tasked not just with identifying the equipment requirements, but also with manpower planning, and developing the operational policies.

Budgetary control was weak. Packages of equipment could be approved for purchase without consideration of Budget constraints. In April 1998 the Equipment Steering Committee agreed that in future, items within packages approved for purchase, though not yet ordered, should be tabled for prioritisation. This is despite the fact that the equipping budget report dated the 7th of Feb 1996 indicated an estimated equipment cost of IR£26.77m. Furthermore this figure was understated, as c.IR£7.5m of the IR£26.77m was based on the initial budget, and as such there was potential for even greater overruns. The response to this overrun was to say that more would have to be transferred from the base hospital. However, nowhere was it clearly identified what could be transferred, and in which case what would ultimately require purchasing. Without doing this, the IR£23m budget could not be prioritised and allocated. It was only in late 1997 that it was decided to develop a complete asset register for furniture in the base hospitals, which was not completed until 1998. It is still not clear what equipment from this register was transferred and more significantly how this impacted on the equipment requirements in the individual packages. If there were savings from transferring from the base hospitals, their quantum is not clear, nor whether these were maximised.

The process for change control was not operated effectively. Limits on spending of individual items were breached. The DOH&C recognised that problems were emerging in 1996 and asked for a strategy to deal with controlling costs. The strategy was never delivered, and unfortunately this non-delivery was never followed up. A simple example relates to the Pharmacy, where additional costs in relation to production of cytotoxic drugs were identified. Whilst this additional cost was deemed to be self financing in the long run, in the short term the costs were intended to be met by a revenue transfer which effectively reduces the capital equipment budget, without consideration of the priorities for equipping the whole Hospital. This is also an example of how users who were better organised and more involved, were likely to do better.

Inexplicably, the steering group was also issuing agreements to purchase subject to budget. As the Equipment Steering Committee was the budget holder, it seems nonsensical to approve purchase without having the budget to do so. It should also be stated that the DOH&C had requested, at a number of the Equipping Steering meetings, that an accounting reconciliation between the tendered cost and a departmental cost be prepared. This has not been delivered. The current projection is that the equipment cost to complete is c.IR£30m.

5.2.4 HAND-OVER ISSUES

There are a number of issues relating to the hand over of the hospital by the TRHB to AMINCH in operational terms (legally this has not yet happened). The issues relating to the dual role of AMINCH's Director of Environmental Services, who also acted as the TRHB project director, were discussed in an earlier section of the report, and affected the hand-over as follows:

- It has created confusion as to where liability for certain expenditure rests, e.g.
    - The use of AMINCH's orderbook for capital expenditure
    - The party responsible for paying certain commissioning costs, and whether they had been clearly identified and agreed
    - The use of AMINCH's maintenance budget for rectification/minor alterations to the buildings and their infrastructure.
    - The decision to contract out Waste Management, which impacts on the revenue budget of AMINCH, and on the Capital Equipment Budget of the THRB.

This confusion is exacerbated by the perception that the THRB would deliver a fully equipped and furnished hospital to AMINCH at opening. There is a lack of understanding of what is meant by 'fully equipped and furnished', which is difficult to accept given that some of the Board members were on both Boards and given that AMINCH's CEO was in attendance at the TRHB Board and equipping group meetings. This further frustrated the hand-over process. Some of the Hospital's equipment had not arrived prior to the move. A final hand-over issue discussed in the introduction to this section relates to the legal negotiations associated with the lease of the Hospital from the DOH&C and the Hospitals request for indemnity in relation to liabilities on the transfer of the TRHB's function to AMINCH.

5.3 FINANCIAL SUMMARY

A financial summary of the capital expenditure position in the Hospital, both building and equipping is shown below. In compiling this summary, we have relied on information provided to us by the TRHB, AMINCH and the DOH&C. It was not within the remit of this study to review the capital related building costs. Our assessment of the out-turn in relation to capital costs excludes costs relating to any possible outstanding building issues and focuses solely on those alterations that have been commissioned by AMINCH.

BUILDING

Table 5.1 below sets out the capital related Building Costs. The Table shows what the total projected costs are, what has been approved by the DOH&C, and how the overruns are currently allocated between either the TRHB, AMINCH, or if the overruns have yet to be attributed. There may be further negotiations with respect to these allocations. This highlights a building cost of c.IR£2.1m attributed to AMINCH, and a further IR£0.9m that has yet to be attributed. This IR£3.0m projected overrun excludes TRHB related overruns, but does include just over IR£0.5m for work related to alterations in the Kitchen and the enclosing of balconies in the children's area. Building work in relation to the Private Wing is also excluded.

Figure 5.1 Projected Building Related Capital Expenditure Costs

Capital Costs (IR£m)	*DOH&C Approved Provisional*	*Projected Costs*	*TRHB Costs*	*AMINCH Costs*	*Unattributed Costs*
Building (note 1)					
Main Hospital Original Scope	105.40	105.99	105.94	0.05	-
Additional Works (note 2)	3.46	4.27	4.27	-	
Computer Room	0.26	0.26	0.26	-	-
Issues Log (note 3)	0.75	2.05	0.75	1.30	
PACS (note 4)	-	0.03	-	0.03	-
Waste Management	-	0.55	0.55	-	-
Proposed Alterations (note 5)	-	0.65	-	0.65	-
Other Alterations (note 6)	-	0.90	-	0.00	0.90
Committed Building Costs - Sub	109.87	114.70	111.77	2.03	0.90
Projected Building Expenses (note 7)	-	0.46	0.14	-	0.32
Total Projected costs for Building	109.87	115.16	111.91	2.03	1.22

Explanatory Notes:

Note 1: The Building costs as set out, include all the design costs. They also include the costs of consultants, project managers and the TRHB executive.

Note 2: Additional works relate primarily to building work or modifications to the OPD, ICU, and X-Ray facilities.

Note 3: The issues log represents expenditure incurred on a series of modifications to the building which AMINCH considers were necessary to open the Hospital. IR£0.75m of the total is approved by DOH&C.

Note 4: This represents part of the cost of PACS net of a proposed borrowing of IR£300,000. Further PACS costs are included in equipping.

Note 5: These relate to alterations to OPD and X-Ray incurred by AMINCH.

Note 6: These relate to various costs incurred by AMINCH on building related issues; these include costs incurred in relation to rectification of drainage problems, cabling, telephone and security system costs and theatre shelving.

Note 7: This represents a schedule of future proposed building work, and excludes any potential work on the atrium or car parking.

EQUIPMENT

The Equipment budget was for c.IR£23m. Due to the cost of consequences of new EU statutory requirements relating to sterilisation of hospital instruments and procedures in pharmacy the DOH&C provisionally approved further funding of c.£IR2m. The total (provisionally) approved DOH&C budget is now IR£24.9m. A summary of equipment related capital expenditure is set out in table 5.2. Liability for certain of the stated expenditures has not yet been agreed. The table also shows proposed further equipping needs identified by TRHB & AMINCH but as yet not committed.

The table shows a potential capital equipment overrun of IR£5.3m. Of this c.IR£0.91m is committed expenditure. It is essential that future requirements are carefully assessed and prioritised, in particular, the amount of IR£3.3m included in the TRHB figures in respect of equipment sought but not yet acquired. With all the incremental spending that has incurred, some of this may no longer be required. The process for reviewing these requirements needs to provide a strict objective view of requirements. This exercise should be carried out on the basis of there being no further funding available, otherwise there is a risk that requirements will expand.

Because of deficiencies in the ordering procedures in the Hospital, there is a risk that further equipment commitments in respect of orders already placed may arise. One such item, amounting to IR£142,000 arose in September 1998 in respect of an order placed for AMINCH on a FDVH order in April 1998. There is also a concern that the requirements of HSSD, Laboratory and Theatre have not yet been fully determined, in which case there may be some incremental costs or double counting of costs within the estimates of costs to complete the equipping.

Equipment costs include additional ISIT hardware and software costs. The ISIT costs of equipping the OPD, which is not budgeted for within the ISIT budget or the equipment budget, have been estimated at IR£257,000, a significant portion of which relates to the provision of computers for PACS. It is significant that the actual requirements were not determined by anyone within either AMINCH or the TRHB until October of this year. There may be some funding for this IT spend available from the ISIT capital budget of IR£4m, of which c.IR£3.5m has been drawn down to date. There is further confusion with this budget, relating to who is responsible for agreeing and approving the requirements for PCs etc. Requirements were supposedly agreed at departmental level with the IT Director. There was an assumption, that prior to the move that all PCs in the base Hospital would be upgraded to a standard to support the software and network within the new Hospital. There is evidence to suggest that this did not happen, leading to requirements for additional PCs after the move.

Figure 5.2 Projected Equipment Related Capital Expenditure Costs

Capital Costs (IR£m) Equipment	***DOH&C Approved Provisional***	***Projected Costs***	***TRHB Costs***	***AMINCH Costs***	***Unattributed Costs***
Committed					
Main Hospital Scope (note 1)	23.94	24.28	23.04	1.02	0.23
Additional Equipment (note 2)	0.98	2.85	1.49	1.31	0.05
Adjustment for PACS (note 3)	-	1.30	-	(1.30)	-
Committed Equipping Costs – Sub-total	24.92	25.83	24.53	1.03	0.28
Estimates to Complete					
Order requisitions held (note 4)	-	0.39	0.15	0.24	-
TRHB Estimate to fully Equip(note 5)	-	3.30	3.30	-	-
HSSD control & barcoding	-	0.13	-	-	0.13
Library	-	0.03	-	-	0.03
Lab Equipment	-	0.25	-	0.25	-
Equipment Subtotal	-	4.10	3.45	0.49	0.16
IT requisitions held in Finance	-	0.07	-	0.07	-
ISIT for OPD Extension (Note 6)	-	0.26	-	0.26	-
IT Subtotal	-	0.33	-	0.33	-
Total Projected costs for Equipping	24.92	30.26	27.98	1.85	0.44
Variance From Approved		5.34			
Net Costs if Further Spends are Frozen	24.92	25.83	24.53	1.03	0.28
Variance		0.91			

Note 1: The AMINCH costs include a significant element of expenditure relating to the laboratory.

Note 2: This represents IR£2.3m relating to PACS and IR£0.5m relating to ICU,OPD and X-Ray.

Note 3: This represents the borrowing in respect of PACS.

Note 4: This represents orders being held in respect of equipment.

Note 5: This represents a list of equipment scheduled by TRHB and required by AMINCH as being necessary to complete the equipping of the Hospital. It includes IR£800,000 in respect of theatre instrumentation.

Note 6: This represents orders in hand not processed relating principally to IT equipment for the OPD extension. DOH&C noted that this amount also includes expected costs in relation to PACS and other PC's in other departments of the Hospital.

In summary, the major incremental costs to budget are set out in the Table 5.2. The major variances within the TRHB spend are set out in Table 5.3 below. As can be seen the table represents major under and over spends in the particular package areas. These have been adjusted to take into account items that have been identified, as necessary within those packages that are already significantly over or under-spent. The IR£2.24m identified as necessary future spend represents 68% of the total identified costs for completion. The

figures in table 5.3 projects an equipment overrun of c.IR£5.1m of the total of IR£5.3m in Table 2.

From this table it is clear that the major areas of over expenditure are:

- Cardiac, theatre, Anaesthetics Ventilation and Respiratory (Packages 19,49 and 9)
- Theatre Instruments
- HSSD
- X-Ray

CARDIAC ETC.

This is one of the instances where the TRHB claims there is a serious budget mismatch i.e. the last purchase of similar equipment was a long time back, and that the prices in the software did not reflect current purchase prices. If the required to complete hospital spend is included this represents a variance on budget of –207%. Clearly a variance of this significance can not all be explained by inflation. A review of the equipment transferred from the base hospitals in this category needs to be carried out.

THEATRE INSTRUMENTS

Problems with the budget for theatre instruments were identified and a meeting to address the issue was held on 2 March 1998. Part of the problem with instrumentation relates to the new HSSD process for sterilisation. The turnaround time for the HSSD process was estimated to be 4-6 hours. In the base hospital there was a process for flash sterilisation in the theatres which would have facilitated an immediate turnaround of a small amount of equipment if required. This turn-around time has a significant impact on the amount of theatre instrumentation required. Effectively three sets are claimed to be required; one on the shelf; one in the HSSD process; and one on the table. The DOH&C regard this as an extreme view of the requirements, the actual requirement for three sets should be dependent on the type and patterns of surgery being undertaken. There was supposedly sufficient instrumentation bought for 10 theatres, but the turnaround time of six hours has not been achieved in HSSD. The tendered cost for theatre instrumentation was IR£4.1m against a budget of c.IR£921,000. This budget excluded any transfer of equipment from the base hospitals. A detailed review of actual requirements in conjunction with an assessment of the operating policy of HSSD needs to be carried out urgently.

HSSD

The budget for HSSD excluding (trolleys) was just under IR£36k, the actual cost to date has come in at c.IR£454,000. Either the process for determining budget was totally inadequate and as a result the budget itself, or the requirements changed significantly. At the time of developing the budget, the mix, range and potential volume of services was known.

Table 5.3 Significant variances to package budget spend as per TRHB (IR£m)

Package Description	*Budget Variance*	*Costs to Completion* [1]	*Projected Variance*
Lasers	-0.12	0.18	0.06
Endoscopy	-0.50	-	-0.50
Theatre General Electro-medical	-0.25	0.13	-0.12
Cardiac, Theatre, Anaesthetics, Ventilation & Respiratory	0.38	0.83	1.20
Physiotherapy/Rehabilitation	0.14	-	0.14
Dental Equipment	-0.15	0.06	-0.09
General Fixed Equipment, Pharmacy	0.13	-	0.13
MPBE	-0.10	-	-0.10
Medi-rails & Carriers	0.09	0.05	0.14
Theatre Instruments	1.29	0.80	2.09
Whole Hospital Instrumentation	0.11	-	0.11
Catering Equipment	0.13	-	0.13
HSSD	0.45	-	0.45
Theatre & HSSD Trolleys	0.13	-	0.13
X-Ray	1.71	0.06	1.77
MPBE Computers	-0.24	0.13	-0.11
Subtotal	**3.20**	**2.24**	**5.43**
Other	-0.08	1.06	0.98
Total	**3.11**	**3.30**	**6.41**
PACS Adjustment	-1.30	-	-1.30
Projected Variance	**1.81**	**3.30**	**5.11**

[1] These are notional costs to complete, they have been prepared by the TRHB, some of these would not have been approved by the Equipment Steering Group.

X-RAY

The projected variance here is of the order of IR£1.7m. Of this IR£1.3m relates to the PACS system, which AMINCH are funding separately. The equipment budget is provisionally funding PACS to a limit of IR£975,000. In the 'selected' tendering process there were a number of quotes for the X-Ray system. The majority were in the IR£600,000 region, one was for IR£975,000. The agreement was that the DOH&C would fund PACS up to the limit that a comparable 'wet' system would cost. There is a view within the DOH&C, that the equipping budget for PACS should have been of the order of IR£674,000 rather than IR£975,000. Part of the overall over-run has been attributed to the cost of decommissioning base hospital equipment and re-commissioning it the new hospital, which according to the Project Director was omitted from the X-Ray allocation of the budget. In addition to this there is a significant ISIT budget requirement to equip OPD with PACS. This cost has not been considered in anybody's budget to date.

LABORATORY

The table above does not show a significant variance in relation to Laboratory equipping costs. There was IR£1.44m in the TRHB budget for the Laboratory. There was a IR£12,000 overrun on the TRHB books in relation to this area. However, there is a significant cost overrun in the Laboratory. Approximately IR£427,000 of the IR£494,000 identified in table 5.1 above, as orders placed by AMINCH, relate to expenditure on Laboratory equipment. In addition to this the Laboratory is looking for additional funding, which if granted would represent a budget variance of c.37%. The TRHB capital budget for the laboratory was consumed by March 1998, at which time it was communicated to the Laboratory staff that no

further purchases could be made. Concern was also raised as to how the Laboratory budget had been prioritised. We are not in a position to assess what equipment was required to operate a facility of this kind, nor are we in a position to assess if all the initial equipment identified has actually been purchased. The services of the Consultant and Chief Technologist in St. James's were utilised in confirming the budget. Given their experience, it is difficult to understand how the actual costs should be at such a variance to the budget, unless the laboratory as it exists today is significantly different to that which was planned. AMINCH claim there is a gap between what was initially specified, and what has now been determined as necessary. In addition to this there was no accounting for the initial stock of reagents that would be required to operate a facility of this nature however, DOH&C stated that stocks would not normally be included in an equipping budget.

FINANCIAL SUMMARY

Table 5.4 sets out an overall summary for capital Expenditure. This shows a projected cost to AMINCH of IR£3.9m, but with a further unallocated cost of the order of IR£1.7m (potential liability of IR£5.6m). The costs incurred to date on capital expenditure by AMINCH and unattributed costs are c.IR£4.3m. This is exclusive of the further potential equipping cost of IR£3.5m shown within the TRHB figures. Not all the projected costs would be incurred in 1998. An assessment of actual equipping requirements needs to be determined and a prioritised programme of expenditure needs to be agreed.

Table 5.4 Overall Summary of Capital Expenditure

IR£m ***Capital Costs Summary***	***DOH&C Approved Provisional***	***Projected Costs***	***TRHB Costs***	***AMINCH Costs***	***Unattributed Costs***
Committed Building Costs	109.87	114.71	111.78	2.03	0.90
Committed Equipment Costs	24.93	25.83	24.52	1.03	0.28
	134.80	140.54	136.30	3.06	1.18
Projected Building Costs	109.87	115.16	111.92	2.03	1.22
Projected Equipment Costs	24.93	30.26	27.97	1.85	0.44
Total	134.80	145.42	139.89	3.88	1.66

5.4 ISSUES & CONCLUSIONS

TIMING

Timing between initial design and actual building completions was too long. The needs of the Hospital, and its surrounding area would have changed significantly since 1984. The Kennedy report in 1993 failed to identify some of the potential changes. Similarly, the timing between initial specification & delivery of equipment was too long, creating difficulty in estimating prices and assessing the impact of changing technology and processes.

PROCESS

There are many issues relating to the process for determining the requirements. Whilst there was significant involvement of users, the users did not own the budget for equipping their departments, and as such were not able to prioritise the available funding. Prioritisation was carried out at the Equipment Steering group. There also seems to have been little feedback on prioritisation. Further difficulty arises from the disconnect between what user groups

specified and the packaged bundles used for tendering. It was difficult for each department to assess what they were getting. Users who were best organised and involved were likely to do better, though this is reflected in significant budget over-runs in these areas. The concept of the 'model room' is good in determining base equipment requirements, however given the age profile of costs kept on the database, it may not be the most appropriate guide for developing the cost budget.

It is our view that the budget should have been allocated to the users and that these users should have been accountable for delivering the equipment requirements for their respective areas within budget. They should have prioritised how they wanted to spend the budget in their area, given the base equipment requirement as identified by the 'model room'. There was concern that if departments were given individual budgets that they would spend up to and beyond that budget. Whatever about spending over the budget, this assumes that departments would spend their budget, thus reducing the flexibility to redistribute under-spent budgets. The approach taken did not satisfactorily address this issue anyway.

PROJECT MANAGEMENT

Project management for the equipping and commissioning processes was contracted out. This proved to be problematic. The project managers did not adequately drive or control the processes. One consequence of this was the late ordering of equipment, and the resultant pressure to get decisions made quickly, late in the process.

'MODEL-ROOM' PLANNING

The difficulties with this approach relate to the historic cost base of the database, and the need to update model rooms on a regular basis to reflect procedural, regulatory and technological changes. Any changes to the above can have a significant impact on the numbers and types of equipment required and thus on the related costs. It is clear that either the costs put forward as per the model room were incorrect or what was purchased for the hospital did not reflect the required equipment on the model room log. There is a view within the DOH&C that the tendered costs seemed comparable with the costs on the equipping system. In either case it reflects a lack of project and budgetary control on the equipping process.

ROLE OF PROJECT DIRECTOR

The dual role of this individual has created confusion as to where liability for certain expenditure rests.

BUDGETARY CONTROL

Budgetary control was poor; the packaging of equipment for the tendering process hindered this. All reporting was at package level rather than at department level. There was no audit trail from package to department. The processes initially allowed for purchase approval without consideration of budget constraints. This was changed in April 1998, when it was determined that items within packages approved for purchase though not yet ordered had to be re-tabled for prioritisation. Significant budget over-runs were predicted from 1996, but there is no evidence of a process being put in place from that time to control the costs. This and the high degree of under and over spending across all the packages is evidence of the lack of budgetary control. In particular the significant levels of costs that are not attributed (IR£1.7m) indicate lack of control and lack of budgetary responsibility.

EQUIPMENT REQUIREMENTS

There is no clear definition of net equipment requirements for each package. The packages did not reflect what was being transferred from the base hospital. The asset register for the base hospitals was not developed until early 1998. Because there is not a clear definition of net equipment requirements it is not possible to determine:

- Whether, too much or too little equipment was bought for each package.
- Whether, the cost over runs and under-runs reflect increased equipment costs or good negotiation skills or:
- Whether the Hospital is over or under equipped for the activities it planned in its service plan.

An assessment needs to be made on how the current budget was actually spent and prioritised.

FUTURE SPENDING

Some notional costs have been provided as the cost to complete the equipping of the Hospital. Careful consideration needs to be given to affecting a complete freeze on any further capital related spending. Whilst, we recognise that this may be impossible, we would recommend that a process for reviewing any further requirements is developed. This process must take a strict objective view of requirements. This exercise should be carried out on the basis of there being no further funding available, otherwise there is a risk that equipment requirements will grow. All future requirements need to be prioritised, and a development plan needs to be prepared and agreed with the DOH&C.

CHANGE CONTROL

There was a change control process set out in the project manager's project handbook. The consistent use of this process is questioned. Certainly there is little evidence of a change control process being used as part of controlling the equipment budget.

CAPITAL BUDGET OVERRUNS

There are some explanations for the over-run in capital costs. Some relate to changes in Health & Safety Standards e.g. HSSD, others relate to changes in technology e.g. Radiology systems. We have not been sought to ascertain the extent of any cost penalties relating to either inflation or currency fluctuations. In the original budget there was a contingency of 16% for inflation and currency and it excluded transfers from the base hospitals. It is worth noting however that much of the equipment purchases have been sourced in the UK, and there have been considerable currency fluctuations between Ireland and the UK during the equipping period.

CONCLUDING REMARKS

The total level of capital expenditure incurred within AMINCH or which is unapproved amounts to IR£4.2m. There may be debate on the extent to which aspects of this expenditure were absolutely necessary. However, from our examination of the circumstances in which this excess capital expenditure was incurred, it appears to us that the expenditure had to be incurred to open the Hospital or to rectify defects, and that AMINCH had little choice but to incur a substantial element, if not all, of this expenditure. These additional capital costs have arisen primarily because of deficiencies in planning for the requirements of the Hospital, late changes in the whole hospital and departmental organisational policies and what appears to be inadequate management/control of the equipping budget within the TRHB.

SECTION 6
1997 FINANCIAL RESULTS

6.1 INTRODUCTION

The three base hospitals, Adelaide, Meath and National Children's Hospitals became part of the AMINCH corporate entity under the Charter on 1 August 1996. From 1 August 1996 to 31 December 1997 the three base hospitals continued to operate as separate management units. The decision of the Board was to continue to operate the hospitals separately as heretofore as three indigenous units. This operational process was reflected in the continuation of the hospitals' management structures including financial management and accounting processes. In addition, the Department of Health continued to fund the hospitals on an individual basis until 1998.

Financial accounts have been prepared for each of the three base hospitals and presented in statutory form by the Hospital's auditors, Pricewaterhouse Coopers (PWC). A draft consolidation of the base hospitals results for the year ended 31 December 1997 was prepared by the Hospital and reviewed by PWC. The audit of the financial statements of the base hospitals for 1997 has not been signed off as at the time of completion of our review. As such, the financial statements may be subject to change. The financial statements of AMINCH for the year ended 31 December 1996, whilst finalised, have not been signed off for audit purposes because the Meath accounts for that year have not had audit sign off. These draft financial statements in statutory form were only presented to the DOH&C by the Hospital in mid November 1998. Based on their initial review of these draft statements, the DOH&C have raised a number of queries, which are unresolved at the time of this report.

The hospitals have operated as three independent entities historically. There have been differences in the accounting treatment of certain items between hospitals. Differences also arose in the expense category of the income and expenditure account in which like costs were shown, but they are not material to an understanding of the overall results of the Hospital. According to the Hospital's management, these costs will be reclassified when the audited consolidated accounts are being finalised.

It should be noted that all accounts for the three base hospitals presented for 1997 state that "these preliminary draft accounts are subject to a number of amendments which have yet to be reflected in the accounts". The latest drafts received as presented in this report were presented on 11 November 1998 and no details of the amendments mentioned were provided to us during our review.

6.2 INCOME AND EXPENDITURE ACCOUNT

A summary of the draft Income and Expenditure Account in statutory format for the three Base hospitals and consolidated for the year ended 31 December 1997 is detailed below.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Pay Expenditure	11,995	20,433	5,612	38,040
Expenditure	7,271	8,626	2,983	18,880
Total Expenditure	19,266	29,059	8,595	56,920
Income	(2,484)	(3,616)	(1,057)	(7,157)
Net Expenditure	16,782	25,443	7,538	49,763
DOH&C Allocation	(16,915)	(25,521)	(7,540)	(49,976)
Excess of Allocation over Expenditure	(133)	(78)	(2)	(213)

The various categories in the summary Income and Expenditure account are analysed in the sections which follow.

DOH&C stated that per its records, IR£50.5m was allocated to the three base hospitals in 1997. The difference of IR£500,000 appears to be in relation to consultants contracts, the costs and allocation for which, according to management, have yet to be reflected in the draft audited financial statements.

6.3 COMMENTARY ON INCOME & EXPENDITURE ACCOUNT

6.3.1 PAY EXPENDITURE

The pay expenditure for each of the three Base hospitals is analysed below according to the draft accounts for the year ended 31 December 1997. In certain of the Base hospitals, the analysis of salaries into separate departments was carried out in greater detail than in others however for the purpose of the consolidated accounts, the relevant costs have been grouped. This variations in levels of analysis has made it more difficult to compare wage costs between the three Base hospitals.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Management & Administration	969	1,817	808	3,594
Medical (NCHD)	1,424	3,148	1,068	5,640
Medical Consultants	1,307	1,610	533	3,450
Nursing	5,690	8,711	2,172	16,573
Para-Medical	1,009	1,649	528	3,186
Support Services	1,101	2,507	372	3,980
Other	3	129	24	156
Maintenance & Technical	131	147	-	278
Superannuation:				
- Pension Payments	314	604	107	1,025
- Refunds	16	75	-	91
- Lump Sums	31	36	-	67
	11,995	20,433	5,612	38,040

6.3.2 NON-PAY EXPENDITURE

An analysis of the non-pay expenditure for the year ended 31 December 1997 for the three Base hospitals and the consolidated total is shown below. Again, the analysis of costs varies from hospital to hospital, which limits comparative analysis however the summary below has grouped the relevant costs as presented in the draft audited accounts.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Drugs & Medicine	823	1,581	1,036	3,440
Medical Surgical Supplies & Equipment	1,920	2,730	579	5,229
X-Ray Imaging	274	465	98	837
Catering	279	388	163	830
Heat, Light & Power	186	357	70	613
Cleaning & Washing	453	826	265	1,544
Furniture, Crockery & Hardware	57	185	24	266
Bedding & Clothing	43	36	12	91
Maintenance	131	141	68	340
Transport & Travel	76	140	79	295
Bank Interest & Charges	11	21	12	44
Rent, Rates & Insurance	89	202	56	347
Bad Debts Expenses	20	147	19	186
Office Expenses	400	672	219	1,291
Computer	97	113	49	259
Professional Services	60	236	80	376
Write Off of DOH&C Balance	-	132	-	132
Miscellaneous	2,352	254	154	2,760
	7,271	8,626	2,983	18,880

DOH&C stated that it did not agree to or request the write off of any balance in the Meath Hospital in 1997 and does not understand the inclusion of the write off in the draft financial statements.

It should be noted that computer expenses exclude the IT budget held by the FDVH.

Non-Recurring Expenditure

Based on a review of the non-pay expenditure, the following expenditure was identified by the Hospital's management as being non-recurring during the year ended 31 December 1997. This expenditure is either capital in nature or relates to the opening of the new Hospital in Tallaght.

Miscellaneous

Included in miscellaneous costs during 1997, was IR£2.239m of costs analysed as Tallaght Specific costs. According to Hospital management, these costs relate to the set-up costs incurred by the Base hospitals in 1997 in respect of the new hospital in Tallaght. These costs were incurred prior to the commissioning in 1998, which had a separate classification in the accounts and also a separate DOH&C allocation.

The amount of IR£2,239,000 is analysed as follows:

	IR£,000
Adelaide Locum Costs – Administration	12
Adelaide Locum Costs – Nursing	44
Adelaide Locum Costs – Para-Medical	15
CEO Budget – Included in Adelaide Budget – Paid to NCH	268
Further Funding from DOH&C - December 1997	1,900
	2,239

6.3.3 INCOME

Income shown in the draft financial statements of the Base hospitals during the year ended 31 December 1997 is analysed below.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Patient Income	1,944	2,593	728	5,265
Superannuation deductions from Payroll	418	739	218	1,375
Canteen Receipts	104	255	93	452
Other Income	18	29	18	65
	2,484	3,616	1,057	7,157

Patient Income can be further analysed as follows:

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
In-patient private & semi-private maintenance	1,561	1,933	528	4,022
In-patient daily levy	275	358	154	787
Parents stay	-	-	11	11
Total In-patient Income	1,836	2,291	693	4,820
Out-patient charge per visit	65	149	13	227
Road Traffic Accident Receipts	43	153	22	218
Total Patient Income	1,944	2,593	728	5,265

6.4 BALANCE SHEET AS AT 31 DECEMBER 1997

The draft balance sheets as at 31 December 1997 for each of the three Base hospitals are summarised below. The summary also includes the consolidated balance sheet as prepared by the Hospital's management.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Fixed Assets	-	15,379	-	15,379
Financial Assets	-	15	-	15
Current Assets				
Stocks	380	796	96	1,272
Department of Health	1,216	2,411	739	4,366
Debtors & Prepayments	1,555	1,375	732	3,662
Bank & Cash Balances	541	-	1,935	2,476
	3,692	4,582	3,502	11,776
Current Liabilities				
Creditors & Accruals	1,757	5,204	1,096	8,057
Bank Loans & Overdrafts	1,904	307	2,404	4,615
	3,661	5,511	3,500	12,672
Net Current Assets/(Liabilities)	31	(929)	2	(896)
Net Assets	31	14,465	2	14,498
Represented By				
Capital	-	123	-	123
Capital Reserve	-	15,218	-	15,218
Non-Capital Allocation	-	19	-	19
Accumulated Surplus/(Deficit)	31	(895)	2	(862)
	31	14,465	2	14,498

6.4.1 FIXED ASSETS

The fixed assets for the Base hospitals as at 31 December 1997 can be analysed as follows:

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Total IR£,000*
Land	-	650	-	650
Buildings	-	14,111	-	14,111
Plant & Machinery	-	619	-	619
Total	-	15,379	-	15,379

It is not clear how much of the equipment actually transferred the new Hospital. No fixed asset register was prepared for the base hospitals in 1997. A fixed asset register was implemented for the base hospitals in early 1998 to facilitate the designation of equipment for transfer to the hew hospital. This process involved a complete inventory of all furniture and equipment and the bar coding of same in the three base hospitals. According to management, whilst it is possible to identify the items which were transferred to Tallaght by the use of the bar coding system and the specific lists of electro medical equipment which were prepared during the move phase, a reconciliation of the asset register details with transferred and disposed equipment has yet to be completed at the time of writing this report. The original

asset register did not attribute monetary values to any assets, nor does the listing of assets transferred attribute any values to assets.

DOH&C have indicated, that under its accounting policy requirements, all capital purchases since July 1996 should be reflected on the balance sheet of the base hospitals. This policy has not been adopted by any of the base hospitals in the preparation of the draft financial statements.

6.4.2 INVESTMENTS

The investments included in the balance sheet of the Base hospitals as at 31 December 1997 are analysed as follows.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Total IR£,000*
Total	-	15	-	15

We understand this balance relates to investments made by the Hospital in the past in Government Bonds which are still yielding small dividends on an annual basis.

6.4.3 STOCKS

An analysis of the stock balance as at 31 December 1997 is summarised below for each of the three Base hospitals and the consolidated amount. The stock levels that were held at 31 December 1997 are indicative of the relative sizes of the three hospitals.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Pharmacy	82	100	64	246
Medical & Surgical Supplies	248	567	17	832
X-Ray Supplies	11	50	-	61
Laboratory Supplies	6	-	-	6
Provisions	3	7	-	10
Cleaning & Washing Supplies	4	13	-	17
Stationary & Office Supplies	21	36	15	72
Maintenance materials & supplies	5	-	-	5
Other	-	23	-	23
	380	796	96	1,272

6.4.4 DEBTORS

An analysis of debtors as at 31 December 1997 is analysed below for each of the three Base hospitals and the consolidated amount.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Patient Debtors	289	428	189	906
Salaries & Wages Control	219	75	72	366
Non-pay Recoverable	-	-	298	298
Inter-hospital Account	900	330	145	1,375
Private Fund of NCH	-	-	28	28
Sundry Debtors	147	542	-	689
	1,555	1,375	732	3,662

In the Base hospitals, income was recognised on an accruals basis except for income in relation to Road Traffic Accidents, Overseas and In-patient levies which are not recognised until cash is actually received. For accounting purposes, it is necessary to enter the invoices in respect of these categories of income onto the accounting system; however, full provision is made against the debtors, and income is not recognised until the cash is received. The levels of actual debtors at 31 December 1997 and the specific provisions in place are detailed below for each of the Base hospitals.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Road Traffic Accident	542	1,632	95	2,269
Overseas	18	83	6	107
In-patient Levy	231	407	-	638
	791	2,122	101	3,014

6.4.5 BANK POSITION

A summary of the bank position in each of the Base hospitals is detailed below.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Bank Balance	541	-	1,935	2,476
Bank Overdraft	(1,904)	(307)	(2,404)	(4,615)
	(1,363)	(307)	(469)	(2,139)

6.4.6 CREDITORS

An analysis of the creditors as at 31 December 1997 is analysed below for each of the three Base hospitals and the consolidated amount.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Creditors	589	1,792	1,096	3,477
Accruals – Pay	563	557	-	1,120
Accruals – Non-pay	279	2,226	-	2,505
PAYE/PRSI	326	629	-	955
	1,757	5,204	1,096	8,057

Based on discussions with management, we understand the accruals of the NCH include an amount of IR£250,000 in respect of a High Dependency unit. This would appear to represent a provision for future planned developments, rather than for a liability existing at 31 December 1997.

6.4.7 DEPARTMENT OF HEALTH AND CHILDREN

The amount due from DOHC can be analysed as follows for each of the Base hospitals. The table below details the opening balance due to each of the Base hospitals as at 1 January 1997 from DOHC, the amount allocated during 1997 and the amounts actually received during the year.

	Adelaide IR£,000	*Meath IR£,000*	*NCH IR£,000*	*Consolidated IR£,000*
Opening Balance – 1 Jan 1997	1,084	2,266	923	4,273
Allocation	16,915	25,521	7,540	49,976
Amount received	(16,783)	(25,376)	(7,724)	(49,843)
Closing Balance – 31 Dec 1997	1,216	2,411	739	4,366
Balance per DOH&C	1,216	2,411	818	4,445
Difference	-	-	79	79

These balances do not agree with the balances per the records of DOH&C as at 31 December 1997. The difference in the NCH figures of IR£79,000, reflects a capital grant which was included in the allocation and the relevant costs included in the income and expenditure account.

The allocations for the three base hospitals excludes an additional allocation totalling IR£526,000 in respect of pension awards and arrears in Consultant Common contract which was paid on 22 December 1997. The related expenditure was also excluded from the draft financial statements. Management stated that this additional allocation and related expenditure will be included in the audited accounts when they are finalised.

6.4.8 AUDIT POSITION

There have been considerable delays in finalising the audits of the AMINCH Accounts for the year ended 31 December 1997. The audit sign off of the 1996 financial statements for the Meath Hospital is also outstanding. The inordinate delay in having audited accounts for AMINCH and the base hospitals is a completely unacceptable situation, particularly in the context of the Board's duty to be accountable for public funds. Management has indicated that the Board did have monthly management accounts available to it. It is not acceptable that the Board does not yet have audited accounts for 1997, particularly as 1997 forms the basis of the 1998 service plan. The DOH&C has been seeking audited accounts since the early part of the current year.

According to AMINCH, factors which contributed to the delay in finalising the 1996 and 1997 audited accounts are detailed below.

- Change in status of the base hospitals in July 1996 and the formation of the AMINCH corporate entity necessitated a separate set of financial reports for each of the three hospitals being produced for 1996, being the period from January to 31 July 1996.

- Change of auditors at one of the base hospitals as at 1 August 1996.

- Different and sometimes conflicting accounting policies adopted by the three base hospitals.

- Diverse accounting concepts adopted within the base hospitals relating to the recognition of contingent or actual liabilities relating to certain payroll costs.

- Renewal of a national agreement relating to remuneration of senior staff members was ongoing during 1996 and 1997, between the DOH&C and staff representative bodies. The historic accounting policies of the base hospitals differed significantly on items relating to these negotiations. The management of the Hospital were of the opinion that as the negotiations were in the final phase, it would be prudent to delay completion of the audit until the relevant matters were clarified by the outcome of the negotiations. These negotiations were finalised during the period when the base hospitals were transferring to Tallaght. The management of the Hospital initiated a process to complete the various audits as soon as the opening phase of the Hospital had been completed.

- The main audit process has now been completed and the relevant unsigned accounts have recently been forwarded to the DOH&C in mid November. These accounts are subject to post audit review which is expected to be completed within four weeks from the date of this report. The results are in line with previously notified projections which were notified to the DOH&C by the Hospital.

- The heavy involvement of finance personnel in the preparation of the service plan and in the move to the new hospital at Tallaght.

DOH&C stated that it does not accept these explanations as justification for the delays.

The Board of AMINCH has no scope for any further delay in the completion of audited accounts for 1997, nor is there any scope for the delayed completion of the audit in future years, particularly given the current financial circumstances of the Hospital.

6.5 FDVH

The FDVH is a separate entity, which has employed certain staff working in the base hospitals Hospital, particularly those involved in ISIT. Historically, the FDVH has held the IT budget for the base hospitals. We have been informed that the FDVH accounts for 1997 have been finalised, but not yet signed off for audit purposes, and that the draft financial statements show a deficit of c.IR£800,000 which it is alleged relate to the Tallaght Hospital project. It is unclear how this deficit is to be funded; whether this has funding implications for the DOH&C or AMINCH needs to be clarified. DOH&C stated that it does not recognise any funding implications in respect of FDVH. Under the Charter, it is envisaged that the responsibilities of the FDVH will transfer to AMINCH in due course.

The existence of a separate budget for the FDVH has been a source of confusion in AMINCH particularly as to whether a budget existed within the FDVH for certain expenditure relating to the Hospital. The existence of more than one budget in respect of Hospital related expenditure can impair accountability for actions taken. In our view, the budget for the FDVH should be consolidated into AMINCH from 1999 onwards, and the responsibilities of the FDVH transferred to AMINCH as provided for in the Charter.

SECTION 7
MANAGEMENT ACCOUNTS FOR THE PERIOD ENDED 31 AUGUST 1998

7.1 INTRODUCTION

This section includes our review of the unaudited management accounts of the Hospital for the period to 31 August 1998. It should be noted that Deloitte & Touche have not verified the amounts included in the management accounts as part of this review unless expressly stated. The section covers the financial performance up to the time of the move, and thereafter. It also includes a summary of relevant activity statistics in the Hospital. A more detailed review of pay costs and costs is included in Sections 8 and 9 respectively.

7.2 INCOME & EXPENDITURE ACCOUNT

7.2.1 SIX MONTHS PERIOD ENDED 30 JUNE 1998

The Income and Expenditure account for AMINCH for the six month period ended 30 June 1998 and related budget are shown below. The budget against which the management accounts are compared is based on the service plan, with minor adjustments to reflect timing and categorisation of expenses. As such, actual performance of the Hospital at 30 June 1998 was being measured against an annual budget some IR£6m in excess of determination as approved by the Board of AMINCH. While this budget has the same total net expenditure for the year as that indicated in the Service Plan, reallocations of total budgeted costs, have been made within categories by the finance department of the Hospital. These adjustments resulted in the recategorisation of some budgets between pay and non-pay. The adjustments were made when the actual results for the year ended 31 December 1997 became available, which was after the service plan was completed.

	Actual IR£,000	***Budget IR£,000***	***Variance IR£,000***
Pay Expenditure	19,840	19,528	312
Expenditure	8,440	8,253	187
	28,280	27,781	499
Income	3,827	3,727	(100)
Net Expenditure	24,453	24,054	399
Tallaght Related			
Pay	1,890	2,259	(369)
	3,199	3,101	98
Total Net Expenditure	29,542	29,414	128

The management accounts for the six months to 30 June 1998 cover the period immediately prior to the amalgamation of the three Base hospitals at the Hospital in Tallaght. A summary of the total net expenditure per the monthly management accounts detailing the build up of

the overall variance with budget is detailed below. It should be noted that the January and February management accounts were prepared at the same time and presented in consolidated form. DOH&C stated that the practice of combining the January and February accounts is not unique to AMINCH.

Month	*Actual IR£,000*	*Budget IR£,000*	*Variance IR£,000*
Jan/Feb	8,847	8,654	(193)
March	4,631	4,512	119
April	5,355	5,434	(79)
May	4,965	4,895	70
June	5,744	5,919	(175)
Total	29,542	29,414	128

The most important aspect of the management accounts for the six months to 30 June 1998 is that prior to the merger, the three hospitals were reporting a position in line with the Hospital's budget.

7.2.2 MANAGEMENT ACCOUNTS FOR THE TWO MONTHS ENDED 31 AUGUST 1998

This period incorporates the move from the Base hospitals to the Hospital in Tallaght. It is the period in which significant additional costs were recorded. A summary of actual results compared against budget for each of the two months is detailed below.

	July 1998			*August 1998*		
	Actual IR£,000	*Budget IR£,000*	*Variance IR£,000*	*Actual IR£,000*	*Budget IR£,000*	*Variance IR£,000*
Pay Expenditure	3,913	3,333	580	4,212	3.383	829
Expenditure	2,454	1,385	1,069	2,073	1,313	760
	6,367	4,718	1,649	6,285	4,696	1,596
Income	438	639	201	510	644	134
Net Expenditure	5,929	4,079	1,850	5,775	4,052	1,723
Commissioning/Developments						
- Pay	430	232	198	239	514	(275)
-	269	227	42	396	484	(88)
Co-operation Agreement	1,927	1,600	327	-	-	-
Total Net Expenditure	8,555	6,138	2,417	6,410	5,050	1,360

The results summarised above as reported by the Hospital show that it was IR£3.8m in excess of budget for the two month period and that the larger variance occurred in July 1998. This deficit included the cost of certain capital items and technical services relating to what management of AMINCH regard as deficiencies in the equipping and the condition of hospital structures. In addition, the deficit includes certain items for which supplementary funding is being sought by the Hospital in respect of items so eligible under the letter of Determination, e.g. PRSI for new staff, increases in consultants pay under the common contract and superannuation related payments.

7.2.3 EIGHT MONTHS PERIOD ENDED 31 AUGUST 1998

The income and expenditure account for the year to date period is summarised below.

		Actual IR£,000	*Budget IR£,000*	*Variance IR£,000*
Pay Expenditure		27,964	26,244	1,720
Expenditure		12,969	10,951	2,018
		40,933	37,195	3,738
Income		4,775	5,010	235
Net Expenditure		36,158	32,185	3,973
Tallaght Specific Costs	- Pay	1,890	2,259	(369)
	-	3,199	3,101	98
Commissioning/Developments	- Pay	669	746	(77)
	- Non-pay	664	711	(47)
Co-operation Agreement		1,927	1,600	327
Total Net Expenditure		44,507	40,602	3,905

It is evident therefore that at 31 August 1998, the Hospital's management accounts showed c.IR3.9m of an excess over budget. Taking into account that the budget itself was IR£5.9m over determination for the year, the position at 31 August 1998 was of the order of IR£8.8m in excess of determination on a weighted year to date basis.

In Section 5, we highlighted other costs of a capital expenditure nature which were incurred using AMINCH orders which AMINCH regard as being a liability of the TRHB. These costs are not included in the management accounts of AMINCH. These are however taken into account in Section 10 in arriving at a projected outturn for 1998.

7.3 INCOME

7.3.1 INTRODUCTION

Income is recognised by the Hospital on an accruals basis except for income generated from Road Traffic Accidents, Patient levies and Overseas patients which are recognised only when cash has been received rather than when the invoice has been issued.

Since the move from the Base hospitals to the new Hospital in Tallaght, the Hospital has commenced using a new patient billing management system which is an element of the new patient administration system called PIMS. This system is different to that used in the Base hospitals being SMS and there have been significant teething problems since the move to Tallaght.

7.3.2 ANALYSIS OF INCOME BY DEPARTMENT

The income for the eight months ended 31 August 1998 is analysed below. The analysis provided does not state whether the patients are public or private. This information is expected to be available in the future from the PIMS system however to date is not included in the management accounts information provided.

	P/E Aug 98 IR£,000	*P/E Aug 97 IR£,000*
Patient Income	3,257	3,381
Superannuation	1,066	922
Canteen & Vending Receipts	327	301
Sundry Income	125	65
	4,775	4,669

It should be noted that:

(i) Because the patient administration system (PIMS) was implemented to treat all inpatients by default as public patients, no private patients were recognised in the Hospital for a period of two weeks after the opening, with the result that income relating to private patients was not recorded. It is not clear whether this default setting was specifically decided upon by the PIMS project team or whether it was a standard default in the system which was installed when the system was purchased. Subsequently, the system was adjusted and procedures were changed to avoid a recurrence of the problem, and the Hospital is seeking to recover the income concerned estimated by management at c.IR£350,000. Management has stated that the procedural element of this problem was such that it may have been solved if greater levels of training on the new system had been provided. Management has indicated that the requirement for additional training was identified but because of the timing of the final version of the system, and unavailability of staff to attend training sessions, the amount of training was less than adequate for the effective functioning of the system. Lack of agreed and tested operational policies was also an issue. According to the ISIT Steering Group project updates, the policies and procedures relating to the successful implementation of PIMS were still in design stage at late June 1998. According to management, the final batch of reports for the PIMS system did not arrive at the Hospital until late May 1998. The project managers had previously stated that they wanted the system to be fully operational for one month prior to opening. The late delivery had an effect on the level of training which could be provided to hospital staff and reduced the testing time available to the project team.

There were also inadequacies in recording discharges on the PIMS system, which resulted some in-patients not being billed, or delayed billings and difficulties with bed allocations.

(ii) It should also be noted that there have been deficiencies in the collection of patient levies (IR£20 Charge) on A&E patients. Until 13 August 1998, A&E Administration staff refused to collect these charges as they contended that security arrangements were inadequate and also there were printing difficulties due to system problems. It was also found that the billing module of the PIMS system could only produce invoices dated on the date of entry and no backdating of invoices was possible. Thus, when invoicing for the period 21 June 1998 to 31 July 1998 was carried out between 29 and 31 July, all invoices were dated in late July. This has given rise to patients querying the bill, as the invoice issued does not indicate the correct date of

their attendance. Furthermore, there were difficulties in producing debtor's statements or reminder letters to follow up on outstanding amounts until 5 November 1998. This has negatively impacted on collection of income in the period since the move.

(iii) Management stated that there have been deficiencies in the collection of some private income as the bed management module of the PIMS system was not always being operated properly. Management stated that while the system was being amended to solve the difficulties detailed in (i) above, an error occurred which caused difficulties in tracking available beds and discharges. There were instances where empty private beds in the hospital were identified as being occupied on the PIMS system, with the result that private patients occupied public beds. The empty private beds were then identified by medical staff working on the wards and in some instances were used by public patients at public income rates. Management are confident that these were teething problems which have been resolved.

Management stated that the IT department has not yet signed off on the PIMS system and currently a list of non-conformance specifications is being drawn up for presentation to the system developers.

7.3.3 ANALYSIS OF DEBTORS BY PAYER

The PIMS system currently does not provide sufficient information in relation to income to identify the eventual payer of the care costs. The debtors system does however track the expected eventual payer of invoices issued.

Detailed below is a summary of the VHI debtors listing as at 31 August 1998 for all patients treated since the move to Tallaght and the balances carried forward from the base hospitals analysed by department in which the invoice was raised. No aged analysis was available in respect of the VHI debtors carried forward from the base hospitals.

AMINCH	***Hospital Maintenance IR£,000***	***Day Ward IR£,000***	***A&E Health Levy IR£,000***	***Health Inpatient Charges IR£,000***	***Total IR£,000***
0-30 Days	231	12	16	137	396
31-60 Days	156	8	-	95	259
Base hospitals 61 Days +	-	-	-	-	1,293
	387	20	16	233	1,948

Based on discussions with the members of staff responsible for debt collection, there are significant amounts of VHI income unclaimed by the hospital. A review of the position at 30 September 1998 (details at 31 August were not available) is set out below:

	Total Due IR£,000		***Unclaimed IR£,000***	***Net IR£,000***
Pre 21 June 1998 – Base Hospitals				
Adelaide	560	}		
Meath	582	}	425	868
NCH	151	}		
Post 21 June 1998 – AMINCH				
Tallaght Hospital	655		432	223
	1,948		857	1,091

The unclaimed balance represents private patient income in respect of which a claim has not been made to VHI. The amount of IR£857,000 has been included in the management accounts for the period ended 31 August 1998; no provision has been made against this income. Of the remaining IR£1.091m net balance due we have been informed by management that c.IR£0.772m is not receivable as it is the excess over the capped total agreed with VHI for the base hospitals and old balances which are not considered receivable. This amount is considered by management to be provided for within the total bad debts provision of IR£899,000.

Management stated that they are currently trying to follow up on all outstanding forms in order to complete the VHI claims and would expect to have claimed c.50% of the total by 31 December 1998. Of the total included amounts at 31 August 1998, IR£298,854 was submitted in October 1998. At the end of October 1998, the level of unclaimed balances amounted to IR£869,674. The reasons given by management for the non-collection of VHI income are:

- that the VHI claim form has yet to be signed off by either the consultant, the patient or in some cases both.
- administration failures to follow up on unsigned forms,
- delays in obtaining patient records from the Base hospitals due to the non-completion of the amalgamation of the three filing systems.
- inefficiencies in consultants administration resulting in uncompleted paper work and;
- difficulties in the standard filing system which results in VHI forms not always being available.

Of the VHI balance, which has been claimed, the delay in the receipt of some of these balances is due to the following reasons:

- Recently submitted to VHI, Hospital awaiting payment
- Claim rejected for payment by VHI
- Claim held by VHI
- Amounts receivable in a year previously capped in the Base Hospitals yet VHI patients were still treated.

It is clear that there is scope to improve the management and collection of private income in this area.

7.4 BALANCE SHEET AS AT 31 AUGUST 1998

7.4.1 SUMMARY

Detailed below is a summary of the Balance Sheet for AMINCH as at 31 August 1998. It should be noted that the management accounts do not reflect the audit adjustments made in the draft December 1997 accounts. This is because these accounts were not available until November 1998 when this report was being finalised.

	August 1998 IR£,000
Fixed Assets	16,527
Investments	15
Current Assets	
Department of Health	4,286
Debtors	4,624
Stock	1,328
	10,238
Current Liabilities	
Creditors & Accruals	9,180
Bank Loans & Overdrafts	5,404
	14,584
Net Current Assets/(Liabilities)	(4,346)
Net Assets	12,196
Represented By	
Capital Accounts	123
Capitalisation Account	16,465
Service Development Reserve	225
Revenue Account	(4,544)
Non-capital Allocation	12,269
Income & expenditure Account	(44,506)
Allocation to 31 August 1998	35,733
Overspend per Allocation	(8,773)
Department of Health	
Allocation	8,700
	12,196

7.4.2 FIXED ASSETS

	Total IR£,000
Land	650
Buildings	14,111
Plant & Machinery	1,766
	16,527

The building relates to the Meath Hospital premises which has been transferred under a High Court CyPres Scheme of October 1998 to the Meath Foundation.

The fixed asset total of IR£16.527m has not yet been adjusted for the 1997 audit adjustments, as to date there have not yet been finalised. According to management, no additions to fixed assets have been included in the management accounts since 31 December 1997. DOH&C queried why the Hospital had not capitalised the value of assets transferred from the base hospitals and all equipment purchased since the move by AMINCH. In response, management stated that to date it had not been hospital policy to capitalise asset values in the balance sheet, however, this could be amended subject to Board and statutory approval.

The base hospitals prepared a fixed asset listing in February 1998 to identify the assets which would be transferred to the new Hospital in Tallaght. Neither listing contained any asset values thus it is not known what value of assets transferred to Tallaght from the base hospitals. Based on discussions with management, the assets which were not transferred from the base hospitals were disposed of by public auction in September/October 1998. No reconciliation has occurred to date between the list of assets before the move, the list of assets transferred, and the list of assets disposed of by the base hospitals.

The Hospital is currently bar-coding all assets in preparation for preparing a detailed fixed asset register. This register is not expected to have values attached to the various assets. Whilst it may be a useful physical record of assets, it will not reconcile to or be used as a basis for fixed assets in the accounts.

7.4.3 STOCKS

Management stated that the stock balance included in the management accounts equals the stock total as calculated per the stock count completed on 31 December 1997. Management stated that any movements in stock since 31 December 1997 have been included in the income and expenditure account.

Management stated that a stocktake of consumables was not carried out in the base hospitals immediately prior to the move to Tallaght, thus it is not known exactly how much stock was transferred during the move. Management has indicated however that all ward, theatre and other cost centre stocks were transferred. Whilst the value of stock transferred was not quantified, a stock take was carried out in the warehouse in Tallaght on 31 July 1998, as part of the implementation of the materials management system.

7.4.4 DEBTORS

The debtors balance as at 31 August 1998 as presented in the management accounts is analysed as follows.

	IR£,000
Patient Debtors	1,182
DOH&C Debtor	1,171
Interhospital Accounts	783
Private Funds	59
Wages Control Account	86
Prepayments	642
Sundry Debtors	701
	4,624

7.4.5 CREDITORS

The creditors balance as at 31 August 1998 per the hospitals management accounts can be analysed as follows:

	IR£,000
Creditors Control	4,306
Accruals – Pay	2,412
Accruals –	1,259
PAYE/PRSI	1,305
	9,180

Arrears of PAYE and PRSI amount to IR£0.946m at 31 August 1998. According to management, the difference between this balance due and the amount paid of IR£1.305m in November 1998 in respect of August 1998 is due to the fact that cheques were written but not sent at 31 August 1998 in respect of PAYE/PRSI which reduced the balance in the management accounts. The August PAYE/PRSI liability was paid in early November 1998. The monthly payment for September and October, due on 15 October and 15 November respectively, are still outstanding. This brings the total indebtedness to the Collector General at the date of this report in respect of PAYE and PRSI to c.IR£2.6m, representing two months deductions.

7.5 CASH POSITION AS AT 6 NOVEMBER 1998

The cash position as at 6 November 1998 as presented by the Director of Finance is summarised below along with the expected working capital requirements to the end of November 1998.

	IR£,000
Net Bank Balance as at 6 Nov 1998	(1,600)
Payments Expected (Excl Creditors)	
Collector General	(1,305)
Payroll	(2,625)
Receipts Due	
Cash from DOH&C	3,565
Sundry Receipts (Est.)	400
Projected Net Bank Position (Pre Creditors Payments)	(1,565)
Overdraft Facility Available	4,000
Cash Available for Creditors	2,435
Outstanding Creditors (Aug – Nov 1998)	
Creditors	5,309
Collector General	2,631
Projected Shortfall in Funds Available	(5,505)

The Hospital increased its overdraft limit to IR£4m in October 1998 with the approval of the DOH&C which is in accordance with the terms of the letter of Determination. It is usual for health agencies to utilise approved overdraft facilities in line with the letter of Determination at this time of the year. This facility is currently being fully utilised.

As noted above, there is scope for the Hospital to improve collection of patient income- had better collection procedures been on place, the cash position could have been improved, although the projected shortfall in funds would still have been significant.

7.6 CREDITORS & PROMPT PAYMENT LEGISLATION

The Prompt Payments of Accounts Act came into effect on 1 January 1998. It was introduced by the Government to ensure that all state funded organisations and companies paid their suppliers within 45 days of invoice. Should the organisation/company not pay a supplier within the required 45 days, an interest charge of 1% per month is payable to the supplier on the amount due. The letter of determination requires AMINCH to have regard to this legislation.

Due to severe constraints on cashflow caused mainly by the expenditure in excess of determination, the management of the Hospital has withheld payments due to suppliers in accordance with their terms of trading. An aged analysis of creditors is shown below.

M/E 31 Aug 1998	***Total Due IR£,000***	***Payments IR£,000***	***Net Due IR£,000***
Aug 1998	1,380	124	1,256
1 Month Overdue	634	48	586
2 Months Overdue	904	66	838
3+ Months Overdue	455	(8)	463
	3,373	230	3,143

The level of overdue creditors has increased significantly since August 1998.

7.7 YEAR TO DATE ACTIVITY DETAILS

One of the responsibilities of the Patient Flow department is the preparation of the activity details for the Hospital. These statistics are vital for the overall running of the hospital and need to be accurately prepared and received by management in a timely manner. Statistics are now being circulated to the management team on a weekly basis however, in the period immediately after the opening of the new Hospital accurate computerised statistics were not available. The information in relation to the period from opening was only provided to management on a month by month basis in late September 1998 and was still in draft form.

The initial difficulties in data preparation related to inaccuracies in the recording of activity. These were due to data entry problems encountered by front-end staff, deficiencies in training on the new PIMS patient management system, input error and differences between diagnosis and patient analysis. Based on discussions with the Patient Flow management these difficulties have largely been resolved, and more accurate and timely reports are now being produced.

Timely and accurate activity data is vital to the management of any hospital. The absence of activity data in the period from the time of opening until September 1998 is a major gap in essential management information.

7.7.1 BEDS AVAILABLE

Bed days available is effectively the capacity of the Hospital for In-patients at any point in time. These are calculated based on the number of beds in the Hospital during a period by the number of days in the period. This can be analysed by specialty when specific numbers of beds are assigned to the particular specialties. Detailed below is a schedule of beds and bed days available for the month ended 30 September 1998.

It should be noted that since the move to Tallaght, the numbers of beds has actually reduced in the short-term from the total beds in the Base hospitals. DOH&C stated that this reduction would normally result in a reduction of activity which it would expect to reduce costs. Management stated that while in theory, this may be the case, the costs are also affected by casemix and length of stay. These have changed from what was experienced in the base hospitals thus making a direct comparison very difficult.

A more detailed analysis of the Bed Days available by speciality is included in Appendix II of this report.

Bed Complement	***Sep-98 Beds***
Public Beds	274
Private Beds	106
Non-Designated Beds	22
Dialysis	7
Day Beds	53
Total Number of Beds	462

Bed Days Available (Excl. Day Beds)	***Bed Days***
Adult Public	6,599
Adult Private	2,520
Paediatric Public	1,080
Paediatric Private	510
Non-designated Adult	719
Non-designated Paediatric	90
	11,518

To date detailed analysis of beds available in the Paediatric wards of the Hospital have not been available.

7.7.2 BEDS USED

The calculation of bed days used shows the overall utilisation of the Hospital's beds by each speciality. The schedules below indicate the utilisation of the beds available in the Hospital.

A more detailed analysis of the bed days used by speciality by month has been included in Appendix II to this report.

	Sept 1998
Bed Days Used	
Adult Public	5,992
Adult Private	2,329
Adult Non Designated	609
Paediatric Public	647
Paediatric Private	332
Paediatric Non Designated	33
	9,942
Utilisation of Bed Days	
Adult Public	90.8%
Adult Private	92.4%
Adult Non Designated	84.7%
Paediatric Public	59.9%
Paediatric Private	65.1%
Paediatric Non Designated	36.7%
	86.3%

7.7.3 IN PATIENT DISCHARGES

The Service Plan was prepared by the Hospital on the basis that activity would not change from the 1997 levels achieved. This may not be achievable as the Hospital has fewer beds than were in the base hospitals. The activity rates as in the Service Plan are compared with the actual 1998 rates below.

A detailed analysis of the discharges by speciality by month has been included in Appendix II of this report.

	Jan-98 to May-98	*Jun-98*	*Jul-98*	*Aug-98*	*Sep-98*	*Total*
1998 Actual						
Adult	5,840	843	875	931	1,031	9,520
Paediatric	2,018	215	273	273	389	3,168
Service Plan						
Adult	5,718	381	1,165	1,238	1,255	9,757
Paediatric	1,716	109	343	368	390	2,926
Variance – Adult	122	462	(290)	(307)	(224)	(237)
Variance – Paediatric	302	106	(70)	(95)	(1)	242
Variance – Total	424	568	(360)	(402)	(225)	5

The number of adult discharges is currently 237 below plan. Management attribute this to the absence of the patient flow acceleration system which was anticipated as a development in late 1998 (see Section 10.9). Management has also indicated serious problems with long stay patients, and equipping and recruiting difficulties in the theatres, all of which factors they regard as contributing to a reduction in inpatient numbers. It should be noted that a phased introduction of theatres was planned.

Management expects the paediatric activity to be in line with service plan by the end of the year.

7.7.4 DAY CASES

Detailed below is an analysis of Day Cases for the nine month period ended 30 September 1998. The table below also sets out a comparison of the actual activity rates achieved in 1998 and the activity rates shown in the service plan. The 1997 activity rates formed the basis of the Service Plan and it was expected that these rates would be achieved in 1998 despite any disruptions suffered due to the move in Tallaght.

The analysis below shows that activity has in fact been lower than service plan since the move from the base hospitals. Management attributes the reduction in day case activity to a lack of availability of theatres; other statistics prepared by the Hospital indicate that the activity in the A&E department has increased by 30% over that achieved in the Base hospitals. It should be noted that the level of paediatric activity has remained reasonably consistent year on year despite the move to Tallaght.

A detailed analysis of the Day Case activity rates by specialty by month has been included in Appendix II to this report.

	Jan-98 to May-98	***Jun-98***	***Jul-98***	***Aug-98***	***Sep-98***	***Total***
1998 Actual						
Adult	4,615	406	592	674	845	7,132
Paediatric	1,680	174	379	392	345	2,970
Service Plan						
Adult	4,457	269	961	1,049	1,057	7,793
Paediatric	1,702	113	342	378	426	2,961
Variance – Adult	158	137	(369)	(375)	(212)	(661)
Variance – Paediatric	(22)	61	37	14	(81)	9
Variance – Total	136	198	(332)	(361)	(293)	(652)

7.7.5 A&E ACTIVITY

The hospital provided the following information regarding A&E activity in the hospital since the move to Tallaght compared to activity in 1997 in the base hospitals. This information is not part of the normal activity statistics prepared and presented to management by the patient flow department. We were informed that each week, A&E statistics are sent from the Hospital to EHB where they are collated with the A&E statistics for other hospitals in the Dublin area for submission to the DOH&C.

	July	***Aug***	***Sept***	***Oct***
A&E Admissions				
1998	612	604	574	590
1997	440	453	428	432
Variance %	39.1%	33.3%	34.1%	36.6%

	July	***Aug***	***Sept***	***Oct***
A&E Attendance				
1998	3,738	3,567	3,628	3,609
1997	3,099	3,034	2,974	2,997
Variance %	20.6%	17.6%	22.0%	20.4%

AMINCH has indicated to us and in writing to the DOH&C that the increase in A&E activity has placed considerable strain on the hospital.

The DOH&C stated that in planning for the move to Tallaght, it was estimated that Adult A&E attendances at Tallaght would be greater than the Meath by up to 40%. In fact, A&E attendances at Tallaght have not reached this level of increase. A&E attendances increased by some 19% between the opening of the A&E at Tallaght in June 1998 and the end of August 1998. In September and October 1998, Adult A&E attendances were up by 17/18% as against comparable statistics for the Meath in 1997.

The DOH&C also stated that while A&E admissions at Tallaght show an increase over the rate of admissions at the Meath, these are still at a rate below that of other comparable hospitals. Furthermore, since the move to Tallaght, 35 non-acute beds have been provided for the exclusive use of Tallaght at the old Meath hospital. These beds are provided by the EHB and do not impact on the resources of the hospital at Tallaght.

SECTION 8
REVIEW OF PAY COSTS

8.1 INTRODUCTION

This section includes our review of the human resource policies and operations, pay costs, staff numbers, temporary staff, payroll system and any other pay and staff related issues identified during our review of the hospital.

8.2 HUMAN RESOURCES POLICIES AND OPERATIONS

RESOURCES COMMITTEE

The Resources Committee was created as a sub-committee of the main Hospital Board to handle issues in relation to human resources, industrial relations, finances, property and the overall management of the hospital. In November 1997, the Resource Committee had its first meeting, and the Committee has subsequently met on a monthly basis. Extracts taken from the terms of reference issued at this meeting in relation to human resources are as follows:

The Resource Committee shall:

- On behalf of the Board arrange for the appointment by merit of all members of staff and for the remuneration of all staff as approved by the Board.
- Implement review and revise the Industrial Relations protocol and any agreements the Board has approved with trade unions or staff representative bodies.
- Ensure adequate evaluation systems are put in place to ensure the performance by all members of staff of their duties and for disciplinary procedures including dismissal for any breach of duties.
- Ensure the availability of an adequate range of staff so that the hospital services may be provided without prejudice to the rights of conscience of individual members of staff.
- Develop and at least annually evaluate, update and make recommendations to the Board on a human resources plan for the hospital, which includes a profile of present staff as well as projections for future staff.
- Recommend to the Board policies for the management and operation of the hospital and ensure the implementation of approved policies in the areas of human resources, finance and facilities.

HUMAN RESOURCES SUB-COMMITTEE

In order to deal directly with the HR issues the Human Resources committee, a sub-committee of the Resource Committee was created. There was a previous committee called the Manpower Steering Committee that originally reported to the TRHB, and which from early 1997 began reporting to the AMINCH Board. The Human Resources committee deals with all specific matters in relation to HR including, recruitment, co-operation agreement, IR and uniforms. The committee reported to the Resource Committee on a monthly basis.

HUMAN RESOURCES DEPARTMENT

The HR department, is responsible for the day-to-day operation of the personnel function in the hospital while also planning for the staffing requirements in the future. The department's policies are largely governed by the Human Resource Sub-committee. An operational outline of the HR department was prepared in December 1996 by the staffing officer of TRHB which set out the responsibilities of the department. The TRHB staffing officer subsequently became the Director of Human Resources for AMINCH and took up the position in April 1997. Many of the responsibilities included in the 1996 plan were incorporated into the job description for the Director of Human Resources. These are set out below:

- Through membership of the management team, to ensure that HR is appropriately represented in the hospitals overall objectives.
- Provide advice to CEO and management team in respect of all aspects of manpower resources and issues, identifying problem areas and recommending solutions.
- Develop and update strategies for a range of HR issues in support of the hospital's objectives.
- Develop HR policies for the hospital and ensure their application throughout the hospital.
- Provide an integrated and comprehensive personnel service which is responsive to the needs of the hospital's management and staff.
- Advise on disciplinary hearings and appeals.
- Provide agreed levels of service within agreed resources and account for the performance of HR related budgets.
- Ensure effective communications with Trade Unions and staff representatives and promote staff consultation.

In September/October 1997, during the commissioning process, department heads could seek approval from their management team member for additional temporary staff to support the commissioning process. In addition, the operations group set up prior to the move, sanctioned additional staff in emergency situations to support commissioning. It appears that such recruitment took place without prior reference to budgets or DOH&C approvals. Management has indicated that staff were moved from one aspect of the project to another where possible. It is not known the exact number of staff recruited under this process however the minutes of the Resource Committee on 7 April 1998, shows that concern was raised regarding the recruitment procedures and staffing numbers in place. The Resource Committee stated that all further recruitment would require prior approval from the Director of Finance. The

Director of Finance stated that he was never requested to approve any staff recruitment as the Director of Human Resources understood that the requirement for approval related only to new posts and not those which were already considered to be within the control total. It should be noted that the employment control total per the Hospital and the HR department differ significantly with that of DOH&C. This is discussed in greater detail later in this section.

It should also be noted that the HR department still recruited all locums without prior approval due to their temporary status. Temporary staff are also discussed in greater detail later in this report. The DOH&C stated that in relation to commissioning positions, it imposed no ceiling on the number of temporary staff which the Hospital could use in order to get the Hospital open, however, it did impose a financial restriction on the budget available for these staff. DOH&C stated that it was always a condition that the number of temporary staff would reduce appropriately after the Hospital opened.

An independent review carried out by an external consultant on behalf of the Board of HR recruitment operations issued on 30 June 1998 stated that at that time the HR department had an abnormal recruitment workload. 20 WTE's, which included 8 commissioning posts, had been assigned to this department. The report also noted that apart from interviewing and selection of candidates, recruitment requires contracts and set-up, including information gathering, superannuation conditions, drafting, agreement and updating payroll. The report states that the recruitment of 331 additional staff was the responsibility of only three members from the total of ten staff in the HR department. The improvements recommended in the report are detailed below. In our opinion, many of the improvements identified relate to areas of responsibility which were identified in December 1996 and it is not clear why these were not put in place prior to the move. It should also be noted that many of the following recommendations have not been acted on to date.

- Develop the following sets of personnel forms
    - Management requests for staff, terminations, permanencies, contract renewals etc.
    - Recruitment pack including application form, paypath, uniform request etc.
    - Paperwork flow from approval to appointment to resignation/termination
- Develop policies and procedures for HR and complete the development of the staff handbook.
- IT department to install the personnel/payroll system which would allow easier preparation of staff census information and also record information relating to staff status as well as payment information.

8.3 PAY COSTS

The pay costs for the eight months ended 31 August 1998 are analysed below by department. The pay costs are further analysed by gross pay, other pay (including overtime, on call allowances and other allowances) and PRSI. Payroll payments made by FDVH and the TRHB on behalf of the hospital also arise. The costs include pay costs which are normally funded by supplementary funding which is provided for in the Letter of Determination (e.g. PRSI for new employees, medical indemnity etc). These are separately identified below.

In all cases where the Hospital's budget is shown, it refers to the amount included in the Hospital Service Plan. This showed net expenditure of IR£5.9m in excess of determination.

	Gross Pay IR£,000	*Other Pay IR£,000*	*PRSI IR£,000*	*Total Pay IR£,000*	*Base Budget IR£,000*	*Variance IR£,000*
Administration	2,122	390	194	2,706	2,395	311
Medical (NCHD)	2,511	1,125	258	3,894	3,737	157
Medical Consultants	2,527	201	90	2,818	2,495	323
Nursing	9,335	1,425	755	11,515	11,696	(181)
Para-Medical	1,751	408	182	2,341	2,185	156
Support Services	2,398	589	204	3,191	2,913	278
Maintenance	156	94	32	282	192	90
Other	121	28	15	164	106	58
Superannuation:						
- Pensions	795	1	-	796	662	134
- Lump Sums & Refunds	257	-	-	257	124	133
Tallaght specific (Pre 21 June 1998)	1,890	-	-	1,890	2,233	(343)
Commissioning/Developments	669	-	-	669	746	(77)
	24,532	4,261	1,730	30,523	29,484	1,039

The larger variances between budget and actual identified above have been explained by Management as follows:

Administration

The significant number of additional staff remaining in administration after the move which were not included in the budget explains most of the variance. Such staff arise in ISIT in respect of the continuing commissioning of the IT system (12), Materials Management (14) and Patient Flow (60). The introduction of PIMS and the change to a team approach to clinic management has resulted in serious backlogs. Commissioning of patient flow is projected to continue until April 1999. In addition, increased levels of overtime have arisen since the opening of the new hospital which are included within the adverse pay variance.

Medical Consultants

The variance is primarily in relation to the payment of arrears in relation to the Common Contract agreed in 1997. The increase in relation to the consultant common contracts is eligible for supplementary funding.

Nursing

The favourable variance is due to an increased number of agency nurses being utilised by the hospital which are included in the non-pay costs. Management stated that the use of agency nurses is required due to difficulties encountered in respect of recruiting nurses.

Support Services

This relates to a higher level of support service staff than budget, and high overtime in the period around the move.

Superannuation/lump sums

The increases are due to 30/40 individuals who took retirement at the time of the move to the new hospital in Tallaght. A claim has been made for supplementary funding in relation to this item.

Monthly Payroll Analysis

The monthly payroll actual cost and budgets for the hospital for each month in 1998 is detailed below. The increases in the various months are largely in respect of the increasing staff numbers in the hospital and the increases in overtime and other costs.

Month	*Actual IR£,000*	*Budget IR£,000*	*Variance IR£,000*
Jan/Feb 1998	6,977	6,975	2
March 1998	3,500	3,440	60
April 1998	3,730	3,861	(131)
May 1998	3,630	3,548	82
June 1998	3,894	4,198	(304)
July 1998	4,342	3,565	777
August 1998	4,450	3,897	553
Total	30,523	29,484	1,039

8.4 PAYROLL ANALYSIS/STAFF NUMBERS

8.4.1 NUMBERS OF STAFF ON PAYROLL

The numbers of WTE staff working in the Hospital at any specific time during this period is not readily available. The only indicator is the number of people actually paid during each month, which is detailed below:

	Staff Numbers Paid per Month
January 1998	1,952
February 1998	2,023
March 1998	2,117
April 1998	2,090
May 1998	2,099
June 1998	2,084
July 1998	2,202
August 1998	2,162
September 1998	2,189
October 1998	2,268

Comparison of monthly numbers using this basis is a guide only as it does not enable one to assess the amount of hours worked by those staff, their status (temporary or permanent), the effect leavers and joiners during the month etc. The staff numbers detailed above do not include pensioners being paid by the hospital.

The very high number of staff on the payroll in the aftermath of the move is in evidence from the above.

It should be noted that while the difference in staff numbers paid in the periods before and after the move is c.80 to 100 employees, the monthly cost has increased by c.IR£550,000. Management have explained this increase as follows:

	IR£,000
Increase in staff numbers (monthly pay costs)	160
Consultants common contracts (arrears and current)	80
Craft workers pay award	20
Increase in other pay (overtime/on call etc)	160
Pensions and gratuity increases	100
PRSI increase	30
	550

8.4.2 OCTOBER 1998 CENSUS

The Hospital has not had reliable and regular data to enable it control its personnel numbers and pay costs. Routine information on numbers of staff in WTE terms, their status, whether approved or not, is not readily available. In an effort to determine this information at a point in time, the Human Resources department was required to undertake a major exercise in early October 1998. The purpose of the exercise was to confirm portfolio complements and to prove the integrity of the payroll. It is also intended to use the information in the implementation of a devolved budgetary control system. This analysis commenced in early October 1998 and was provided in final form on 13 November 1998. This information has been requested continuously at management and Resource Committee meetings for many months.

There are still deficiencies in the information provided. The analysis does not give any details as to the build-up of actual staff numbers and whether the staff are permanent, temporary or contract. The analysis also does not provide cost data on the employees required, recruited and positions vacant. DOH&C stated that in certain respects, the information as prepared by the hospital does not agree with their records. This is particularly relevant in respect of approved posts and the funding position of some posts.

The staff numbers have been built up in the following stages:

STAGE 1

The opening position is the last known number of approved and funded posts taken from the personnel records of the base hospitals. To this is added:

- Certain posts which had existed for some time in the base hospitals but were not specifically approved by DOH&C.
- A complement of former temporary staff who had acquired employment rights once they had been on the Hospital payroll for one year

- Posts approved by the DOH&C.

STAGE 2

The second stage takes the total derived from stage 1 and adds to it:

- Staff agreed by the Task Force
- Positions included in Service Plan, yet to be agreed with DOH&C
- Positions to be discussed with DOH&C
- Staff associated with proposed developments in the Hospital. Management stated that these were negotiated at the time the transfer of certain psychiatric services from St Loman's was agreed. DOH&C stated that final approval has not been given for these developments.
- Certain commissioning staff retained

STAGE 3

The third stage provides a reconciliation of the control totals derived in Stage two with actual numbers employed, and identifies vacancies within the employment control total.

8.4.3 REVIEW OF STAGE 1

Portfolio	*Opening DOH&C Approved WTE*	*Base Hospitals Unapproved WTE*	*1-Aug-97 WTE*	*DOH&C Approved Posts WTE*	*Leavers/ Upgrades/ Redundant WTE*	*Recruit/ Redeploy/ Upgrades WTE*	*Staff Pre Move WTE*
CEO	12.00	-	-	3.00	(12.00)	6.00	9.00
Organisational Development	1.00	-	2.00	-	-	8.50	11.50
Information Technology	5.73	-	-	15.61	(5.73)	6.73	22.34
Human Resources	12.00	-	1.00	1.00	(13.00)	11.00	12.00
Finance	38.50	2.00	3.00	1.00	(32.50)	32.50	44.50
Environmental Services	206.80	8.00	12.00	7.00	(21.00)	27.00	239.80
Programmes Portfolio	61.27	3.15	1.00	82.50	(2.00)	3.00	148.92
Programmes - Child Health	96.00	-	-	-	-	-	96.00
Clinical Support	77.20	10.00	-	7.50	(1.00)	6.50	100.20
Medical	287.33	6.89	9.70	13.00	(19.00)	32.45	330.37
Nursing	734.50	-	-	-	(25.00)	23.00	732.50
Tallaght Hospital Board	10.00	-	-	-	(10.00)	6.00	6.00
FDVH	18.60	1.00	-	-	(19.60)	4.00	4.00
Cardiology	13.26	1.00	-	-	(4.00)	4.00	14.26
	1,574.19	32.04	28.70	130.61	(164.83)	170.68	1,771.39

- ***Opening DOH&C Approved***

  These relate to positions which the Hospital consider to be approved by DOH&C while in the base hospitals. We have not however, been provided with an analysis of this total by base hospital or provided with any documentation confirming the opening position by the Hospital. The records of DOH&C state that the opening control total was 1,567.66 WTE's, indicating a difference of 6.53 WTE's.

- ***Base Hospitals Unapproved***

  These relate to positions and staff existing within the base hospitals, which were not approved by the DOH&C. As these positions were not approved, they were consequently not specifically funded by DOH&C. Historically, these staff were being paid out of the annual allocation even though they were not specifically within the agreed employment control ceiling. As part of the move to Tallaght from the base hospitals, DOH&C approved these position, on the basis that they would continue to be funded out of the annual determination as before. The cost of these positions amounts to c.IR£600,000 on an annual basis DOH&C stated that per its records, the total is 46.15 WTE's, indicating an increase of 14.11 WTE's. These additional positions are included by the Hospital in the "yet to be discussed" with DOH&C in Section 8.4.4 of this report.

- ***Base Hospitals Unapproved – from 1 August 1997***

  In order to prepare for the move from the base hospitals to the Hospital in Tallaght, a number of staff from the base hospitals were taken from their normal posts. These staff had to be replaced in the Base hospitals mostly with temporary staff. Management stated that many of the temporary staff were employed for greater than one year and were therefore entitled to permanent status and were agreed in 1997 as part of the Industrial Relations Protocol. According to Hospital management, DOH&C approved the posts at the time of the move, however no additional funding was provided. DOH&C stated that these positions (which were similar to the 'base hospitals unapproved' staff discussed above) were approved in August 1997 and were already being funded in the annual allocation to the base hospitals. The annualised cost of these staff is estimated at c.IR£570,000. DOH&C stated that based on their records, the total should be 37.5 WTE's indicating an increase of 8.8 WTE's.

- ***DOH&C Approved Posts***

  These posts were approved by DOH&C, the majority of which were in respect of the laboratory and IT, on the basis that the requisite funding was to be included within the original Determination. DOH&C stated that per its records, the total should be reduced by 0.61 WTE in respect of IT, 9 WTE in respect of medical consultants (already in base figures) and 3.5 WTE in respect of chaplains in clinical support. It is expected that the positions of chaplains will be approved and regularised shortly.

  The following points are also relevant to the above:

  (i) Laboratories

  The projected staffing of the laboratory as shown in the service plan is summarised below:

Department	*Budget Pre 30-Jun-98 IR£,000*	*Budget Post 30-Jun-98 IR£,000*	*Budget Total IR£,000*	*Total Staff Required*
Administration	40	104	144	12
Medical (NCHD)	-	80	80	4
Medical Consultants	163	164	327	6
Paramedical	424	1,067	1,491	66
Support Services	41	153	194	17
	668	1,568	2,236	105

The September payroll indicates that the laboratory operated with 88 staff in the month, which compares to the service plan complement of 105.

In their letter of 18 December 1997, the DOH&C approved a total of 83 posts in the laboratory, which number excluded consultants, registrars and administrative staff. The letter indicates that this number is inclusive of existing staffing in the base hospitals of 7.5 WTEs, or an increase of 75.5 WTEs for the staffing of the new laboratory. In addition, the letter indicates that the DOH&C was prepared to approve 14 posts in relation to clerical administrative staff. The sanction included in the letter was conditional on the funding being provided by the Hospital from within Determination.

Significant pay costs were incurred in the laboratory in respect of overtime and other pay costs in September. This is expected to recur at current staffing levels.

(ii) ISIT

The ISIT development budget relates to the installation and integration of the new IT systems and the transfer of certain existing systems into the Hospital in Tallaght. The budget was based on a requirement for 22 staff to complete the IT developments. The budgeted funding requirement for ISIT was reduced on the basis that the FDVH would fund the pay costs of four of the ISIT staff. The ISIT development budget analysed by number of staff, number of WTE's, numbers recruited and amounts funded by FDVH is shown below.

	Number of Staff	***Number of WTE's***	***1998 Budget IR£,000***
Staff Recruited per Service Plan	19	18	420
Consultant Recruited	1	1	93
Positions Vacant per Service Plan	2	2	82
Total Budget per the Service Plan	22	21	595
Funding Currently in FDVH	(4)	(4)	(92)
Net Cost	18	17	503

It should be noted that at the time of writing this report, four of the ISIT staff are being paid through the FDVH payroll system.

Based on the HR personnel report, the total number of staff in ISIT in early October 1998 was 33 WTE, 12 WTE in excess of the complement included in the service plan. The excess staff are regarded as commissioning staff.

- ***Leavers/Upgrades/Redundant***

This column represents those staff in the base numbers who left posts at any time. For the purposes of this schedule, the HR Department have assumed that this includes numbers of staff which were upgraded within the Hospital. The analysis also includes any staff who left the Hospital or accepted redundancy at any time during the period.

This reduction in staff numbers shown in respect of staff leavers should be reviewed in conjunction with the increase in numbers recruited, redeployed or upgraded as it includes many of the same staff members and positions. No detailed analysis has been provided to date showing the breakdown of this total between leaver, redundancies and upgraded staff. DOH&C have not included these adjustments in its control total.

- ***Recruitment/Redeployment/Upgrades***

  As noted above, the increase shown in this column should be reviewed in conjunction with the number of leavers, redundancies and upgrades. The recruitment included in this number relates to the recruitment for positions vacated due to leavers or redundancies. In certain cases the same individuals are included in the leavers column and the recruitment column due to upgrades. These are staff which were upgraded within the Hospital and the original grade position was not filled by another individual. DOH&C did not include these adjustments in its control totals.

  It should be noted that at the time of the move from the base hospitals, DOH&C records had 1,768.81 WTE's per its records which is a difference of 2.58 WTE's from the Hospital's control total.

8.4.4 REVIEW OF STAGE 2

This stage of the analysis is shown below and covers the changes in staff numbers associated primarily with the move to Tallaght:

Portfolio	***Staff Pre Move WTE***	***Task Force Agreed WTE***	***Service Plan WTE***	***To be discussed with DOH&C WTE***	***Clinical Services Developments WTE***	***Commiss-ioning WTE***	***Control Total WTE***
CEO	9.00	-	-	-	-	1.00	10.00
Organisational Development	11.50	-	-	-	-	-	11.50
Information Technology	22.34	-	-	-	-	12.70	35.04
Human Resources	12.00	-	-	-	-	-	12.00
Finance	44.50	-	-	16.00	-	-	60.50
Environmental Services	239.80	-	-	28.00	-	-	267.80
Programmes Portfolio	148.92	-	-	13.50	10.00	-	172.42
Programmes – Child Health	96.00	14.50	12.00	14.00	-	-	136.50
Clinical Support	100.20	-	-	-	2.00	-	102.20
Medical	330.37	-	8.00	5.00	4.00	27.00	374.57
Nursing	732.50	14.00	14.00	-	13.00	-	773.50
Tallaght Hospital Board	6.00	-	-	-	-	-	6.00
FDVH	4.00	-	-	-	-	-	4.00
Cardiology	14.26	-	-	16.00	6.00	-	36.26
	1,771.39	28.50	34.00	92.50	35.00	40.70	2,002.09

- ***Task Force – Agreed***

  During June 1998, immediately prior to the move from the base hospitals to the new Hospital in Tallaght, a Task Force was formed. The Task Force consisted of representatives from Hospital management, the DOH&C, Trade Unions and HSEA. The terms of reference of the Task Force were as follows:

  - A high level group will focus on the staffing levels critical to the running of the hospital and issues not resolved at sectoral level will be referred to either management or staff.
  - It will not deal with issues relating to individuals.
  - The membership will be drawn from hospital management, HSEA, appropriate trade union representative(s) and DOH&C representative.

  Based on discussions with Hospital management, it was their understanding that any posts approved by the Task Force were to be fully funded. DOH&C stated that during the three meetings of the Task Force, it approved 28.5 additional posts which would obtain additional funding.

  According to DOH&C, this additional funding was to be provided from the surplus expected in the budget of IR£2m held by DOH&C in respect of IR issues related to the Hospital. This funding was on the understanding that these positions would be recruited for the last 3 months of 1998.

- ***Service Plan***

  These staff numbers relate to positions identified by the Hospital as being required and which were included in the service plan for 1998. The Hospital is of the view that additional funding should be provided for these posts. However, the DOH&C stated that there was no discussion at any stage concerning the 8 Medical posts although it notes that these were included in the service plan under the heading of Paediatric A&E. With respect to the Nursing (14) and Child Health (12) posts, DOH&C noted that at the Task Force meetings in June 1998 these posts were included in the Service Plan. The DOH&C states that it gave no commitment to provide additional funding for these posts and that it was a matter for the hospital to manage these within Determination.

- ***To be discussed with DOH&C***

  Management stated that these positions are additional posts identified by the Hospital which are required to ensure the efficient running of the Hospital. Management also stated that they regard these positions as to be agreed at future task force meetings. This is not accepted by the DOH&C. DOH&C stated that some of these positions had been approved within the overall structure of the Hospital and that others had never been discussed. Detailed below is a summary of the status of these positions per the records of DOH&C.

	Total WTE	*Approved within Structure WTE*	*Other WTE*
Finance (Materials Mgt)	16.00	9.00	7.00
Environmental Services	28.00	7.00	21.00
Programmes Portfolio	13.50	-	13.50
Programmes – Child Health	14.00	-	14.00
Medical	5.00	-	5.00
Cardiology – HSSD	16.00	-	16.00
	92.50	16.00	76.50

Of the 16 materials management positions included in finance, 9 of these positions were approved in the overall Hospital staffing structure based on the opening control total to be funded from Determination. These 16 positions were not included in the service plan. The additional posts were not agreed by DOH&C. 28 positions in respect of Environmental Services were included in the Service Plan. Of those, seven positions were approved by DOH&C for the technical services department on the basis that they would be funded by the hospital within Determination. No submission was received by DOH&C in respect of the remaining 21 posts. The Service Plan included 28 posts for Environmental services although differently structured. The HSSD positions were also referred to in the Service Plan but no submission has been received by DOH&C regarding these posts. The DOH&C also stated that 27 posts which it has included in the Stage 1 figures were confirmed by the Task Force on the basis that they were already being funded (14.5 Paediatric nursing posts and 12.5 clinical support posts).

- ***Clinical Services Developments***

  These staff are positions filled to date in relation to a series of developments planned for the Hospital in relation to enhanced patient management systems. The Hospital regarded these posts as having been approved at the time agreement was reached on the move of certain psychiatric services from St Loman's. These developments are discussed in greater detail in Section 10. The developments have yet to be finally approved by DOH&C and as a consequence no funding is available for the staff requirements relating to these developments. No discussions took place with the DOH&C on these recruitments. These staff already recruited by the Hospital are principally in radiology and cardiology. The annual cost of these positions already recruited is estimated at c.IR£900,000.

- ***Commissioning Staff***

  The Commissioning staff are defined as staff who transferred from the base hospitals to the new Hospital in Tallaght a number of months prior to its opening in order to facilitate a smooth transfer of patients and staff to Tallaght. In the Service Plan most of the staff designated as commissioning are named and their position and grade given. At the time of completing the Service Plan, 23 of the total of 112 proposed commissioning positions were vacant. The service plan for commissioning staff is summarised below:

Department	*Staff Costs IR£,000*	*Staff Number*	*Positions Vacant*
Nursing	172	16	8
Human Resources	55	7	-
IT	146	16	2
Administration	233	34	8
Training	37	6	-
Medical	165	15	6
Paramedical	53	5	-
Laboratory	64	6	-
Radiology	48	5	1
Environmental Services	76	10	-
Maintenance	35	4	-
Catering	60	5	-
Clinical Support	8	1	-
	1,152	130	25

Based on discussions with management of the Hospital, it appears that all staff members transferring to Tallaght as part of the commissioning staff were replaced in the base hospitals. These replacement staff were to be temporary staff, who would (in theory) be let go by the Hospital after the move to Tallaght. It appears that many of the commissioning staff have been assumed back into the general staff of the Hospital. There is no evidence of any systematic plan to release the temporary staff in the aftermath of the move/commissioning process, as staff completed their commissioning tasks. Indeed, we understand certain temporary staff had to be made permanent in line as they had been employed by the Hospital in excess of twelve months.

Based on the Human Resources records, 40.7 WTE's have been retained in specific departments to complete certain commissioning tasks. The commissioning budget has ceased therefore, the commissioning posts required are unfunded. These positions are not expected to cease until April 1999.

8.4.5 REVIEW OF STAGE 3

Detailed below is an analysis of the current payroll numbers calculated as WTE's which is compared with the control total of approved positions as provided by the Human Resources department.

Portfolio	*Control Total WTE*	*Actual Staff 11 Oct 98*	*Actual Staff WTE*	*Variance WTE*
CEO	10.00	8.00	8.00	(2.00)
Organisational Development	11.50	12.00	11.50	-
Information Technology	35.04	33.00	32.04	(3.00)
Human Resources	12.00	15.00	14.60	2.60
Finance	60.50	59.00	55.50	(5.00)
Environmental Services	267.80	300.00	259.94	(7.86)
Programmes Portfolio	172.42	161.00	152.98	(19.44)
Programmes - Child Health	136.50	143.00	128.06	(8.44)
Clinical Support	102.20	129.00	117.09	14.89
Medical	374.37	424.00	377.76	3.39
Nursing	773.50	810.00	742.58	(30.92)
Tallaght Hospital Board	6.00	6.00	6.00	-
FDVH	4.00	4.00	4.00	-
Cardiology	36.26	27.00	25.76	(10.50)
	2,002.09	2,131.00	1,935.81	(66.28)

The Actual Staff WTE total per department has been calculated by the HR department by taking the actual number of hours worked by the actual staff employed in the month, divided by the standard number of hours attributable to the various grades and categories of staff.

8.4.6 RECRUITMENT/VACANCIES

The staff numbers as presented show a variance of 66 WTE's which the Hospital regards as vacancies as at 11 October 1998. If one excludes commissioning staff on the basis that these staff should not be required over the longer term, the following adjusted vacancy position arises:

	Position regarded as Vacancies Per HR Schedule WTE	*Commissioning WTE*	*Revised Total WTE*
Financial Accounts	4.00	-	4.00
Technical Services	7.00	-	7.00
Laboratory	2.00	-	2.00
Radiology	12.30	-	12.30
Physiotherapy	0.61	-	0.61
Social Work	-	-	-
Patient Flow Management	2.28	27.00	(24.72)
Medical Staff	(9.19)	-	(9.19)
Specialist Nurses	8.50	-	8.50
Staff Nurses	22.42	-	22.42
HSSD	3.00	-	3.00
Cardiology	7.50	-	7.50
Other Departments	5.86	13.70	(7.84)
	66.28	40.70	25.58

This calculation indicates that the vacancies net of commissioning as at 11 October 1998 is actually 25.58 WTE's. There are a number of points of relevance to this amount:

- A significant level of excess staff over approved complement exists in patient flow and medical staff. Management stated that the patient flow excess is due to significant operational problems in this area since the move to Tallaght. It should be possible to reduce excess numbers in this area over the coming months as backlogs are tackled and more effective work practices are instituted.

- There are currently some 30.92 WTE vacancies in nursing. Additional nurses will be required as new theatres are opened, in respect of any developments which come on stream, and in the year 2000 to service the new private wing.

  If one eliminates the present overstaffing in patient flow management and medical staff, actual vacancies in other areas amount to 59.49 WTE's. Based on the fact that DOH&C has not approved all of the posts identified by the hospital, these vacancies, cannot in all cases be considered as genuine vacancies.

8.4.7 APPROVED/NON-APPROVED STAFF

A reconciliation of staff numbers as presented by the Hospital to those approved by DOH&C is shown below. It should be noted that only 28.5 WTE positions have been approved with funding additional to the 1998 Determination.

	Total WTE	***Approved by DOH&C WTE***
Opening Control Total	1,771.39	1,768.81
Task Force – Agreed	28.50	28.50
Service Plan	34.00	-
To be discussed with DOH&C	92.50	-
Clinical Services developments	35.00	-
Commissioning	40.70	-
	2,002.09	1,797.31

Based on the information detailed above, the Hospital is indicating that it requires 205 WTE staff in excess of the number approved by DOH&C. Of these 35 relate to staff recruited to date in relation to the proposed clinical developments not approved by the DOH&C. The estimated annual payroll cost for these 205 WTE positions is estimated at c.IR£5m per annum. It should be noted that not all 2002 WTE positions identified by the Hospital are currently filled; the schedules show 66 vacancies. The vacancies carry an annual payroll cost of c.IR£1.5m.

This annualised cost of unapproved staff is very significant and this has for the most part been the reason for the significant overrun in payroll costs by the Hospital. There does not appear to be any plan or strategy in place within the Hospital to reduce these staff numbers or reduce the cost. The Hospital are of the view that apart from the commissioning staff which will be phased out over the next year, all other WTE positions are required for the proper running of the Hospital.

8.4.8 TEMPORARY AND CONTRACT STAFF

The Hospital policy is that all staff receive and sign a contract before taking up employment, which in the case of temporary contracts are either fixed term or specified purpose. The temporary staff report produced by the Human Resources on 21 October 1998, indicated that there were 414 temporary staff employed by the Hospital (the high number is attributed to changing structures in the Hospital). Of these staff, 296 will not have been employed for more than 12 months by 31 December 1998 based on the contract start dates detailed on the report. It should be noted that as the temporary staff report does not detail the number or length of other contracts served by an individual, the total length of employment may exceed twelve months and this would not be evident from the report. Thus the number of potential permanent staff on the temporary staff payroll may exceed the 118 shown as at 21 October 1998. Detailed below is an analysis of the temporary staff report.

	Total Staff No.	***Staff Exceeding 12 Months Staff No.***	***Staff Less than 12 Months Staff No.***	***Other Staff No.***
Contract Ended Pre 30 Oct 1998	64	64	-	-
Contract Ended Pre 31 Dec 1998	136	-	136	-
Contract Ended Post 31 Dec 1998	149	-	149	-
To be made Permanent	15	15	-	
Status for Review	39	39	-	-
Staff Left	2	-	-	2
Staff Leaving	9	-	-	9
	414	118	285	11

This analysis of temporary staff can be further analysed by type of staff as follows:

	Staff No.
Nurses	163
Medical/Non-Administration	86
Administration/Other	165
Total	414

Management stated that the Hospital policy is that all staff receive and sign a contract of employment before taking up a position and that the temporary contracts are for either a fixed term or a specified purpose. The large number of temporary staff present at the time of this review was because of the changing structures in the Hospital, particularly in patient flow.

Any employee recruited on a temporary basis will remain temporary until a full year (11 months plus holidays) has elapsed. After this period has elapsed and the individual is still being employed by the Hospital, the Hospital is legally obliged to offer him/her a full-time position. This period of one year relates to the total period of continuous employment even if this is a combination of a number of separate contracts.

Currently, the Hospital can produce a report detailing the number of temporary staff in employment in the Hospital. This report details the temporary staff name, start date, contract expiry date, staff whose contract is subject for renewal in the newt month, three months and beyond. Currently, this report is reviewed on an ad hoc basis and inadequate regard is paid to the length of employment by any temporary staff. In the future, the Human resources department intends to print this report on a monthly basis for review. Based on the monthly

report, a memo will be sent to each of the department Heads with information on each temporary employee in their respective departments as to when their contracts will terminate. This process should help to identify when temporary contracts are approaching renewal dates and also, where a vacancy exists, the departmental head can recommend that a suitable temporary employee can be made permanent. The Human Resources would then make the temporary person permanent providing the relevant department has a vacancy for that position and is within the Hospitals and the department's budget.

The temporary staff report generated only gives details of current contracts in place and does not identify whether this contract is actually the individuals first with the Hospital or not. The system is deficient in that it does not recognise situations where contracts have been renewed. We have been advised that exception reports cannot be run on the Human Resources system to identify such personnel.

It is imperative the temporary staff complement is managed in a proactive way, so that only temporary staff which the Hospital plans to retain on a permanent basis are retained, otherwise there is a risk that temporary staff will become permanent by default. Accurate reports of the status of temporary employees are required on a regular basis. A routine process of ensuring temporary staff do not, by default, gain permanent status is urgently required. An immediate review by department is required to assess the current position, and agree actions to lay off temporary staff where possible.

8.5 OTHER PAY COSTS

8.5.1 SUMMARY

A summary of the other payroll costs by department for the period to 31 August 1998 is shown below:

Department	*Overtime IR£,000*	*On Call IR£,000*	*Allowance IR£,000*	*Weekend IR£,000*	*Night Duty IR£,000*	*Other IR£,000*	**Total IR£,000**
Administration	225	-	139	4	20	-	388
Medical	931	-	98	-	-	97	1,126
Med Consultants	-	138	21	-	31	9	199
Nursing	90	39	79	348	867	-	1,423
Para-Medical	26	363	15	-	-	-	404
Support Services	461	-	44	23	55	7	590
Maintenance	71	10	-	9	-	-	90
Other	24	-	3	-	-	-	27
Pensions	-	-	15	-	-	-	15
	1,828	550	414	384	973	113	4,262

Detailed below is an analysis by department by month of each of the above areas of other pay costs. This analysis indicates the trend of expenditure in each of the pay areas and the trends in each department.

8.5.2 OVERTIME

The overtime costs for the period to 31 August 1998 is analysed below by department and by month. It should be noted that all overtime is generally paid one month in arrears, for example, the June overtime is paid in July.

Department	*Jan 98 IR£,000*	*Feb 98 IR£,000*	*Mar 98 IR£,000*	*Apr 98 IR£,000*	*May 98 IR£,000*	*Jun 98 IR£,000*	*Jul 98 IR£,000*	*Aug 98 IR£,000*	*Total IR£,000*
Administration	11	14	14	14	17	27	82	46	225
Medical	63	101	104	109	134	126	145	149	931
Med Consultants	-	-	-	-	-	-	-	-	-
Nursing	8	8	12	10	4	10	28	10	90
Para-Medical	1	2	2	1	2	1	16	1	26
Support Services	55	41	41	46	57	53	101	67	461
Maintenance	3	5	6	6	6	11	21	13	71
Other	2	2	2	2	3	3	7	3	24
Pensions	-	-	-	-	-	-	-	-	-
	143	173	181	188	223	231	400	289	1,828

Based on the analysis above, it is clear that there was a significant increase in overtime costs during the period immediately prior and after the move from the base hospitals to the new Hospital in Tallaght. It appears that the overall overtime amount in the Hospital has remained higher since the move to Tallaght; it has however reduced from the peak in July 1998. Management are of the view that this period reflects the significant additional effort associated with the move, and additional work arising on arrival at the new Hospital. A number of deficiencies were identified in the issues log which along with deficiencies in training and IT problems causing backlogs in standard hospital work further increased the level of overtime, particularly in patient flow department. The September 1998 overtime total of IR£253,000 indicates a further reduction in the monthly totals. Payroll data for October 1998 confirms overtime continuing to run at September levels. Based on discussions with the Hospital's management, the September 1998 level of overtime is likely to continue into the future based on current staffing levels. DOH&C stated that in its view, there are no reasons why the increased level of overtime should continue into the future and that this problem should have been solved by the Hospital. Overtime has been running in recent months at c.IR£70,000 per month over and above the overtime levels previously experienced in the base hospitals. This has an annualised additional cost of c.IR£840,000 which does not appear to have been included in the Hospital's base budget.

Overtime payments in the laboratory have been high. A summary for September is set out below. It can be seen that overtime and other payroll costs comprise c.24% of the total pay costs in the month. DOH&C noted that while the overall overtime/on call cost would appear to be reasonable, the costs in relation to para medical staff at 46% of gross pay is considered higher than normal.

	Gross Pay IR£	*Other Pay IR£*	*PRSI IR£*	*Total Pay IR£*
Administration	7,462	170	415	8,047
Medical (NCHD)	1,574	119	203	1,895
Medical Consultants	37,822	6,235	1,633	45,690
Paramedical	118,591	54,855	10,221	183,667
Support Services	17,237	1,146	1,629	20,012
Nursing	3,542	16	75	3,634
	186,228	62,541	14,176	262,945

There are currently 17 vacant positions in the laboratory relative to service plan. We understand that it is intended to fill these positions. If the positions are filled at salary levels in line with service plan and if as a consequence overtime is eliminated, then the hospital's budget should still be adequate. However, the implications of increasing laboratory staff, including the impact on overtime, need to be fully understood before additional posts are to be filled. If overtime is not reduced, there is a significant risk that costs in this area could be materially in excess of service plan/budget.

8.5.3 ON CALL

Department	*Jan 98 IR£,000*	*Feb 98 IR£,000*	*Mar 98 IR£,000*	*Apr 98 IR£,000*	*May 98 IR£,000*	*Jun 98 IR£,000*	*Jul 98 IR£,000*	*Aug 98 IR£,000*	**Total IR£,000**
Administration	-	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-	-
Med Consultants	6	22	14	14	28	21	14	19	138
Nursing	5	6	5	5	6	6	3	3	39
Para-Medical	36	38	36	41	39	40	46	87	363
Support Services	-	-	-	-	-	-	-	-	-
Maintenance	2	1	1	1	1	1	2	1	10
Other	-	-	-	-	-	-	-	-	-
Pensions	-	-	-	-	-	-	-	-	-
	49	67	56	61	74	68	65	110	550

The total monthly On Call amounts paid by the Base hospitals prior to the move to the new hospital in Tallaght appear to have remained reasonably consistent based on the summary above. This trend continued until July 1998 after which there was a significant increase. This increase management believe reflects changes associated with consultant contracts, and increases in the laboratory and radiology. The increasing amounts payable has also continued into September 1998 with the total paid amounting to c.IR£150,000. Of this total, c.IR£101,000 is in respect of the Para Medical department and c.IR£43,000 in respect of Medical Consultants. The increased levels of monthly on call charges have not been included in the base budget per the Service Plan and have been part of the reason for the overrun on budget in August 1998. DOH&C stated that the increased costs in relation to the consultants contracts can be claimed back by the Hospital.

8.5.4 ALLOWANCES

Department	*Jan 98 IR£,000*	*Feb 98 IR£,000*	*Mar 98 IR£,000*	*Apr 98 IR£,000*	*May 98 IR£,000*	*Jun 98 IR£,000*	*Jul 98 IR£,000*	*Aug 98 IR£,000*	*Total IR£,000*
Administration	13	16	18	21	18	18	16	19	139
Medical	12	14	13	14	13	14	7	11	98
Med Consultants	1	1	1	1	1	1	5	10	21
Nursing	8	8	8	9	9	10	16	11	79
Para-Medical	2	2	2	2	3	2	1	1	15
Support Services	4	5	5	5	6	12	2	5	44
Maintenance	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	1	16	1	-	3
	40	46	47	52	51	73	48	57	414

The levels of allowances paid to staff appear to have remained reasonably constant over the eight month period ended 31 August 1998.

8.5.5 WEEKEND PAY

Department	Jan 98 IR£,000	Feb 98 IR£,000	Mar 98 IR£,000	Apr 98 IR£,000	May 98 IR£,000	Jun 98 IR£,000	Jul 98 IR£,000	Aug 98 IR£,000	Total IR£,000
Administration	-	-	-	-	1	1	1	1	4
Medical	-	-	-	-	-	-	-	-	-
Med Consultants	-	-	-	-	-	-	-	-	-
Nursing	48	39	33	49	43	50	48	38	348
Para-Medical	-	-	-	-	-	-	-	-	-
Support Services	2	2	2	3	4	2	5	3	23
Maintenance	1	1	1	1	1	1	2	1	9
Other	-	-	-	-	-	-	-	-	-
Pensions	-	-	-	-	-	-	-	-	-
	51	42	36	53	49	54	56	43	384

The payroll payments in respect of weekend work appear to have remained reasonably constant during the eight months to 31 August 1998 and this trend appears to have continued into September 1998. On the basis that there have been no significant change in the monthly amounts, it would appear that the budget per the Service Plan adequately provides for these payments on a monthly basis.

8.5.6 NIGHT DUTY

Department	*Jan 98 IR£,000*	*Feb 98 IR£,000*	*Mar 98 IR£,000*	*Apr 98 IR£,000*	*May 98 IR£,000*	*Jun 98 IR£,000*	*Jul 98 IR£,000*	*Aug 98 IR£,000*	*Total IR£,000*
Administration	2	2	2	2	2	2	3	5	20
Medical	-	-	-	-	-	-	-	-	-
Med Consultants	6	7	-	2	2	9	1	4	31
Nursing	117	113	94	126	96	113	99	109	867
Para-Medical	-	-	-	-	-	-	-	-	-
Support Services	5	5	5	6	14	7	7	6	55
Maintenance	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-
Pensions	-	-	-	-	-	-	-	-	-
	130	127	101	136	114	131	110	124	973

The level of Night Duty allowance payments has remained reasonably constant throughout the eight month period ended 31 August 1998. There has however been an increase in the total amount paid in September 1998 to c.IR£148,000. This increased level of Night Duty pay is expected to continue into future periods. The largest increase in September 1998 is in respect of Nursing staff. According to the Hospital's management, this increase was due to the increased numbers in nursing staff in the period.

8.5.7 OTHER

Department	*Jan 98 IR£,000*	*Feb 98 IR£,000*	*Mar 98 IR£,000*	*Apr 98 IR£,000*	*May 98 IR£,000*	*Jun 98 IR£,000*	*Jul 98 IR£,000*	*Aug 98 IR£,000*	*Total IR£,000*
Administration	-	-	-	-	-	-	-	-	-
Medical	10	10	10	10	10	10	17	20	97
Med Consultants	-	1	-	4	1	3	-	-	9
Nursing	-	-	-	-	-	-	-	-	-
Para-Medical	-	-	-	-	-	-	-	-	-
Support Services	1	1	1	1	1	1	1	-	7
Maintenance	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-
Pensions	-	-	-	-	-	-	-	-	-
	11	12	11	15	12	14	18	20	113

These other pay amounts are in respect of additional amounts paid to staff who are required to assume responsibilities above those normally required of their grade due to more senior staff being on holidays or on sick leave within a department. The amounts involved are relatively small, however, the Hospital noted that the increased level in July and August 1998 was because staff were requested to defer holidays until the move had been completed

OVERTIME AND OTHER ALLOWANCES- KEY ISSUES

It is evident from the above analysis that since the move to the new Hospital in Tallaght, there has been a considerable increase in the overall level of overtime and on-call costs. While the total amounts have reduced since July 1998, the totals are still in excess of that being paid in the base hospitals prior to the move.

Previously, any overtime claimed by an employee had to be authorised by their departmental head. The overtime requisition was then sent straight to the payroll department where only very unusual claims were returned and the Director of Finance's approval sought. Since the move to the new Hospital, it has been found that the total levels of overtime have increased. This is a combination of a small number of particularly large claims and increases in the overall levels of overtime claimed by other staff in the Hospital. Since September 1998, the Director of Finance has insisted that he approve all overtime payments exceeding 10% of gross pay. Initially, this only happened in a haphazard manner, and has only recently began to be adhered to on a more consistent basis.

In future, and until such time as department managers have specific pay and non-pay budgets, we would recommend that the department heads should submit their overtime analysis to the Finance Director on a weekly basis to enable any impending problems to be dealt with as early as possible.

Another difficulty encountered in respect of overtime is that some employees are not claiming overtime on a timely fashion. In order to enable costs to be controlled on a month to month basis and for proper budgeting to be possible, it is recommended that every effort should be made to ensure that overtime claims are made in a timely manner. The fact that claims are made months in arrears also makes it difficult for the department heads to question the levels of overtime being claimed for accuracy. In future, reasonable deadlines should be set for overtime claims.

The Hospital currently does not operate a clock-card system except for porters. It is recommended that a clock-card system be introduced in the Hospital particularly in the departments with most overtime. The introduction of clock-cards for the porters is only recent and it is too early to see if any benefits can be derived from the system.

A review of the August 1998 payroll details showed that the levels of overtime and other pay earned by a small number of staff accounted for a significant amount of the total monthly costs. It is clear that if these larger payments can be reduced, the overall cost can be reduced significantly over the year. Detailed below is a summary of the August 1998 payroll compared to the totals of the higher earners of other pay during the month. It should be noted that some of these employees doubled their monthly pay with other pay in the month.

	August 1998 Total IR£,000	*Overtime Selection IR£,000*	*On Call Selection IR£,000*	*Allowance Selection IR£,000*	*Night Duty Selection IR£,000*	*% of Total %*
Number of Staff	2,381	12	11	4	6	1.5
Gross Pay	3,280	29	33	15	11	2.7
Overtime	290	36	-	-	-	12.4
On Call	111	-	27	-	-	24.3
Allowance	58	1	-	14	-	8.9
Week End	44	-	-	-	1	2.3
Night Duty	124	-	-	-	5	4.0
Other	20	1	-	-	-	5.0
PRSI	255	5	2	1	-	3.1
	4,182	72	62	30	17	4.3

8.6 CO-OPERATION AGREEMENT

This payment was agreed between the Hospital, DOH&C, the employees and their unions prior to the move to the new Hospital in Tallaght. The maximum payment of IR£957.60 was paid to all staff who transferred to Tallaght on "a permanent basis". The Co-operation Agreement payment was paid on a pro-rata basis, with any employee who moved to Tallaght and was working a full quota of hours per week receiving the maximum benefit. In July 1998, 1,558 employees were paid IR£1,374,356, which is an average of 92% of the maximum payment per employee. In addition, IR£552,329 was at that stage paid in pensions.

The Co-operation Agreement placed no obligation on the employee to remain in Tallaght for any specified period after receipt of the payment. During the course of our review we identified that 99 of the staff which transferred to the new Hospital in Tallaght from the Base hospital left the Hospital in the period between 21 June 1998 and 30 September 1998. The total amount of co-operation agreement payments made to these former staff members was IR£89,691.

8.7 PAYROLL/PERSONNEL SYSTEM

In 1995, the three base hospitals purchased the computer system used for processing/controlling both the Payroll and Human Resources functions in the Base hospitals. In 1996, a project team which included the software company, the finance department, ISIT committee and the HR department was formed to consolidate all three Payroll/Personnel systems into one. This consolidation has not occurred to date due to variances in coding of staff between the three base hospitals. According to hospital management, the finance department has commenced a manual review of the staff coding and a process of recoding has commenced. This process will include the standardisation of post codes in the HR department. Further meetings with the HR department are required to identify the most efficient way of amending the personnel and payroll systems for the new coding structure.

Currently, monthly payroll reports are generated from the Meath, Adelaide and NCH payroll ledgers and these form the basis of journals which are manually inputted into the Nominal Ledger.

Personnel currently make all changes to staff records including grade codes, cost centre/department codes and by default, category codes. All cost centre codes remain the same as were used in the Base hospitals. In certain instances, these classifications have no particular relevance to the current structure in the new hospital. It has also been noted that certain of the Base hospitals classify the same categories of staff into different codes which has resulted in some misanalysis on consolidation in the new Hospital.

As the payroll systems have not been integrated, the Finance Department has designated an MS ACCESS database used in conjunction with a computer package called "Business Objects". Each month a full download of the three payrolls are transferred, where they can be consolidated and then interrogated on a consolidated basis to give trending analysis. Due to the inconsistencies in cost centre/department codes, the usefulness of this database interrogation is restricted to top level analysis only, e.g. comparison of portfolio totals or for quick interrogation of individual staff trending on overtime. Any more detailed enquiries into the payroll information provided would require separate analysis of the three payrolls and a consolidation of the results, thus trebling the workload, and increasing the risks of error.

The following recommendations have been identified during the course of our review, which should assist in the preparation, and interrogation of payroll and Human Resources information.

- Consolidate all of the payroll systems into one system which integrates with the Nominal Ledger in the Finance Department.

- Revise all cost centre coding in the payroll system to reflect the new Hospital structure. This will allow the use of the detailed account coding structure, which was devised for the proposed new Nominal Ledger software.

- One specific department should have responsibility over cost centre/departmental coding. The Finance department would appear the most obvious candidate for this role through its payroll section. Currently, there are no controls in place to ensure the maintenance of identical cost centre coding.

- All new posts being recruited should be subject to budgetary approval from the Director of Finance.

- A full review of the Payroll/Personnel software should be carried out to evaluate its capabilities in the light of the new hospital's needs.

- A routine reporting package to be produced from Payroll/Personnel on a monthly basis the contents of which to be agreed, but which must include departmental overtime analysis, starters/leavers by department changes in grade, etc. There is currently no such information provided.

- Utilisation of the Access database to analyse trends across all elements of pay.

- Create a similar database for Personnel information.

8.8 FDVH/ISIT

Five of the personnel involved in the ISIT Department of the Hospital are currently paid through the FDVH. It is important that the personnel are transferred to AMINCH as quickly as possible. This will assist in overall control of personnel numbers.

8.9 ABSENTEEISM

Each Departmental Head sends out weekly reports by employee to Personnel which is then input into the three individual hospital personnel systems. As with the payroll system, departmental comparisons are only possible by individual hospital and the results must be consolidated to be useful. Exception reports cannot be run on the current system. Departmental analysis reviews/trending analysis has not historically been carried out.

As part of our review, we investigated the level of absenteeism apparent in the various departments in the Hospital. Detailed below is a sample of absenteeism levels identified in specific departments for specific months. The summary details the percentage of days lost through absenteeism each month in these specific departments. It should be noted that not all departments are included in the summary below. Year to date statistics and overall hospital statistics are not available in relation to absenteeism.

	Jan 1998 ***%***	***July 1998*** ***%***	***Aug 1998*** ***%***
Nursing – ICU	3.72	2.64	2.65
Child health	1.22	1.47	0.96
Housekeeping	4.69	8.29	8.22
Catering Assistants/Housekeepers	5.04	14.53	11.51

Management believe the ICU statistic represents a significant improvement due to the quality of working environment, a feature also of child health. The issues in housekeeping are attributed to two problems; changes in housekeeping practices, and issues with the physical facility in catering.

SECTION 9
REVIEW OF NON-PAY COSTS

9.1 ANALYSIS OF NON-PAY COSTS

9.1.1 INTRODUCTION

This section includes our review of the non-pay costs of the hospital for the period to 31 August 1998. It includes an analysis of the costs in the period, a review of the non-recurring expenditure, which occurred in July and August 1998, and a review of the variances against budget in the same months excluding the non-recurring expenditure. It is important to note that these variances are generally controllable and the current levels of expenditure are not necessarily the level which should recur if a programme of cost containment were in place.

Where reference is made to the budget in this section, it refers to the overall budget used by the Hospital, which is prescribed in its service plan. As such, the budget is IR£5.9m over Determination for the year.

9.1.2 Summary

Detailed below is an analysis of non-pay costs for the eight month period ended 31 August 1998 compared to budgeted figures for the same period. The table below separates the period before and after the move to the new Hospital in Tallaght.

It is evident from the table that the Hospital has incurred significant overruns in non-pay costs in the two months of July and August 1998. Prior to July 1998, the base hospitals were operating within the Hospital's budget in respect of their expenditure. The monthly variances against budget excluding any commissioning or development expenditure bear this out.

Month	*Actual Total IR£,000*	*Budget Total IR£,000*	*Variance IR£,000*
Jan-98 & Feb-98	2,761	2,745	16
Mar-98	1,378	1,336	42
Apr-98	1,556	1,555	1
May-98	1,443	1,409	34
Jun-98	1,304	1,208	96
Jul-98	2,454	1,385	1,069
Aug-98	2,073	1,313	760
	12,969	10,951	2,018

	Jan-Jun Actual IR£,000	*July Actual IR£,000*	*August Actual IR£,000*	*YTD Actual IR£,000*	*Jan-Jun Budget IR£,000*	*July Budget IR£,000*	*August Budget IR£,000*	*YTD Budget IR£,000*	*YTD Variance IR£,000*
Drugs	1,417	160	235	1,812	1,220	292	190	1,702	110
Blood	528	110	56	694	445	38	32	515	179
Gases	107	12	20	139	110	44	22	176	(37)
Medical & Surgical Appliances	2,550	424	502	3,476	2,427	400	368	3,195	281
Medical Equipment	257	10	30	297	230	24	55	309	(12)
X-ray	333	172	27	532	400	87	52	539	(7)
Pathology	20	47	-	67	28	6	3	37	30
Catering	416	93	78	587	422	73	65	560	27
Heat, Light & Power	270	48	68	386	284	34	36	354	32
Cleaning & Washing	840	260	149	1,249	778	126	137	1,041	208
Furniture, Crockery & Hardware	85	48	48	181	144	10	21	175	6
Bedding & Clothing	67	32	26	125	51	5	4	60	65
Maintenance	136	227	125	488	197	27	37	261	227
Farm & Grounds	2	3	4	9	1	1	-	2	7
Transport & Travel	138	36	36	210	141	26	24	191	19
Bank Interest	25	8	15	48	29	1	10	40	8
Bank Charges	1	1	-	2	1	-	-	1	1
Insurance	180	38	37	255	171	28	37	236	19
Audit	93	2	14	109	98	4	34	136	(27)
Legal	4	24	3	31	1	-	-	1	30
Bad Debts Expense	81	4	8	93	56	4	4	64	29
Office Expenses	589	340	232	1,161	578	104	114	796	365
Office Equipment	15	5	-	20	25	4	1	30	(10)
Computer	128	211	170	509	130	-	18	148	361
Professional Services	38	49	6	93	41	18	6	65	28
Sundries – includes security	122	90	184	396	245	29	43	317	79
	8,442	2,454	2,073	12,969	8,253	1,385	1,313	10,951	2,018
Tallaght Related Costs	3,199	-	-	3,199	3,101	-	-	3,101	98
Commissioning/Developments	-	269	397	666	-	227	484	711	(45)
	11,641	2,723	2,470	16,834	11,354	1,612	1,797	14,763	2,071

The reasons for the significant variances are discussed in detail below.

9.1.3 ADJUSTMENT FOR NON-RECURRING NON-PAY COSTS

For the purposes of our review, we focused mainly on the expenditure in July and August 1998, on the basis that the major variances on budget occurred in these months. The expenditures in these months were discussed in detail with the management of the Hospital and every effort was made to identify any items of expenditure which were not expected to recur in the future. Detailed below is a summary of our findings for each month. The specific non-recurring items are discussed in detail later in this section.

	July Total IR£,000	*July Non Recurring IR£,000*	*July Other IR£,000*	*August Total IR£,000*	*August Non Recurring IR£,000*	*August Other IR£,000*
Drugs	160	-	160	235	-	235
Blood	110	-	110	56	-	56
Gases	12	-	12	20	-	20
Medical & Surgical Appliances	424	-	424	502	-	502
Medical Equipment	10	-	10	30	-	30
X-ray	172	14	158	27	-	27
Pathology	47	-	47	-	-	-
Catering	93	-	93	78	-	78
Heat, Light & Power	48	16	32	68	-	68
Cleaning & Washing	260	62	198	149	12	137
Furniture, Crockery & Hardware	48	-	48	48	15	33
Bedding & Clothing	32	14	18	26	15	11
Maintenance	227	134	93	125	57	68
Farm & Grounds	3	-	3	4	-	4
Transport & Travel	36	6	30	36	9	27
Bank Interest	8	-	8	15	14	1
Bank Charges	1	-	1	-	-	-
Insurance	38	-	38	37	-	37
Audit	2	-	2	14	-	14
Legal	24	-	24	3	-	3
Bad Debts Expense	4	-	4	8	-	8
Office Expenses	340	69	271	232	60	172
Office Equipment	5	5	-	-	-	-
Computer	211	190	21	170	100	70
Professional Services	49	-	49	6	-	6
Sundries – includes security	90	80	10	184	30	154
	2,454	590	1,864	2,073	312	1,761

July 1998 – Non Recurring Expenditure

The management of the Hospital provided a detailed analysis of the non-recurring expenditure in July 1998. As part of our review, we considered whether the amounts identified were actually non-recurring given the levels of expenditure identified in August 1998. The management identified IR£1m of non-recurring expenditure in July 1998, however we have reduced this figure on the basis that some similar expenditure was incurred in August 1998. Detailed below is a brief explanation as provided by management for each non-recurring item identified. It should be noted that some of the non-recurring expenditure incurred may be the responsibility of the building contractor or design team through the TRHB; hospital management are of the view that compensation may be due in respect of these items.

X-Ray ***IR£14,000***

This is in respect of the supply and fitting of X-ray tubes and illuminators which was considered to be a non-recurring event.

Heat, Light & Power ***IR£16,000***

This relates to electrician call outs to the Meath hospital prior to its closure and the Meath's May 1998 ESB bill. The recurring costs are in respect of the ESB costs for the Hospital. It is important to note that costs associated with the former base hospitals will recur until these properties are sold. Management stated that the sale of two of the base hospitals have been completed. Some other costs not considered non-recurring in July 1998 were in respect of alterations required to the Hospital after the move. Some of these costs may be claimed in the future, however, the amount involved has not been quantified to date.

Cleaning & Washing ***IR£62,000***

The non-recurring costs can be analysed as follows:

	IR£,000
Waste Disposal	8
Initial Cleaning of Hospital	36
Work on Air Handling Units	18
	62

Bedding & Clothing ***IR£14,000***

The non-recurring element of this cost is in respect of the initial stocking up of linen in the new Hospital. It is not expected that the monthly charge will be as high in the future.

Maintenance ***IR£134,000***

The non-recurring expenditure identified relates to alterations required in the Hospital due to the need for temporary accommodation for certain departments. These costs have been assumed by the Hospital as the TRHB had no available budget and also because the change in accommodation arrangements was at the request of the Hospital. It is possible that some of these costs may be claimed by the Hospital from TRHB or the building contractor, however, to date such claims have not been formulated.

Office Expenses ***IR£69,000***

These non-recurring costs can be analysed into the following categories of costs.

	IR£,000
Advertising	30
Stationary/Printing	23
Telephones	16
	69

Computer Costs ***IR£190,000***

The computer costs, which were identified, as being non-recurring are analysed below. Management stated that the 30 PC's purchased in the month, in addition to the PC's purchased through the Hospital's capital budget, were required for the opening of the hospital and are being used in X-ray and A&E. The PC's were ordered by the Hospital's IT department through FDVH but the cost was recharged to AMINCH. It appears that these PC's were in excess of the Hospital's PC requirement originally identified in the IT capital budget. An overall capital budget of IR£4m was provided to the Hospital of which only

c.IR£3.2m has been spent to date. The balance is expected to be spent over the remainder of 1998 and 1999.

	IR£,000
Printers	27
PC Computers (30)	51
Cabling	65
Other IT/Software Costs	47
	190

Security ***IR£80,000***

The costs identified by the Hospital as non-recurring are principally capital items purchased for the Hospitals security system during the month. These capital items included the swipe card system. When the Adelaide, Meath and NCH base hospitals are sold, security savings of c.IR£21,000 per month will be achieved. The security contract for the new hospital has not yet been put to tender however management have stated that this is currently being arranged.

August 1998 – Non-Recurring Expenditure

Cleaning & Washing ***IR£12,000***

The cleaning contract was tendered in early 1998. The tender was awarded jointly to two separate operators. Ineffective cleaning contract management within the Hospital resulted in a higher than anticipated number of hours being worked initially by the contractors. Agreement has now been reached with the contract cleaners of the number of hours required to carry out the contract and a reduction of approximately IR£20,000 per month is expected to be achieved from November 1998.

Furniture ***IR£15,000***

The remit of the TRHB included that of furnishing the Hospital. The items of furniture which were purchased by the Hospital were regarded as essential items by the management of the Hospital not provided by TRHB. Management of AMINCH has advised us that in April/May 1998, the furniture budget of the TRHB was reduced by 50% and this caused some of the furniture deficits. Furniture regarded by AMINCH as essential had then to be purchased by AMINCH. These additional costs were not included in the service plan or budget for 1998. Since September 1998, all non-essential purchases have been stopped. In September 1998, the furniture expenditure was under budget as a consequence of this policy. DOH&C understood that some of the shortfall in furniture was to be satisfied by transfers from the base hospitals. As no final reconciliation has been completed in this respect, it is not clear as to the level of savings this actually provided.

Bedding & Clothing ***IR£15,000***

The non-recurring expenditure identified is a combination of a once off payment on bedding of IR£9,000 and expected future savings on the rent of Clinitron beds of IR£6,000. The current monthly charge for Clinitron beds which are used primarily in the Age Related Care department amounts to c.IR£11,000. Currently, there are insufficient controls in place to ensure that all Clinitron beds not in use are returned so as to reduce the rent payable. The Unit managers have the responsibility for ordering the beds and it is anticipated that when proper controls are put in place, savings of up to 50% will be achieved. A separate cost centre will be set up by the Finance department to track the use and cost of these beds in the relevant wards.

Maintenance ***IR£57,000***

The non-recurring expenditure in August 1998 identified is analysed below.

	IR£,000
Building Alterations	16
Drains Contract	21
Cabling/Trunking	3
Annual Maintenance Contract – Pager System	17
	57

The non-recurring element of the drains contract is 50% of the total charge for August. This relates to work done in rectifying the Hospitals drainage system. This monthly cost is expected to reduce by a further 25% in October 1998. The maintenance contract for the Hospital's pager system was charged in full in August rather than spread over 12 months. All maintenance expenditure was ordered or approved by the Environmental Services Department of the Hospital.

Management are of the view that much of the maintenance costs incurred to date relates to rectification work. They are of the opinion that these costs should be reclaimed from TRHB, however, no such claim has yet been formulated. Management stated that there is no doubt that this higher level of expenditure will continue until the log of building issues has been completed. As accommodation was not available for a significant number of staff at the time of the move, additional maintenance costs can be anticipated until all such accommodation issues are addressed.

Transport ***IR£9,000***

The non-recurring transport expenditure is in respect of moving expenses and taxi expenses. The Hospital incurred IR£5,000 in respect of moving equipment from the base hospitals to Tallaght. While this cost will not continue into the future, additional furniture moving costs were incurred in September in respect of the base hospitals amounting to c.IR£27,000. These costs are viewed as non-recurring. In July and August 1998, the Hospital incurred significant taxi charges significantly in excess of what was expected. Controls have now been placed on the use of taxi's in the Hospital which are expected to yield cost savings in future months.

Bank Interest ***IR£14,000***

According to the Hospital's management, this represents an amount which was paid to an estate agent involved in the negotiation of leases for the shop and bank in the Hospital lobby. This cost is wrongly analysed to the "Bank Interest" cost category and is not expected to recur. Management expect that the service plan budget will be achieved for the remainder of the year despite the cash-flow difficulties being experienced. The Hospital has been financing itself through creditors rather than through bank funds which has saved on bank interest. The Hospital do not appear to have provided for any interest payable to creditors in line with the Prompt Payment legislation which based on September 1998 creditors listing amounts to c.IR£43,000.

Office Expenses ***IR£60,000***

The office expenses identified by the Hospital's management as being non-recurring in August 1998 is analysed as follows.

	IR£,000
Stationery	12
Couriers	3
Office Equipment – Printers, phones & Dictaphones	45
	60

During August 1998, seven printers, phones for the nurse's bays and 42 dictaphones were purchased. These costs are considered non-recurring. A review of the September 1998 invoice listing indicated that a further IR£142,000 was incurred in relation to the telephone system. This was ordered in April 1998 on a FDVH order form, apparently in relation to the PACS system. An invoice for this equipment was initially sent to the FDVH; a replacement invoice was sought in the name of AMINCH. This invoice was received by the Hospital in September 1998. The Finance Department in AMINCH had no prior knowledge of this order, nor the attaching liability. This is a matter of some concern, particularly as it raises questions as to whether this was an isolated incident or whether other similar, as yet unidentified, liabilities could emerge in future months. It emphasises the need for all orders to be placed through an effective centralised materials management function. It also highlights the need to bring the FDVH within AMINCH and have one budget for the entire organisation, thus avoiding any repeat of the lack of control and accountability, which is evident from the process under which this telephone system was acquired.

Computer ***IR£100,000***

The non-recurring expenditure identified by management included in the Computer cost relates mainly to capital costs. During the month, 55 PC's were purchased through FDVH at a cost of IR£86,000 having been ordered by the Hospital's IT department. This cost was billed on to the Hospital by FDVH. These PC's were mainly required for the patient flow department.

It is not clear why these additional PC's were not originally factored into the Hospital's IT capital budget or why this cost has not been included in the capital spend to date. It should be noted that c.IR£800,000 of the IT capital budget has not yet been spent. DOH&C are of the view that while the IT capital budget is held by FDVH, a transfer should be made where the Hospital is incurring IT capital expenditure.

The other non-recurring expenditure identified was in respect of consultant's fees for the radiology system and the trunking of the Finance department. Only IR£14,000 of these costs are considered non-recurring.

We are informed that from September 1998 onwards, all computer equipment/expenses are to be purchased through the Hospital rather than FDVH. It is imperative that all ISIT orders are processed through the Materials Management function to enhance the control over expenditure.

The new OPD unit is expected to open in late 1998. Originally it had been expected that the IT costs of opening this facility would be c.IR£257,000. DOH&C stated that c.IR£100,000 of this estimate was in relation to the PACS system in radiology which was to be funded privately by the Hospital. The Hospitals management has identified that an additional

IR£86,000 will be required for the unit. Management stated that this additional equipment will be purchased from the 1998 capital allocation.

Sundries ***IR£30,000***

Management have identified IR£30,000 of costs incurred in the month in relation to the security swipe/lock system which is considered non-recurring. Also included in the costs are security costs in relation to the Meath and NCH hospitals amounting to IR£21,000. This cost will not recur after the sale of these hospitals.

9.2 REVIEW OF ADJUSTED EXPENDITURE

The summary of costs included in section 9.1.2 of this report details the monthly costs versus budget, and the variances arising. Certain of the variances have been explained above as exceptional capital or non-recurring expenditure. However, there remain variances relative to budget, substantially of a recurring nature, based on the current operations of the Hospital. While these variances may currently be recurring, the costs are of a controllable nature, and cost reduction is possible.

Management are of the view that some of the increases in recurring expenditure are a consequence of the design and equipping decisions for example in relation to the increased cost of consumables which arise as a consequence of the type of capital equipment installed.

The table below provides a summary of the total monthly costs excluding all commissioning and development costs, and non-recurring expenditure and identifies the variances attributable to recurring costs. For the purposes of this review, we have concentrated on the management accounts for the months of July and August 1998, the months in which, for the most part, the variances arose.

	Jan – Jun IR£,000	***July IR£,000***	***August IR£,000***	***Total IR£,000***
Total Actual Expenditure	8,442	2,454	2,073	12,969
Total Budget Expenditure	8,253	1,385	1,313	10,951
Variance	189	1,069	760	2,018
Non Recurring Costs Identified	-	590	312	902
Remaining Variance	189	479	448	1,116

The variances identified can be further analysed as follows:

	July Recurring IR£,000	*July Budget IR£,000*	*July Variance IR£,000*	*August Recurring IR£,000*	*August Budget IR£,000*	*August Variance IR£,000*
Drugs	160	292	(132)	235	190	45
Blood	110	38	72	56	32	24
Gases	12	44	(32)	20	22	(2)
Medical & Surgical Appliances	424	400	24	502	368	134
Medical Equipment	10	24	(14)	30	55	(25)
X-ray	158	87	71	27	52	(25)
Pathology	47	6	41	-	3	(3)
Catering	93	73	20	78	65	13
Heat, Light & Power	32	34	(2)	68	36	32
Cleaning & Washing	198	126	72	137	137	-
Furniture, Crockery & Hardware	48	10	38	33	21	11
Bedding & Clothing	18	5	13	11	4	7
Maintenance	93	27	66	68	37	31
Farm & Grounds	3	1	2	4	-	4
Transport & Travel	30	26	4	27	24	3
Bank Interest	8	1	7	1	10	(9)
Bank Charges	1	-	1	-	-	-
Insurance	38	28	10	37	37	-
Audit	2	4	(2)	14	34	(20)
Legal	24	-	24	3	-	3
Bad Debts Expense	4	4	-	8	4	4
Office Expenses	271	104	167	172	114	58
Office Equipment	-	4	(4)	-	1	(1)
Computer	21	-	21	70	18	52
Professional Services	49	18	31	6	6	-
Sundries - includes security	10	29	(19)	154	43	111
	1,864	1,385	479	1,761	1,313	448

Explanations for the larger variances in respect of either month as provided by management are provided below.

Drugs

The total drugs budget for the year is IR£3.3m. Despite the fact that the Hospital was IR£109,000 over budget at 31 August 1998, management are satisfied that the variance with budget will not increase by the end of the year. The reasons for the variances to date are mainly due to the increased use of drugs and the introduction of new drugs on the market; however efficiencies are being achieved due to the presence of a clean room. Drug costs, like all other care costs, are primarily activity related. Management stated that apart from the ambisome related variances which are discussed below, drug costs are relatively in line with budget. [Activity in the Hospital is down relative to the Service Plan since the move to Tallaght]. The reasons why no reduction in costs has occurred despite a reduction in activity, is mainly due to a change in casemix as a result of an increased level of A&E activity than previously in the base hospitals.

A significant amount of the overall variance to date is in respect of an increased use of a drug called Ambisome after the base hospitals moved to Tallaght. Ambisome, an antibiotic used to control the effects of a fungus in haematology/leukaemia patients and other blood related illnesses, was given to all paediatric haematology and leukaemia patients as a preventative measure after the move to Tallaght. The cement dust in the Hospital's atmosphere due to the ongoing building work was recognised as a potential threat to patients. The drug was administered for three months at a cost of c.IR£110,000. Ordinarily, the drug is used to treat established infection rather than prevent it. Management stated that this course of action was taken after taking advice from the Hospital's resident medical and clinical staff and other external paediatric specialists. DOH&C question the need for this treatment based on its own clinical advice received.

The 'clean room' introduced in the Hospital has allowed the expiry date of drugs to be expanded. Prior to the move to Tallaght, particularly with paediatric patients, there was significant wastage of drugs as once opened, any excess of the drug could not be re-used at a later date. With the 'clean room' in operation, the excess can be re-used elsewhere in the Hospital, which results in savings over time. DOH&C stated that this 'clean room' was to be funded from savings made, however, this does not appear to be happening to date.

Blood

According to the Hospital's management, blood technology products (recombinant factor 7, 8 & 9) are now being used for all haemophilia patients since the Blood Tribunal in 1997. The increase in cost and the increase in activity were not factored into the service plan budget. Management stated that the number of paediatric patients requiring this treatment has increased by c.60% since 1997. Additional funding of IR£300,000 was provided in 1997 and DOH&C stated that this remained in the budget for 1998. The costs are further increased by the fact that patients develop resistance to the continuous blood treatments especially recombinants and than require a higher dose or recombinant factor. This increased level of dosage required cannot be predicted with accuracy.

Medical & Surgical Supplies

This cost category can be analysed as follows in respect of expenditure incurred in July and August 1998.

	July IR£,000	***August IR£,000***
Needles	12	20
Catheters	9	35
Gloves	26	43
Other Disposables	3	17
Anaesthetic Supplies	11	17
Suture Material & Other	24	57
Orthopaedic Implants	36	35
Medical & Surgical Appliances	62	58
Other	241	220
	424	502

According to Hospital management, part of the increases in cost categories is linked with the increased level of A&E activity in the Hospital. In August and September, the level of activity increased by 7.5% and 15.7% respectively over previous months activity, however, the overall activity level is lower than 1997 levels. Management expect that the activity levels had stabilised by mid-October 1998.

Immediately after the move from the base hospitals to the new Hospital in Tallaght, significant levels of medical & surgical appliances were purchased for stock purposes. Based on discussions with medical staff in the Hospital, at opening date, each ward was issued with an equal complement of medical & surgical supplies. Certain of the supplies issued were considered excess to requirements on some wards and during our review we found on some wards that certain of these supplies had yet to be used. We were informed by medical staff that the wards were not asked for their specific requirements and had this been done, certain cost savings could have been achieved.

Our discussions with medical staff indicated that there is still no consistency in products being supplied through the material management department. Apparently, different brands of products used in the base hospitals carry out the same function. The stores department appears to be continuing to purchase a range of branded but nevertheless similar products. It is probable that cost savings could be achieved if greater standardisation in product purchasing was achieved.

Maintenance

In section 9.1.3 above, IR£191,000 of non-recurring costs were identified by the Hospital's management in this category in July and August 1998. Other maintenance costs incurred in July and August 1998 which have not been included as non-recurring and which may not continue into the future account for a significant part of the remaining variance. These additional costs relate to the ongoing drain problems, which were expected to be rectified by late October 1998, plumbing, trunking/cabling of alternative office spaces and alterations to rooms in the Hospital. For the moment these costs have been considered as recurring as the Hospital will have to continue to carry out this type of work until all departments are located where originally planned. The precise quantum of future costs in this regard is not known.

9.3 DEVELOPMENTS COSTS

The management accounts show non-pay development/commissioning costs of IR£269,000 and IR£397,000 for the months of July and August respectively. Since June 1998, this category has related to development costs and includes the recurring non-pay costs of the Laboratory, which is shown within developments in the current year. Management have estimated the recurring monthly cost in this category at IR£210,000 per month.

9.4 PURCHASE MANAGEMENT

In the immediate aftermath of the move, a significant level of the budget overrun related to costs. The Hospital has established a Materials Management function to process and control non-pay costs. Section 3.8 of this report has documented difficulties associated with the staffing of the Materials Management function, and to delays in system implementation. These delays resulted in the system being operational just in time for opening. Whilst training courses for the staff of the Base hospitals were given, there is evidence that procedures were not adhered to in the immediate aftermath of the move; in particular significant levels of

expenditure in relation to building and maintenance work came to light which had not been processed through the Materials Management system. Most of these items related to rectification work associated with the building issues. Management stated that these items were discussed on a weekly basis with the project team and as such management considered them the responsibility of TRHB. Items such as rectification work for the additional accommodation was approved by management as a proper Hospital expense. Concerns were raised in June/July 1998 regarding the ownership of such building related liabilities at meetings with DOH&C, TRHB and at internal meetings. Based on these meetings, a memorandum was issued from the Materials Management Department to senior management, reaffirming hospital policy on purchasing procedures, and emphasising the need for compliance.

In September 1998, when it was evident that certain support departments had expressed concerns over their inability to order direct (i.e. without going through the materials management system as had been their practice in the base hospitals), the Director Of Finance issued a further memorandum reaffirming the required procedures. It remains to be seen whether this tightening of controls is effective. There are still concerns that orders are still being placed for goods and services outside the system. The Hospital has a list of approved suppliers in an attempt to standardise products and quality throughout the Hospital however, this can not be achieved where orders are not being placed through the materials management system

There have been teething difficulties, since opening with the operation of the new Materials Management system. The product listing imported into the new system was previously used in the Meath however many of the prices were incorrect and the product coding different. The Meath product listing also did not have any products specific to the laboratory or paediatric medicine. When these products were first being purchased through the system, a significant length of time was spent inputting the details and pricing onto the system. These delays occurred until late September 1998, although the system appears now to be operating more effectively. Difficulties are still occurring, as not all the costs on the system have been verified. Delays due to product set up difficulties have been cited as part of the reason why all purchases were not put through the system.

Critical to any prospect of controlling cost is strict adherence to policies and procedures of the Materials Management function, and a prohibition on ordering outside the proscribed system. It seems that some of the ordering practices reflect the modus operandi in the base hospitals, which appear to have had less formal systems in place and appear to have allowed greater latitude in ordering. The new Hospital is a larger more complex entity, and requires formal ordering and purchasing procedures. It is imperative staff understand this and adhere to procedures.

In future, no purchases in the hospital should be made except through the Materials Management system. In cases where emergency purchases are required, it is recognised that alternative procedures are required, however the Finance Department have recently established a series of control procedures for these items. It is important that systems are established to measure, at the time of ordering, whether particular departments are ordering in excess of budget. i.e. taking into account not only expenditure incurred but also that committed under orders placed not yet fulfilled. This will require that each Department is provided with an annual budget analysed on a month by month basis. As all purchases will be made through the system it will be possible to identify, at the time of ordering, any expenditure over budget. Currently, the Director of Finance has no authority to implement spending controls on departments. This authority should be provided to ensure no department spends over the budget provided on a monthly and annual basis. The Director of Finance must also have the authority to implement further purchasing and spending controls as the need arises in the future.

SECTION 10
PROJECTED 1998 OUTTURN AND IMPLICATIONS FOR 1999

10.1 INTRODUCTION

This section builds on the information contained in the earlier sections of this report to show a projected outturn for 1998, showing the constituent elements of revenue and capital costs, and those of a recurring and non recurring nature. The projection to year end has been prepared by management, is based on minimum spend, and is commented on in this section.

10.2 CURRENT FINANCIAL POSITION

At 31 October 1998, AMINCH had incurred net expenditure in excess of Determination of approximately c.IR£11m. In addition, liabilities for capital expenditure of the order of IR£3.2m exist which are as yet not agreed by AMINCH as they regard them as liabilities of the TRHB, and as such the liabilities are not reflected in their books. The total deficit of c.IR£14m is being funded in the main by a combination of creditors and the forward drawdown of allocation. Liabilities to trade creditors overdue in excess of 45 days amounted to c.IR£6m at 31 October 1998 (which includes the IR£3.2m of capital expenditure). In addition, amounts owing to the Collector General in respect of PAYE/PRSI deductions at 31 October 1998 amounted to IR£3.9m, of which IR£1.3m was for the then current month of October 1998. The balance of IR£2.6m due relates to August and September 1998. The August PAYE/PRSI liability of IR£1.3m. was paid in November 1998. The approved bank overdraft facility of IR£4.0m is being fully utilised at the present time which is in respect of future cash drawdowns from DOH&C.

The current level of recurring net expenditure being incurred on a monthly basis is c.IR£6.1m The funding available under the Letter of Determination is c.IR£4.5m per month on average. It is evident that the deficit is increasing at the rate of c.IR£1.6m per month on this basis. Due to the profile of the drawdown schedule for cash, only IR£3.5m and IR£2m remains to be drawndown by the Hospital in cash terms in November and December 1998 respectively against the amount provided in the Determination. In addition, supplementary funding of c.IR£3m was claimed by the Hospital in November 1998. At current levels of available funding, the deficit is increasing on a daily basis. The Hospital cannot continue to operate in this way; at present, it is not in a position to meet its liabilities as they fall due and is incurring fresh liabilities which, at the level of funding available to it, it cannot meet. It will be unable to fund its activities from creditors for much longer. The Hospital is in a financial crisis of the most serious nature. Immediate action is required to resolve the situation.

10.3 PROJECTED OUTTURN

10.3.1 FINANCIAL OVERVIEW

The projected outturn for the year ended 31 December 1998, as prepared by management of AMINCH, is shown below. The projection has been prepared on the basis of minimum spend to year end.

IR£m	*Management accounts Eight Mths to 31 Aug 1998*	*Projected Sept to Dec 1998*	*Projection For the Year Ended 31 Dec 1998*	*Service Plan*	*Letter of Determination & IR Budget*
Net Revenue Expenditure	41.6	24.9	66.5	59.5	53.7
IR Costs	1.9	0.5	2.4	-	2.0
	43.5	25.4	68.9	59.5	55.7
Capital Expenditure					
- recorded in AMINCH Books	1.0	-	1.0	-	-
- Other incurred including Unattributed	3.3	-	3.3	-	-
	47.8	25.4	73.2	59.5	55.7

(Note: The actual figures above are stated before claims for supplementary funding amounting to c.IR£3m claimed by the Hospital in November 1998)

10.3.2 KEY POINTS:

Net Revenue Expenditure

The total projected overrun in AMINCH over Determination for the year ended 31 December 1998 is IR£17.5m. This arises from three principal sources;

(a) An excess of net revenue expenditure over Determination of IR£12.8m; this includes IR£1.9m of expenditure in respect of which the Hospital submitted a claim for supplementary funding on 11 November 1998, covering, inter alia, PRSI for new employees, payments in respect consultant common contracts, non nursing pay increases, and increases in medical defence.

(b) IR£0.4m of IR related costs over the available budget of IR£2m. The Hospital submitted a claim for supplementary funding for c.IR£0.9m in respect of pension lump sum payments on 11 November 1998. DOH&C confirmed that it was always intended to deal with the superannuation payment under supplementary funding.

(c) IR£4.3m of capital expenditure. IR£1m of this is recorded in the books of AMINCH, for which it had no budget. Further expenditure of IR£3.3m (described as unattributed) has been incurred in relation to building modifications and equipment, but is not shown in AMINCH's books as it is regarded by AMINCH as a liability of the TRHB. Each of these elements of excess expenditure is reviewed in further detail below.

The projected net revenue expenditure for the year is IR£12.8m in excess of Determination and IR£7m in excess of the AMINCH Service Plan. This is because the Service Plan adopted by AMINCH for 1998 was IR£5.9m in excess of Determination.

When the claim for supplementary funding is taken into account, the excess net revenue expenditure, including IR related costs, for the year is c.IR£10.5m. The Hospital claimed c.IR£3m in November 1998 in respect of supplementary funding.

Note 1: Net expenditure for the eight months ended 31 August 1998 is taken from the management accounts. These accounts contain certain expenditure of a non recurring nature under both pay and non-pay headings.

Note 2: Recurring expenditure for pay has been based on the September and October payrolls which, including pension payments and medical indemnity, have amounted to c.IR£4.4m per month. Recurring non-pay has been gauged by reference to August 1998 non-pay costs, and source documentation/expenditure reports for September 1998.

IR Payments

The IR costs relate to payments under the Co-operation Agreement (IR£1.5m) and lump sum payments on retirements (IR£0.9m). We understand that the DOH&C held a separate budget of IR£2m relating to IR issues arising in respect of the move to Tallaght. It should be noted that 28.5 WTE positions were approved by the DOH&C in June 1998 (as part of the Task Force) on the basis that there would be funding available within the IR budget. As noted above, the IR£0.9m pension lump sums paid are the subject of a separate claim by AMINCH for supplementary funding.

Capital Expenditure

The TRHB had responsibility for the planning, building, equipping and furnishing of the Hospital. A summary of total capital expenditure on the project is given below. These costs include the total of IR£4.3m of capital expenditure shown as relating to either AMINCH or as unattributed referred to above.

IR£m	*DOH&C Approved (Provisional)*	*Total Costs*	*TRHB Costs*	*AMINCH Costs*	*Unattributed*
Committed Building Costs	109.9	114.7	111.7	2.1	0.9
Committed Equipment Costs	24.9	25.8	24.5	1.0	0.3
	134.8	140.5	135.2	3.1	1.2
Projected Building Costs	-	0.4	0.1	-	0.3
Projected Equipment Costs	-	4.5	3.5	0.8	0.2
	134.8	145.4	139.8	3.9	1.7

(Figures supplied by DOH&C and TRHB, these were not verified by Deloitte &Touche)

Key Points:

(a) Committed capital expenditure incurred is IR£140.5m, IR£5.7m over the DOH&C provisionally approved level of IR£134.8m. IR£4.8m of this excess relates to buildings, IR£1.8m of which is shown as a liability of the TRHB. The balance of IR£3.0m is split IR£2.1m as to AMINCH and IR£0.9m unattributed.

(b) Potential further capital expenditure of IR£4.9m is shown. This has yet to be incurred. It represents expenditure which AMINCH/TRHB considers necessary for the completion of the building and equipping of the Hospital. IR£4.5m of the IR£4.9m relates to equipping issues.

The further capital spend in relation to the development of the private wing is not included in the above assessment.

10.4 NET REVENUE EXPENDITURE

A summary of net revenue expenditure for 1998 is shown below.

IR£m	*Projected for Year*	*AMINCH Budget*	*Variance*
Pay			
Base staff and developments	46.5	42.6	3.9
Commissioning	1.9	2.3	(0.4)
	48.4	44.9	3.5
Non-pay			
Base	21.6	19.1	2.5
Commissioning	3.4	3.2	0.2
	25.0	22.3	2.7
Total Expenditure	73.4	67.2	6.2
Income	(6.9)	(7.7)	0.8
	66.5	59.5	7.0

(Note: the AMINCH budget is consistent with its service plan, i.e. IR£5.9m over Determination, therefore the projected outturn for the year is in fact IR£12.8m over Determination. The above figures are before claims for supplementary funding amounting to c.IR£3m submitted on 11 November 1998)

10.5 PAY COSTS

10.5.1 PAY COST VARIANCE

The projected variance on pay costs for the year ended 31 December 1998 of c.IR£3.5m relates to the following factors:

(a) Higher numbers of persons employed

There were 1936 WTE's on the payroll on 11 October, the date of a Hospital wide census. This compares with a DOH&C approved level of staff of 1797 WTE, a difference of 139 WTE's. An analysis of staff numbers per the census, the AMINCH service plan, and DOH&C approvals is shown below.

(WTE's)	*Per Census*	*Per Service Plan*	*DOH&C Approved*
Employment Control			
Staff in Base Hospitals	1,640.8	1,593	1,651.3
Developments & New Posts			
Laboratory	93.5	93.5	93.5
ISIT	15.6	21.0	15.0
Other	21.5	38.0	9.0
Nursing	28.0	-	14.0
Paediatric A&E	12.0	12.0	-
Paediatric Nursing	28.5	12.0	14.5
Medical (NCHD's)	13.0	-	-
Environmental Services	28.0	28.0	-
Materials Management	16.0	-	-
Radiology	13.5	-	-
Staff recruited re future developments	35.0	-	-
	1,961.4	1,797.5	1,797.3
Commissioning	40.7	-	-
	2,002.1	1,797.5	1,797.3
Positions not filled at census	(66.3)	-	-
	1,935.8	1,797.5	1,797.3

Key Points

- Staff numbers on the payroll on 11 October 1998 were 139 WTE in excess of DOH&C approved levels. These were in addition to 66 WTE positions regarded by AMINCH as vacant at the time of the census, a total difference of 205 WTE's if all positions were filled. A high level comparison of AMINCH personnel numbers with other hospitals of similar size in the Irish hospital system indicates this level of staffing is high. Direct comparison may not be entirely appropriate given factors such as the recent merger, different specialties, focus on paediatric care in AMINCH; however the extent of variation points to a need to examine the level of staff currently employed in AMINCH.

- The staff complement includes 40.7 WTE commissioning staff remaining primarily in Patient Flow Management (26 WTE) and ISIT (12.7 WTE). The budget for the year anticipated that most commissioning staff would be released shortly after the opening of the Hospital. AMINCH has indicated that the retention of staff in Patient Flow Management is due to significant operational difficulties in establishing this new department in areas such as patient registration, sourcing of medical records is further affected by space constraints in the department, and staff turnover. ISIT staff are required regarding the implementation of the Order Communications project. AMINCH anticipates that all commissioning staff will be released by April 1999.

- The staff complement includes the 35 staff recruited in relation to future developments. These relate principally to enhancements to improve patient management systems in the Hospital, planned to commence in the last quarter of the year. These enhancements were agreed in principle with the DOH&C at the time agreement was reached between AMINCH, the DOH&C and the

Eastern Health Board on the transfer of certain psychiatric services from St Loman's. The DOH&C's indicated at the time agreement in principle was reached that final approval was dependent on detailed costings being received; they have also indicated that a service justification was required from AMINCH in respect of these developments. The Hospital had regarded the necessary costings as having been submitted, regarded agreement as having been reached, and had commenced recruitment for the developments planned.

- A Task Force was established in June 1998 to focus on the staffing levels critical to the running of the Hospital, which could not otherwise be agreed at sectoral meetings. The Task Force comprised hospital management, a representative of the HSEA, trade union representatives, and representatives of the DOH&C. 28.5 WTE's were approved at the Task Force on the assumption that they would be in the Hospital for the last quarter of the year. The DOH&C estimated that these could be funded from an element of the IR£2m IR budget projected to be unutilised.

- There are a further 129.1 WTE posts which the Hospital regards as necessary. The DOH&C stated that it approved 16 of these positions for structure (materials management (9) and technical services (7)) without commitment to an increased ceiling and on the basis that they would be funded from within Determination.

  Of the remaining posts, The DOH&C regard 26 Nursing and Child Health posts as having been included in the Service Plan although not formally submitted for approval by the Hospital. The DOH&C listed the following posts which have not been the subject of any submissions by the Hospital: portering (11), telephonists (8), HSSD (16), radiology (12.5), MPBE (1), NCHD's (22) and additional clerical staff for Patient Flow (5). Some but not all of these are included in the Service Plan.

- The census indicates that there were 66 vacant posts within the AMINCH employment control total at 11 October 1998. These posts arise primarily in the areas of nursing (31 WTE). Not all vacancies are in respect of approved posts.

(b) Higher levels of overtime and on call payments than budget

These costs are currently running at c.IR£150,000 per month in excess of levels prior to the move.

(c) Payment in respect of consultants common contracts

These amount to c.IR£1m, which includes payment of arrears over available funding. The increased recurring monthly costs associated with remuneration to consultants on foot of the common contract is c.IR£80,000.

(d) Higher levels of pension payments than budget

This is due to a higher number of retirements at the time of the move. This excess amounts to c.IR£20,000 per month, or c.IR£100,000 in 1998.

(e) Pay increases to non nursing staff on foot of national agreements

These amount to IR£270,000, paid in September 1998.

(f) PRSI in respect of new employees and medical indemnity

PRSI under this heading amounts to IR£345,000, and increases in medical indemnity to c.IR£100,000.

Based on the foregoing, certain pay costs fall within categories of expenditure eligible for supplementary funding under the Letter of Determination. The total of such costs for 1998 included in the above is estimated by management at c.IR£3m which is the subject of a separate claim for supplementary funding by AMINCH, submitted on 11 November 1998.

The critical issue is that payroll costs are currently exceeding the Hospital's service plan by c.IR£550,000 per month. Approximately IR£150,000 – IR£175,000 of this can be regarded as due to factors outside the Hospital's control (increases in common contract, increased pension payments, pay awards etc). The remainder is due to primarily to increased staff numbers not approved or funded, and overtime/on call payments.

10.5.2 ISSUES AND REQUIREMENTS REGARDING PAY COSTS

(a) The Hospital prepared a manpower requirement plan for the new facility in Tallaght in late 1997. This showed a staffing requirement of 2578 WTE's. This level of staffing, by any benchmark, was unrealistic. The DOH&C rejected this plan. The AMINCH service plan showed that numbers employed would progressively increase to c1800 WTE'S by the end of 1998. The actual number of 1936 WTE'S employed in October 1998 is significantly in excess of service plan. The Hospital never had a realistic manpower plan.

(b) Staff recruitment has occurred without adequate consideration being given to the consequent funding implications. Until recently, staff were being recruited without the sanction of the Director of Finance.

(c) There is a lack of accurate, timely information on personnel and pay. The Hospital has continued to operate the three separate payrolls of the base hospitals since the move. These systems operate different coding structures for like staff. A major once off exercise in early October 1998 was required so that the Hospital could accurately determine the number of staff employed, and their status. Regular, routine personnel data is fundamental to the control of pay costs. This has been singularly lacking in the Hospital. The lack of personnel data has been recognised as a problem in AMINCH for some time; it was identified and discussed at a meeting of the Resource Committee of the Board in April 1998.

It is imperative that the Hospital consolidates the three base hospitals' payrolls into one payroll for AMINCH. A set of routine personnel/payroll reports need to be specified and circulated to managers on a regular basis. Each Department head needs to monitor and control payroll costs, and be accountable for same. The consolidation of systems, and production of relevant and accurate reports is urgently required. It is

a considerable failing of management that systems to control personnel numbers and employee status have not been in place. In our view, the Hospital has not had adequate systems in place to manage and control increases in staff over the past year. The focus would appear to be too much on perceived requirements, and not enough on whether funding was available for staff increases. There is currently a complete absence of regular and reliable personnel information on matters such as numbers of employed, status (temporary/permanent), absenteeism etc. Without regular, reliable information on personnel and payroll, it is not possible to manage and control payroll costs in an effective manner; such has been the position in AMINCH.

(d) The staffing requirements for the new Hospital have not been adequately assessed. The numbers of staff employed in various departments throughout the Hospital reflect a process of combining staff from the base hospitals, and the deemed staffing needs of certain new functions. The organisation of staff in certain functions (particularly support services) has not been rigorously evaluated to assess the optimum number and structure of staff. in those functions. It is essential that an independent assessment of personnel requirements across the Hospital is carried out, having regard to optimum organisation structure and business processes. Because the requirements have not been critically assessed throughout the Hospital, it is not possible at this juncture to determine what the appropriate level of staffing for the Hospital should be. In particular, there is a need to assess requirements in terms of organisation and staffing in support service functions, such as technical services, finance, materials management, and human resources. A systematic review of all areas of the Hospital is needed to identify staffing required to operate the new facility.

(e) It is possible, on conclusion of the systematic review referred to above, that certain staff not approved by the DOH&C will be required to operate the Hospital in Tallaght. Given the fact that this Hospital is in its infancy, it is essential that agreement is reached between the Hospital and the DOH&C on an approved level of staff, and that the approved level of staff is specifically funded. We recognise that in a stable environment, management have flexibility to fund incremental increases in approved staff levels out of Determination, and that the DOH&C could approve posts on this basis. In AMINCH's case, as in any other of significant change, it is essential that a specific relationship is established between approved staff levels and funding, if nothing else to optimise control over pay expenditure in an agency and to avoid any risk of a mismatch between employment control approvals and funding for what is the largest element of cost in a hospital.

(f) One would expect that the merger of three entities would ordinarily result in efficiencies in staffing. Whilst we have concerns that a systematic plan to identify the scope for synergies/redeployment was not in place, we recognise that the security of tenure given to staff under the IR Protocol places some limitation on the extent to which staff synergies could be achieved. Indeed, we would be surprised if this has not created inefficiencies in the organisation and staffing of certain functions of the Hospital. These may take some period of time to eliminate; at present, because a critical review of functions has not taken place, it is not possible to assess the extent of any such inefficiency.

(g) There are currently some 400 staff on the payroll on temporary contracts. The processes in place to manage such temporary staff are inadequate. It is essential that procedures are put in place to identify temporary staff being used in each Department on a regular basis, and rigorously assess whether they continue to be needed. We are particularly concerned that the current inadequate arrangements could, by default, result in temporary staff gaining employment rights, an entitlement after one years continuous employment.

(h) The census indicates a significant level of vacancies in the Hospital. The filling of such vacancies would result in increased payroll costs. It is essential that vacancies are filled only in respect of approved and funded posts.

(i) Staff recruitment should be frozen until the aforementioned review of requirements is completed. Over the past year, staff recruitment was undertaken to meet the perceived needs of the Hospital, without adequate being given to funding available. All future recruitments should be approved by the Director of Finance.

(j) A systematic plan to reduce commissioning staff is required. There were 40 WTE commissioning staff identified on the October census. We recognise that these cannot be released immediately; some are involved in important aspects of continuing IT systems development. A definitive plan to effect the appropriate release of the remaining commissioning staff is however required to ensure the Hospital's objective of releasing commissioning staff by April 1999 at the latest is met.

(k) Improved controls over authorisation and approval of overtime payments are required. These should include prior approval of overtime over certain levels. We understand such controls have recently been established. Such controls were lacking in the immediate aftermath of the move.

10.6 NON-PAY COSTS

10.6.1 NON-PAY COST VARIANCE

The projected adverse variance on revenue costs for the year ended 31 December 1998 is IR£2.7m. The principal reasons for the variance are:

(a) non-pay costs of an exceptional once-off nature associated with the move and the commencement of operations on the new site in Tallaght. Such costs will invariably arise on any project of this magnitude, and are not possible to budget with accuracy. It is difficult to be precise about the quantum of such exceptional non-pay expenditure; our best estimate is that such costs amounted to between IR£400,000 and IR£500,000 in the period July to September 1998 for which no budget remained. These related to matters such as initial cleaning of the Hospital, initial bedding costs of the Hospital, initial stocking requirements for supplies and consumables, and once-off care costs associated with the move. Had operational plans been in place, these items could have been predicted and budgeted for with greater accuracy.

(b) costs of medicines, blood and gases for the period to 30 June 1998 prior to the move which were running ahead of budget. By year end, these are projected to account for an excess over budget of IR£600,000. These relate to the circumstances of the move and to the level and nature of activity.

(c) the costs of medical and surgical supplies which have increased significantly since the move. Management attribute this largely to the significant increase in A&E activity at the Hospital relative to the base hospitals. By year end, an excess of c.IR£900,000 over budget is projected under this heading.

(d) the costs associated with the laboratory which have been running at c.IR£210,000 per month, which is c.IR£100,000 per month higher than budget. The allocation of budget by AMINCH to the laboratory was probably inadequate; the matter nevertheless deserves review.

The critical issue is that non-pay costs are currently running at c.IR£2.1m per month. The non-pay costs in the management accounts of the Hospital for each of the months of July to September 1998 have shown a significant level of exceptional, unpredicted expenditure. It is not clear yet what level of non-pay costs should arise in a stable environment in the Hospital. It is evident that significant increases in care costs (medicines, drugs, bloods, medical and surgical supplies) have arisen since the move. The reasons for this should be investigated.

10.6.2 ISSUES AND REQUIREMENTS REGARDING NON-PAY COSTS

The following are required:

(i) A programme of cost review and reduction needs to be urgently implemented. A significant element of non-pay costs are controllable, and can be reduced through management action. The non-pay costs in Tallaght are high by comparison with established hospitals in the Irish health system of similar size.

(ii) All ordering of goods and services must, except in exceptional circumstances, be processed through the Materials Management function. All staff must be made aware of the procedures and the requirement for strict compliance. Compliance with procedures was lacking in a number of instances after the move. This was identified, and followed up; controls and compliance with procedures appear to have improved. Orders being placed need to be monitored against available budget before being placed, taking into account orders already committed.

(iii) A review is required of the level of costs in the laboratory (which are high) to assess where savings are possible. We understand that no activity data has been available from the laboratory to date – this needs to be provided and reviewed by management on a periodic basis.

(iv) Care costs need to be managed through management of activity. Activity data was not available in the aftermath of the move until late September 1998 because of difficulties with the use of the new Patients Information System. We understand that regular, timely data is now being provided on activity.

(v) A developed system of budgetary control system is required to make managers accountable for spending decisions. The current system of budgetary control is inadequate, as managers do not hold budgets nor manage their activities in a way which adequately recognises the financial consequences of decisions they are making.

10.7 INCOME

Income earned has reduced on a monthly basis by c IR£150,000, primarily as a result of the reduced number of private/semi-private beds in the Hospital, pending the building of the private wing, scheduled for completion in late 1999/early 2000. There were also difficulties with the use of the Patient Information Management System after opening which adversely affected income; it appears that these arose partly because of lack of user familiarity with the new system, a lack of operational policies, and system issues. These caused wrong identification of private patients as public patients at time of registration, and difficulties in billing public patients for A&E attendance. In 1999 and beyond, additional income will be receivable in respect of rent from the Car Park (IR£470,000 p.a.) and rent from the shops (c.IR£50,000p.a.).

10.8 IMPLICATIONS FOR REMAINDER OF 1998 AND 1999

This section is concerned with identifying the implications for the remainder of 1998 and 1999 arising from the financial performance of the Hospital since the time of its opening.

Formal budgets for 1999 have yet to be prepared by the Hospital. In line with normal practice, a service plan incorporating a budget for 1999 will be provided in response to the Letter of Determination. This section does not therefore present in any sense a formal budget for 1999 nor address all the issues which management may wish to reflect in the finalisation of that budget; it does however address a range of matters relevant to the prospective financial position of the Hospital in 1999.

10.8.1 PAY COSTS

It is evident from the above that payroll costs for the months of September and October 1998 have been of the order of IR£4.5m per month. This relates to some 2,100 persons (excluding pensioners) on the payroll together with pension and medical indemnity payments.

If one annualises the level of pay costs arising in September and October 1998, total pay expenditure in a full year is of the order of IR£54m. This does not include any adjustments, which will be required in 1999 in respect of inflation or pay increments.

Section 8 highlighted a number of departments in which there are currently vacancies. To the extent that these positions are filled, pay costs in excess of those arising in the months of September and October 1998 will arise. Two areas are particularly relevant in this regard.

(i) Nursing

There are currently vacancies in the nursing area. Additional nurses will be required as new theatres open, for any new developments proposed and for the private wing when it opens in late 1999 and the year 2000. Additions to the nursing complement for such purposes need to be made in a controlled manner having regard to funding implications.

(ii) The number of staff in the laboratory is lower than the complement included in the Hospital service plan. We understand that further recruitment is in hand and planned for the laboratory. Once again, the financial implications of any increases in numbers needs to be taken into account.

10.8.2 NON-PAY COSTS

It is evident from Section 9 that there was a significant level of unpredictability in the level of costs in the months of July to September 1998. When exceptional or non-recurring items are excluded from these months, the level of recurring arising appears to be of the order of IR£2.1m per month. It must be stressed that the months from which this estimate is derived are those in the immediate aftermath of the move, and as such it may not be an entirely reliable guide to the recurring level of costs in the future period. If one extrapolates costs at this average of IR£2.1m per month, the full year cost is of the order of IR£25m. It should be noted that income received in respect of the accommodation to be made available for certain psychiatric services being transferred from St Loman's is expected to result in a small recovery of overhead in 1999.

10.9 DEVELOPMENTS

The Hospital has given us a list of proposed developments for 1999. These are not finally approved by the DOH&C. There are three categories of developments:

Category 1: Developments relating to proposed Consultant Appointments

As early as late 1996, the Hospital identified 16 consultant posts deemed necessary to enable the Hospital provide a satisfactory service from the new facility in Tallaght. Three of these posts (namely a consultant Gastroenterologist, a Consultant Vascular Surgeon and a Consultant Physician -Respiratory Medicine) were approved by the DOH&C on 27 June 1997. In addition the post of Consultant Histopathologist was approved on 5 December 1997. In March 1998, the DOH&C indicated it was prepared to approve the posts of Consultant Paediatric General Surgeon and Consultant Paediatrician with an interest in Community Child Health on the strict understanding that funding for these posts was available within the existing determination. The Hospital had indicated that these posts had to be immediately filled and that there would be no additional financial implications from doing so in a letter from the Chairman of AMINCH to the Secretary of the DOH&C on 23 June 1997. The formal applications submitted in December 1997 stated additional costs per post of IR£148,500 and IR£82,000 respectively.

The pay and costs associated with all 16 consultant posts for 1999 is set out below. It is evident that the posts in gastroenterology, histopathology and respiratory medicine were filled during 1998.

Consultant Post	*Start Date*	*Pay IR£,000*	*IR£,000*	*Total IR£,000*
Anaesthetist	Aug 1999	37	-	37
ENT	Dec 1999	20	-	20
Gastroentrology	1998	180	350	530
General Surgery	July 1999	100	20	120
Histopathology	1998	-	-	-
Child & Adolescent Psychiatrist	Apr 1999	190	20	210
Medical Oncology	July 1999	150	300	450
Orthopaedic (Trauma)	Aug 1999	165	10	175
Paediatric Surgery	July 1999	80	10	90
Community Paediatric	March 1999	-	-	-
Geriatrics	Apr 1999	400	85	485
Rheumatology	Oct 1999	25	60	85
Respiratory	1998	400	500	900
Plastics	Oct 1999	75	35	110
Radiology	March 1999	75	-	75
Vascular	June 1999	135	75	310
		2,032	1,565	3,597

The Hospital has also indicated that consultants are required in ophthalmology, dentistry and in the post anaesthetic care unit. These are in addition to the 16 posts previously under discussion with the DOH&C.

Category 2: Developments to improve Patient Flow in the Hospital

Service developments proposed arise in the following areas:

	Pay IR£,000	*IR£,000*	*Equipment IR£,000*	*Total IR£,000*
Pre admission clinics	147	6	-	153
Radiology	599	456	-	1,055
General Gynaecology Services	168	50	27	245
Age related day care	190	150	-	340
Accident & Emergency	490	125	-	615
Cardiology:				
- Cat laboratory/chest pains clinic/cardiac rehab services	667	900	-	1,567
Post anaesthetic care unit	42	50	-	92
ICU	331	103	-	434
Endoscopy	86	50	-	136
Paediatric Orthopaedics	113	96	-	209
Phlebotomy	42	-	-	42
Respiratory	104	50	-	154
	2,979	2,036	27	5,042

The following points are relevant to the above:

- In May 1998, discussions took place with the Department on the transfer of acute psychiatric services from St Loman's Hospital to the new Hospital in Tallaght. The Board of AMINCH had initially decided to defer the transfer of such services to the new Hospital in Tallaght until 1 August 1999 to enable it continue to provide the same level of services as in the base hospitals. Following discussions between the parties and the Eastern Health Board, an agreed solution to the issues was found which provided for:

  (i) the transfer of acute psychiatric services from St Loman's to Tallaght as soon as possible,

  (ii) the provision of a 35 bed facility by the Eastern Health Board for patients who would otherwise inappropriately occupy beds in the Hospital, and

  (iii) agreement in principle between the DOH&C, AMINCH and EHB with regard to the following enhancements to improve patient management in the Hospital:

  - Pre Admission Systems
  - A&E system improvements
  - Admission Process Flow
  - More efficient discharge planning

  The DOH&C indicated that it would require detailed proposals with regard to the issues scheduled under the above headings, principally in relation to the costing of the service developments, before granting final approval.

  The above agreement in principle on enhancement on services has been the subject of considerable correspondence between the Hospital and the DOH&C in recent months. The Hospital believe that an agreement was reached with the DOH&C in May 1998 to implement these developments and that they submitted the necessary costings to the DOH&C at a meeting on 27

July 1998. The DOH&C's position is that final approval has not been given pending, inter alia, completion of their review of the costings associated with the development.

The developments shown in the table above relating to pre admission clinics, radiology, general gynaecology services, age related day care, accident and emergency and cardiology relate to this matter. A total of 99 WTEs are projected in respect of these developments. 35 of these positions are shown as being filled in the personnel analysis of early October 1998.

AMINCH has asked us to record that it is extremely unhappy at the DOH&C's decision not to sanction these developments in October 1998, particularly as AMINCH sees this as compromising its public commitment to provide the same level of clinical service as in the base hospitals. The Board of AMINCH is of the opinion that a solemn agreement exists in the Charter to provide at least the same range and level of services as in the base hospitals. The CEO has indicated that he feels ethically compromised because in his view patients
are not receiving the level of service promised.

The DOH&C's view is that these developments, while agreed in principle, required the submission of detailed costings and a service justification. A service justification was not received by DOH&C until October 1998.

Category 3: Developments designed into the new Hospital

These developments relate to facilities built in the new Hospital, not yet in use, as described in Section 2. The developments include hydrotherapy, ophthalmology, liaison psychiatry, dialysis, paediatric high dependency unit etc. The Hospital has estimated a sum of IR£2m will be required during 1999 for these developments. A detailed make up of this amount has not been prepared.

Overall cost of proposed developments

The Hospital has identified a range of developments for 1999 which it sees as necessary to provide a proper service in Tallaght, and to improve patient management and patient care. The funding associated with these is very significant, some IR£11m in 1999 and IR£13m to IR14m on a full year basis.

Total funding on a full year basis of c.IR£87m would arise if all developments proposed were to proceed, in the absence of cost reduction in the current expenditure base. This level of funding would be materially at variance with other hospitals of similar size and profile in the Irish health system.

The followings points are critical:

- The first objective must be to stabilise the Hospital for its current operations; the review of staffing requirements, organisation, and pay and non-pay costs referred to above is necessary. This will enable an informed decision to be made on the appropriate level of funding for an approved level and type of service.

- The Hospital and the DOH&C need to agree a medium term development plan for the Hospital. This should clarify developments which are agreed, their funding implications, and the timescale for implementation. Particularly in the context of the current financial situation in the Hospital, we would expect any such plan to be

phased over a number of years. An explicitly agreed approach would also leave no room for misunderstanding between the parties on future development.

- The Hospital is not yet predictable in financial terms for its current activities. Surprises continue to emerge on a monthly basis. Significant room for improvement exists in controlling pay costs, and in tightening controls over the ordering of goods and supplies. It would undoubtedly be financially prudent for the Hospital to stabilise its performance in financial terms before engaging in new areas of developmental expenditure, particularly as without the necessary improvements in controls and procedures, there are risks that developments will themselves exceed budget. Clearly in the current climate, such a risk is untenable. We recognise that the developments proposed may be important in terms of patient care considerations, but such considerations would have to be compelling and urgent for developments to proceed at the present time.

- All future developments and their associated funding must be specifically agreed between the Hospital and the DOH&C before implementation.

- The Private wing is due to come on stream in late 1999/early 2000. This is being funded by borrowings of IR£7.5m. It has been approved by the DOH&C on the basis that it will be self financing. This needs to be critically evaluated to ensure that the strategy to operate the private wing in terms of staffing and funding will achieve the objective of being self financing. The capital costs associated with this development are outside the scope of this study

SECTION 11
CONCLUDING COMMENTS

The new Hospital in Tallaght is in a financial crisis of the most serious kind. It has received a very significant commitment of public funds. The problem needs to be urgently addressed by AMINCH in consultation with the DOH&C. In the absence of an injection of funds in the short term, the Hospital will run out of funds. It is already significantly in arrears in paying its creditors, the principal funding source for the deficit.

The current relationship with the DOH&C is strained, considerably worsened by the current financial difficulties, and AMINCH grievances over patient management developments negotiated at the time that agreement was reached on the move of St Loman's to Tallaght. The relationship needs to be rebased; the agreement of a longer term strategy between the parties and funding for an approved level of service in the new facility in Tallaght is essential in this regard. Developments should be agreed on a phased basis as part of a medium term plan. The primacy of letter of determination needs to be recognised going forward. Prompt service planning within Determination is also vital.

We have identified and commented on the primacy of the Letter of Determination as a means of controlling and managing costs in the Irish healthcare system. Every agency, whether public or private, should understand the absolute requirement to operate within its budget. There is no process which allows an agency to operate on the basis that any service level can be provided regardless of the costs involved. Accountability legislation means just that, everyone involved is accountable ultimately to the Oireachtas and the taxpayer.

We find it difficult to reconcile the governance issues involved where the Board adopted a budget of IR£59.5m, some IR£5.9m in excess of its Letter of Determination, and failed to insist on the development and installation of adequate information systems which would enable the Hospital to be monitored even against its own budget and is now facing an overall outturn for 1998 which is IR£7m in excess of this budget and IR£12.8m in excess of Determination. We are also unclear as to where the authority exists for the level of creditors and which arise as a consequence of the Hospital continuing to operate at levels of expenditure in excess of income and Determination.

At the same time, there is a series of projects and developments being contemplated which will require IR£11m in net revenue expenditure in 1999, and if fully implemented, would leave the Hospital with an operating cost profile of IR£87m on a full year basis. A cost base of this magnitude is significantly out of line with other acute hospitals in the Irish healthcare service.

Given the difficulties experienced to date, there is an absolute requirement for the Board to devolve all management responsibility to a properly structured hospital management team. At the same time, the Board should insist on the development and implementation of an effective management information system with an appropriate board reporting system which would enable the Board to monitor the care and financial performance of the Hospital. This report identifies a wide range of actions which need to be taken in relation to management reporting and control, systems, organisation, service planning, and cost containment. These

need to be addressed if the Hospital is to meet its own objective of being a highly cost effective and efficient service provider.

The Board must insist that management manage the Hospital within its agreed cost and operating profile before any further developments are approved. Before the Board would approve any such developments, it needs to have a detailed breakdown of capital and net revenue expenditure and written confirmation from the DOH&C that the additional funding has been approved and the timing of such funding.

In our view, it is not acceptable for the Board to continue to seek funding to develop the Hospital until such time as they have demonstrated a capacity to create an effective management system for the present profile of the Hospital, and operate at net expenditure levels which are accepted as appropriate for the size, nature and circumstances of the Hospital, from its new location in Tallaght.

APPENDIX I

LETTER OF DETERMINATION

APPENDIX II

ACTIVITY DETAILS

CONTENTS

Bed Days Available Analysed by Speciality

	Jan 98 - May 98 Beds	*June 98 Bed Days*	*Jul 98 Bed Days*	*Aug 98 Bed Days*	*Sept 98 Bed Days*	*Jun-Sept Total Bed Days*
Adult Public						
Cardiology	6	140	434	434	420	1,428
Endocrinology	11	40	150	155	150	495
Gastro-Enterology	6	20	88	93	90	293
Neurology	8	50	181	186	180	597
Medicine	1	450	1,119	1,224	1,094	3,887
Gynaecology	6	50	160	186	180	576
ENT	4	10	41	120	120	291
Orthopaedics	35	426	1,395	1,485	1,704	5,010
Surgery	24	190	634	1,073	1,140	3,037
Urology	-	96	270	372	501	1,239
Renal/Medical	-	160	496	496	480	1,632
Haematology	-	-	31	31	30	92
Age Related Health Care	-	-	349	403	390	1,142
Other	176	-	-	-	-	-
Respiratory Medicine	-	-	-	-	120	120
	277	1,632	5,348	6,258	6,599	19,837
Paediatric Public						
General Medicine	19	120	533	752	1,080	2,485
Paediatric Haematology	6	-	-	-	-	-
Paediatric Orthopaedic Surgery	6	-	-	-	-	-
Paediatric Surgery	6	-	-	-	-	-
Paediatric ENT	3	-	-	-	-	-
	40	120	533	752	1,080	2,485
Adult Private						
Cardiology	3	30	93	93	90	306
Endocrinology	4	30	93	93	90	306
Gastro-Enterology	3	30	93	93	90	306
Neurology	3	30	90	93	90	303
Medicine	1	190	620	620	570	2,000
Gynaecology	5	20	62	62	60	204
ENT	3	10	62	62	60	194
Orthopaedics	15	108	434	434	420	1,396
Surgery	11	116	434	403	420	1,373
Urology	-	78	446	496	450	1,470
Renal/Medical	-	20	62	62	60	204
Haematology	-	-	31	31	30	92
Age Related Health Care	-	-	62	62	60	184
Other	50	-	-	-	-	-
Respiratory Medicine	-	-	-	-	30	30
	98	662	2,582	2,604	2,520	8,368
Paediatric Private						
General Medicine	5	130	403	407	510	1,450
Paediatric Orthopaedic Surgery	5	-	-	-	-	-
Paediatric Surgery	5	-	-	-	-	-
Paediatric ENT	2	-	-	-	-	-
	17	130	403	407	510	1,450

Bed Days Available Analysed by Speciality

	Jan 98 - May 98 Beds	*June 98 Bed Days*	*Jul 98 Bed Days*	*Aug 98 Bed Days*	*Sept 98 Bed Days*	*Jun-Sept Total Bed Days*
Adult Non Designated						
Cardiology	4	10	31	31	30	102
Medicine	-	20	31	31	30	112
ENT	-	10	31	31	30	102
Orthopaedics	1	18	62	62	60	203
Surgery	2	16	62	62	60	200
Urology	-	8	31	31	30	100
Renal/Medical	-	10	31	31	30	102
Age Related Health Care	-	-	31	31	30	92
Other	12	-	-	-	-	-
ICU/CCU	-	-	-	-	419	419
	19	92	310	310	719	1,431
Paediatric Non Designated						
General Medicine	1	30	93	93	90	306

Bed Days Used

	Jan 98- May 98 Days	*June 98 Days*	*July 98 Days*	*Aug 98 Days*	*Sept 98 Days*	*YTD Total Days*
Adult Public						
Cardiology	1,683	244	380	320	238	2,865
Endocrinology	1,386	116	155	73	139	1,869
Gastro-Enterology	715	90	183	172	85	1,245
Neurology	966	78	154	165	97	1,460
Medicine	15,437	2,210	971	1,235	1,434	21,287
Gynaecology	722	40	46	51	84	943
ENT	399	48	61	94	93	695
Orthopaedics	8,447	734	966	1,215	1,459	12,821
Surgery	6,010	931	780	955	1,026	9,702
Urology	3,615	421	315	453	477	5,281
Renal/Medical	1,090	227	353	348	271	2,289
Haematology	-	-	3	5	10	18
Age Related Health Care	-	-	459	507	561	1,527
Dermatology	-	-	31	31	14	76
Anaesthesia	-	-	-	5	4	9
Adult Stroke	-	-	3	9	-	12
	40,470	5,139	4,860	5,638	5,992	62,099
Paediatrics Public						
General Medicine	3,496	315	144	185	192	4,332
Paediatric Haematology	869	144	59	32	38	1,142
Paediatric Orthopaedic Surgery	263	48	50	16	71	448
Paediatric Surgery	1,179	46	62	87	132	1,506
Paediatric Cystic Fibrosis	-	-	28	69	67	164
Paediatric Dentistry	-	-	1	-	2	3
Paediatric Respiratory Medicine	-	-	36	57	44	137
Paediatric A&E	-	-	38	15	31	84
Paediatric Dermatology	-	-		5	1	6
Paediatric ENT	206	-	21	14	26	267
Paediatric Endocrinology	-	-	-	-	2	2
Paediatric Diabetic	-	-	-	19	38	57
Paediatric Cardiology	-	-	-	-	2	2
Paediatric Psychiatry	-	-	-	-	1	1
	6,013	553	439	499	647	8,151

Bed Days Used

	Jan 98-May 98 Days	*June 98 Days*	*July 98 Days*	*Aug 98 Days*	*Sept 98 Days*	*YTD Total Days*
Paediatrics Private						
General Medicine	911	71	104	134	137	1,357
Paediatric Haematology	246	36	40	31	16	369
Paediatric Orthopaedic Surgery	142	12	13	20	26	213
Paediatric Surgery	567	23	52	68	44	754
Paediatric Cystic Fibrosis	-		24	1	27	52
Paediatric Dentistry	-		2			2
Paediatric Respiratory Medicine	-		7	16	11	34
Paediatric A&E	-		17		22	39
Paediatric Dermatology	-					-
Paediatric ENT	96		10	5	16	127
Paediatric Urology	-				2	2
Paediatric Endocrinology	-				1	1
Paediatric Diabetic	-	-	-	10	30	40
	1,962	142	269	285	332	2,990
Adult Non Designated						
Cardiology	519	28	114	92	87	840
Endocrinology	68	-	22	-	3	93
Gastro-Enterology	16	3	7	14	2	42
Neurology	10			18	46	74
Medicine	5	21	173	187	178	564
Gynaecology	3	-	-	-	-	3
ENT	-	-	1	-	8	9
Orthopaedics	26	13	78	66	71	254
Surgery	297	27	111	116	117	668
Urology	-	9	24	31	27	91
Renal/Medical	-	6	13	58	60	137
Haematology	-	-	6	14	-	20
Age Related Health Care	-	-	49	26	10	85
	944	107	598	622	609	2,880

Bed Days Used

	Jan 98-May 98 Days	*June 98 Days*	*July 98 Days*	*Aug 98 Days*	*Sept 98 Days*	*YTD Total Days*
Paediatrics Non Designated						
General Medicine	-	1	-	-	-	1
Paediatric Haematology	-	8	80	74	30	192
Paediatric Orthopaedic Surgery	-	3	-	-	-	3
Paediatric Diabetic	-	-	-	-	3	3
	-	12	80	74	33	199

In Patient Discharges

	Jan 98 - May 98 Cases	*June 98 Cases*	*July 98 Cases*	*Aug 98 Cases*	*Sept 98 Cases*	*YTD Total Cases*
Discharges – Adult						
Cardiology	306	42	79	61	43	531
Endocrinology	176	16	15	8	15	230
Gastro-Enterology	90	12	41	24	11	178
Neurology	180	12	16	22	23	253
Medicine	1,401	297	181	204	260	2,343
Gynaecology	173	11	21	16	23	244
ENT	184	29	21	38	47	319
Orthopaedics	1,149	143	150	184	218	1,844
Surgery	970	138	158	178	171	1,615
Urology	1,076	105	113	140	149	1,583
Renal/Medical	135	38	48	29	34	284
Haematology	-	-	4	4	2	10
Age Related Health Care	-	-	27	22	34	83
Rheumatology	-	-	1	-	-	1
Dermatology	-	-	-	-	1	1
Adult Stroke	-	-	-	1	-	1
	5,840	843	875	931	1,031	9,520
Paediatric						
General Medicine	1,169	115	105	103	163	1,655
Otolaryngology	105	-	13	-	-	118
Paediatric Haematology	134	47	32	28	25	266
Paediatric Orthopaedic Surgery	126	22	23	20	33	224
Paediatric Surgery	484	31	56	80	78	729
Paediatric Cystic Fibrosis	-	-	7	4	11	22
Paediatric Dentistry	-	-	2	-	3	5
Paediatric Respiratory Medicine	-	-	16	28	31	75
Paediatric A&E	-	-	19	2	16	37
Paediatric Dermatology	-	-	-	-	1	1
Paediatric ENT	-	-	-	8	21	29
Paediatric Urology	-	-	-	-	1	1
Paediatric Cardiology	-	-	-	-	1	1
Paediatric Diabetic	-	-	-	-	4	4
Paediatric Endocrinology	-	-	-	-	1	1
	2,018	215	273	273	389	3,168

Day Case Activity

	Jan 98 - May 98 Cases	*June 98 Cases*	*July 98 Cases*	*Aug 98 Cases*	*Sept 98 Cases*	*YTD Total Cases*
Day Cases – Adult						
Cardiology	77	7	18	15	15	132
Endocrinology	22	6	8	10	17	63
Gastro-Enterology	353	40	168	165	151	877
Neurology	25	5	7	9	9	55
Medicine	378	44	11	9	15	457
Gynaecology	244	9	34	47	67	401
ENT	96	11	11	13	20	151
Orthopaedics	551	67	90	88	129	925
Surgery	1,281	112	183	224	284	2,084
Urology	1,559	101	34	51	82	1,827
Renal/Medical	29	4	5	5	6	49
Haematology	-	-	3	4	20	27
Age Related Health Care	-	-	1	2	1	4
Dermatology	-	-	17	20	23	60
Anaesthesia	-	-	2	11	6	19
Ophthalmology	-	-	-	1	-	1
	4,615	406	592	674	845	7,132
Day Cases – Paediatric						
General Medicine	265	26	19	21	26	357
Otolaryngology	102	-	-	-		102
Paediatric Haematology	294	58	146	166	115	779
Paediatric Orthopaedic Surgery	96	7	11	7	10	131
Paediatric Surgery	923	83	142	155	147	1,450
Paediatric Cystic Fibrosis	-	-	-	5	2	7
Paediatric Dentistry	-	-	6	2		8
Paediatric Respiratory Medicine	-	-	9	8	7	24
Paediatric A&E	-	-	-	2	1	3
Paediatric Dermatology	-	-	1	-	-	1
Paediatric ENT	-	-	26	12	27	65
Paediatric Neurology	-	-	2	2	1	5
Paediatric Urology	-	-	17	12	8	37
Paediatric Endocrinology	-	-	-	-	1	1
	1,680	174	379	392	345	2,970

Inpatient Discharges Per Service Plan– Based on 1997 Activity Adjusted

	Jan to May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Total*
Adult									
Cardiology	309	19	61	71	60	75	73	66	734
Endocrinology	137	11	30	47	37	38	39	39	378
Gastro-Enterology	81	5	13	20	18	23	25	25	210
Neurology	193	14	36	29	39	40	42	34	427
Medicine	1,278	82	285	292	257	275	279	318	3,066
Gynaecology	143	12	16	29	33	39	37	24	333
ENT	173	11	24	28	47	38	50	42	413
Orthopaedics	1,211	83	250	209	240	289	288	317	2,887
Surgery	1,018	64	191	222	246	240	214	230	2,425
Urology	1,027	75	223	255	246	223	276	240	2,565
Renal/Medical	148	5	36	36	32	25	30	28	340
	5,718	381	1,165	1,238	1,255	1,305	1,353	1,363	13,778
Paediatric									
General Medicine	963	54	160	178	204	223	216	205	2,203
Otolaryngology	109	5	16	21	23	18	22	22	236
Haematology	121	5	20	25	16	24	23	23	257
Orthopaedic Surgery	103	11	40	32	34	37	31	31	319
Surgery	420	34	107	112	113	106	105	106	1,103
	1,716	109	343	368	390	408	397	387	4,118

Day Cases Per Service Plan – Bases on 1997 Activity Adjusted

	Jan to May	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Total*
Adult									
Cardiology	86	5	14	16	20	23	20	21	205
Endocrinology	26	3	2	8	5	9	7	5	65
Gastro-Enterology	318	19	85	64	72	69	71	59	757
Neurology	11	-	1	-	5	-	1	3	21
Medicine	341	23	82	85	78	76	75	69	829
Gynaecology	183	18	26	47	49	47	53	45	468
ENT	101	8	24	14	15	22	23	23	230
Orthopaedics	502	29	120	98	132	118	119	87	1,205
Surgery	1,194	80	269	264	308	298	258	237	2,908
Urology	1,670	83	333	450	369	425	447	285	4,062
Renal/Medical	25	1	5	3	4	4	5	5	52
	4,457	269	961	1,049	1,057	1,091	1,079	839	10,802
Paediatric									
General Medicine	247	20	51	56	54	77	63	58	626
Otolaryngology	112	6	14	21	29	18	24	22	246
Haematology	199	15	56	64	57	63	55	50	559
Orthopaedic Surgery	121	5	19	18	20	21	24	22	250
Surgery	1,023	67	202	219	266	234	244	223	2,478
	1,702	113	342	378	426	413	410	375	4,159

THE ADELAIDE AND MEATH HOSPITAL, DUBLIN,

INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL ("THE HOSPITAL")

REPORT TO THE MINISTER FOR HEALTH & CHILDREN

ON MANAGEMENT REPORTING AND CONTROL,

SERVICE PLANNING, AND THE

FINANCIAL POSITION OF THE HOSPITAL, IN THE CONTEXT OF

THE RECENT MERGER OF THE BASE HOSPITALS, AND

THE MOVE TO THE NEW HOSPITAL AT TALLAGHT

by

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3 DECEMBER 1998

GLOSSARY OF TERMS

"AMINCH" or "the Hospital" :	The Adelaide & Meath Hospital, Dublin, Incorporating the National Children's Hospital
"the base hospitals" :	all or any of the Adelaide Hospital, the Meath Hospital or the National Children's Hospital, as the context requires
"the Charter" :	The Charter of AMINCH, dated 1 August 1996
"C&AG" :	Comptroller and Auditor General
"DOH&C" or "the Department" :	Department of Health & Children
"ERHA"	Eastern Regional Health Authority
"FDVH" :	The Federated Dublin Voluntary Hospitals
"HSEA" :	Health Service Employers Agency
"HSSD" :	Hospital Surgical Sterilisation Department
"ISIT" :	Information Systems Information Technology
"ICU" :	Intensive Care Unit
"Minister" :	The Minister for Health & Children
"NCH" :	National Children's Hospital
"NCHD" :	Non-consultant Hospital Doctor
"PIMS" :	Patient Information Management System
"St James" :	St James Hospital
"PACS" :	Picture Archiving & Communications System
"PWC" :	Pricewaterhouse Coopers
"OPD" :	Out Patient's Department
"TRHB"	Tallaght Regional Hospital Board
"WTE" :	Whole Time Equivalents