Q1 Senator Colm Burke – HSE

The need for the Minister for Health and the HSE to set out in detail the number of people employed within the Health Service for the year ending the 31st of December 2014, the 31st of December 2015, the 31st of December 2016 and the 31st of December 2017 under each of the following categories.

1. Consultants
2. Medical/other
3. NCHDs
4. Nurse Managers
5. Nurse Specialists
6. Staff Nurses
7. Public Health Nurses
8. Nursing Students
9. Nursing/other
10. Therapists
11. Health and Social Care/Other
12. Management
13. Clerical and Administrative
14. Ambulance
15. Care Staff
16. Support Services

HSE Reply

Direct Public Health Service Employment 2016-2017

The public health service is the largest employer in the state with (at the end of 2016) over 125,000 personnel (excluding home helps) directly employed, by the HSE and Section 38 voluntary hospitals and agencies, in the provision of public health & social care. Numbers equating to service levels are expressed as whole time equivalents (WTEs) taking account of part-time working.

At the end of December 2017, health services' employment stood at 110,795 WTEs. This represents an increase of 3,710 (3.5%) in 2017. Details by staff grouping for the yearend 2014 onwards, as requested, are set out in the following table:

By Staff Group: December 2017:

Staff Group	WTE Dec 2014	WTE Dec 2015	WTE Dec 2016	WTE Dec 2017	change Dec 2014 to Dec 2015	change Dec 2015 to Dec 2016	change Dec 2016 to Dec 2017
Overall	**99,327**	**103,884**	**107,085**	**110,795**	**+4,557**	**+3,201**	**+3,710**
Consultants	2,635	2,724	2,862	2,971	+89	+137	+109
NCHDs	5,397	5,814	6,060	6,331	+417	+246	+271
Medical (other) & Dental	786	798	801	820	+12	+3	+19
Nurse Manager	6,602	6,947	7,279	7,434	+345	+332	+155
Nurse Specialist	1,332	1,475	1,579	1,706	+143	+104	+127
Staff Nurse	24,423	24,749	24,768	25,315	+326	+19	+547
Public Health Nurse	1,460	1,501	1,499	1,514	+41	-2	+15
Nursing Student	404	387	405	500	-17	+19	+95
Nursing (other)	289	295	305	308	+6	+10	+2
Therapists (OT, Physio, SLT)	3,764	4,002	4,234	4,441	+237	+233	+207
Health Professionals (other)	9,875	10,576	11,130	11,509	+701	+554	+380
Management (VIII+)	1,186	1,327	1,445	1,610	+142	+118	+165
Clerical & Supervisory (III to VII)	13,927	14,837	15,322	16,105	+910	+485	+783
Support	9,419	9,494	9,448	9,454	+74	-46	+6
Ambulance	1,556	1,601	1,640	1,745	+45	+39	+105
Care	16,274	17,359	18,308	19,034	+1,085	+949	+725

Source: Health Service Personnel Census

Q2 – Kate O'Connell – DoH- Health Protection

To ask the Minister and the Department for an update on the plan to extend the HPV vaccine to first year boys. She would like to know the plans of the department and a time frame for rolling out the vaccination expansion. The earlier this roll out is announced the better so parents of young boys can become involved in the conversation about the importance of the vaccination for boys and the risks of not being vaccinated.

DoH Reply

Following a request from the Department of Health, HIQA has commenced work on a comprehensive Health Technology Assessment (HTA) on proposed changes to the National HPV Immunisation Programme.This includes an evaluation on the costs and benefits of extending the programme to boys.

In addition, there are a range of practical elements (such as the type of vaccine, age groups too be considered, the vaccine schedule, ethical considerations and how it might be organised) that need to be considered as part of this evaluation.

The first meeting of the HIQA Group (both the Department and HSE are represented on the Group) took place today (31 Jan 2018). HIQA are planning to have a draft report available for public consultation in September 2018.

However it is likely that the Department will have an indication of the results of the cost benefit evaluation by the end of June 2018.

Q3 – Senator Burke – DoH – Health Systems & Structures

In view of the changing demographics of the Irish population and in particular that there will be a substantial increase in the number of people over 65 years, will the Minister and the HSE:

A) Agree to the setting up of a forum to plan for the health care needs of an aging population.
B) Agree to invite all of the major stakeholders both in the voluntary, public and private health care sectors to become involved.
C) Set out a clear vision as to how we should plan for these changing health care demands.

Response:

Overall change in model of care

Our population is growing older and this will lead to an increase in demand for health and social care services.

The share of our population aged 65 years and over is projected to increase from one in eight to one in five by 2030 and the number of people aged 85 years and over is projected to almost double.

With this changing profile comes a rise in care needs and in particular in chronic disease and multi-morbidity which requires a different type of care that is preventative, on-going and managed close to home.

It is clear that a new model of coordinated health and social care is required to meet the needs of our older population, who are living longer with a complex set of clinical and social care needs.

Increases in capacity matched with reforms in the way we deliver care will be required over the next decade to meet the needs of our growing and ageing population.

The Committee on the Future of Health's Sláintecare report strongly supports a real shift in our model of care, moving from a hospital-centric approach to one which is focussed on prevention and early intervention and which will provide the majority of care in the community.

The Government has affirmed its commitment to implementing a significant programme of reform as outlined in the report and I expect to present a response to the report along with a proposed implementation plan to Government shortly. This will set out our ambitions for the next decade and concrete plans for the immediate years ahead which will be overseen by a new Sláintecare Programme Office. It is envisaged that there will be significant stakeholder consultation as part of the implementation process. Indeed this has already commenced with stakeholder consultation on-going in relation to the removal of private practice from public hospitals and we will shortly consult with stakeholders on the alignment of hospital groups and Community Healthcare Organisations.

Current Initiatives

The HSE's Integrated Care Programme for Older Persons, established in 2015 and working in conjunction with The National Clinical Programme for Older People, is leading on the development of cohesive primary and secondary care services for older people with a specific focus on those with more complex needs and frailty. To date, 12 pioneer sites have been supported and are in development nationally.

Integrated care aims to join up our health and social care services, improving quality and putting patient outcomes and experiences at the centre of everything we do.

The Programme operates using a 10-step integrated care framework, at the centre of which is the fundamental need to support older persons to live well and to lead healthier, independent lives in their communities.

The Programme is working in partnership with local providers, user and carer representatives, policy makers and system enablers to deploy and test the current framework.

I believe that this change in the way that care is provided, with greater integration between primary and acute care, will deliver improvements in person-centred care and outcomes for our older patients. It is essential that we attend to the care of our older people as a priority.

Q4 – Senator Burke - DoH SFOP

In June 2017 it was agreed that there would be a review of the operation of the Fair Deal Scheme. Will the Minister and the HSE set out:

A) When it is proposed to publish the report from the Interdepartmental Working Group which was to review the pricing mechanism for the Fair Deal Scheme.

DoH Response

When the NHSS commenced in 2009, a commitment was made that it would be reviewed after three years. The Report of the Review was published in July 2015. A number of issues have been identified for more detailed consideration, including a review of pricing mechanisms by the NTPF, with a view to:

- Ensuring value for money and economy, with the lowest possible administrative costs for clients and the State and administrative burden for providers;
- Increasing the transparency of the pricing mechanism so that existing and potential investors can make as informed decisions as possible; and
- Ensuring that there is adequate residential capacity for those residents with more complex needs.

A Steering Committee has been established to oversee the review of the pricing system for private long-term residential care facilities. This Steering Committee is chaired by the NTPF and includes representatives from the Department of Health, the Department of Public Expenditure and Reform, and the NTPF, work in this area is on-going and well advanced.

The NTPF have responsibility for the development of this report. The most recent update from the NTPF is that the report will be finalised and ready for my review in the first half of 2018.

B) If changes are now proposed to be introduced to deal with high dependency patients in private nursing homes .

The review of the NHSS, 2015, considered that the NTPF has done an effective job in introducing and managing a pricing system for long-term residential care facilities and this

system should continue for the immediate future. The report however recommended that the NTPF review its pricing mechanism and submit future pricing proposals to the Minister for Health in the context of:

- Ensuring that there is adequate residential capacity for those residents who require higher level or more complex care,
- Ensuring value and economy, with the lowest possible administrative cost for clients and the State and administrative burden for providers,
- Increasing the transparency of the pricing mechanism so that existing and potential investors can make as informed decisions as possible

I look forward to receiving the NTPF Report later this year and to consider its findings thereafter. However, I am not in a position to prejudge the outcome or findings of this report.

C) What mechanism can be put in place to care for the needs of elderly residents in private nursing homes and community hospitals to help reduce the referral into hospital through Accident and Emergency Departments.

The development of primary care is central to the Government's objective to deliver a high-quality, integrated and cost effective health service. The Programme for Government and Sláintecare commit to shifting the model of healthcare towards a more comprehensive and accessible primary care service in order to deliver better care close to home in communities across the country. The development of a new, modernised contract for the provision of general practitioner services will be a key element in facilitating this process.

GPs contracted under the GMS scheme are paid an annual capitation fee for each medical card or GP visit card holder on their panel. I am aware that that there is disparity in the level and frequency of medical cover being provided by GPs to GMS patients in nursing homes and that the current arrangements are no longer adequate to meet the needs of patients or nursing homes.

It is my intention that the issue of GP services to nursing homes will be addressed in the context of the on-going review of the GMS and other publicly funded contracts involving GPs.

The overall aim is to develop a contract which has a population health focus, providing in particular for health promotion and disease prevention and for the structured on-going care of chronic conditions. I am hopeful that agreement can be reached in the coming months and that priority service developments can start to be introduced during 2018.

D) If there are any proposals to put in place a scheme for HSE dieticians to call to private nursing homes and community hospitals in order to help reduce the referrals to outpatient departments in public hospitals.

Community dieticians treat malnutrition, diabetes, obesity and medical-related conditions/illnesses in adults and children. Services are delivered in various settings including primary care networks and residential care services for older people.

In relation to private nursing homes, the HSE has advised that there are currently no plans in place for HSE dieticians to call to these settings. There is however, a limited dietetic service provided to Community Hospitals. The role of dieticians has been developed in recent years and dieticians are currently involved in the replacement and management of gastrostomy tubes both in patients' homes and in residential care sites.

The provision of a community dietetic service has faced challenges particularly so in relation to staffing levels. However, I understand that the HSE is currently examining in detail the provision of community dietetic services with a view to developing a strong evidence base to inform future strategic and planning decisions in relation to the provision of this important service.

Q5 – Senator Burke – HSE & DoH

It was recently reported that 140 medicines were out of stock in Ireland, will the Minister and the HSE clarify:

A) What action is being taken to ensure that there is an adequate supply of all licenced medicines and pharmaceuticals which are covered by the drug refund scheme.
B) What medicines which should currently be available are not available or are in short supply.
C) What further action is required to guarantee continuity of supply of all such medicines and pharmaceuticals.
D) What work is being done to plan for the UK exit from the EU in view of the fact that a large proportion of pharmaceuticals and medicines are supplied through the UK.

Response:

A) What action is being taken to ensure that there is an adequate supply of all licensed medicines and pharmaceuticals which are covered by the drug refund scheme?

Medicines shortages in Ireland can occur for a multiplicity of reasons, can originate at any point in the supply chain, can involve and impact on many different stakeholders and accordingly require a multi-faceted, multi-stakeholder response.

Close collaboration and interaction with stakeholders in the medicines supply chain will be essential. To that end, the Department of Health has asked the Health Products Regulatory Authority (HPRA) to undertake a co-ordinating function in Ireland's response to the management of medicines shortages and to ensure that these issues are addressed in a more proactive manner. The HPRA's Strategic Plan for 2016 to 2020 identifies addressing medicine shortages as a strategic objective and is in the process of establishing this new function.

Specific actions to meet this objective include the HPRA taking the lead in the co-ordination of efforts by national agencies to manage medicines shortages, including the development of new initiatives and refinement of existing measures. Close interaction and collaboration with key stakeholders is a central part of the overall strategy. The HPRA will be working with stakeholders, including the HSE, to develop an effective approach to the management of medicines shortages. The HPRA has met with representatives of a wide range of stakeholders within the medicine supply chain, including representatives of marketing authorisation holders, wholesale distributors, community and hospital pharmacists, and patients. The HSE is actively engaged and collaborating with the HPRA in this initiative.

As a result of international shortages of key, critical medicines, there has been significant interest at a European level in this area. Recently, the Heads of Medicines Agencies, in collaboration with the European Medicines Agency, convened a task force on medicines availability, including the issues of supply disruption, however its impact on shortages is

likely to be more in the medium-to-long term; the HPRA is actively participating in this initiative.

The Department of Health also continues to contribute to efforts at a European level to consider initiatives to mitigate the risk and disruption caused by medicines shortages.

As part of the engagements around the National Framework Agreements with the Pharmaceutical Industry (the IPHA Agreement 2016) negotiators were very aware of the importance of continuity of supply.

To that end, providing an element of certainty around the list pricing mechanisms that would be applied across the 4 years which the Agreement covers enables suppliers to have reasonable levels of certainty around the pricing that will apply in the market. This is one of the key advantages of a framework agreement.

The Agreement also included a full section (Section 11) on continuity of supply. This included a commitment from all parties that continuity of supply was crucially important. Processes were included around foreseeable or prolonged shortages which included responsibilities on suppliers to endeavour to source alternative supplies.

The agreement includes a requirement that 12 months notice be given in advance of the discontinuation of a medicine with no alternative and processes to be followed when market authorisations are transferred from one supplier to another.

The agreement also includes a requirement that marketing authorisation holders notify the HSE of shortages or potential shortages.

The agreement re-enforced the responsibilities and obligations placed on marketing authorisation holders and distributors under EU directives.

The agreement also included price modulation terms and exceptional circumstances clauses to ensure that processes are in place to appropriately manage continuity of supply issues (Section 13.3 and Section 13.4).

In addition to the interactions outlined above, the HSE continues to engage with the Pharmaceutical Industry to ensure timely notification and response to notifications of shortages (and potential shortages) of medicines of concern.

B) What medicines which should currently be available are not available or are in short supply?

The figure of 140 products that has been reported as unavailable may not accurately reflect the current status of medicines availability nor the impact on patients. In some cases, medicines were reported as in short supply but may have not have been available for more than a year or have been discontinued. In the case of prolonged unavailability or

discontinuation, patients' treatments have been changed or there may be directly substitutable generics available.

To date in 2018, the HSE has received new notifications from the relevant Marketing Authorisation Holders that 19 medicinal products are the subject of current or potential shortage issues. Note a potential shortage relates to a circumstance where there is a constraint in supply which carries a risk of shortage but a shortage may yet be avoided.

Of these 19 notifications, 13 are expected to be resolved before the end of February 2018, 5 before the beginning of April 2018 and one shortage is expected to be intermittent through the first half of 2018 (this product has generic alternatives in the market).

Of the 19 notifications, in 7 cases, direct substitutes (i.e. generic or branded alternatives) are available.

Of the 19 medicines notified, 15 of the notifications are related to manufacturing issues or quality control issues during manufacturing. 4 of the medicines notified relate to significantly higher demand than forecast (i.e. due to a greater than 2 fold decrease in demand over same time period in the previous year).

Recent Example: the HSE recently received a notification in relation to Oseltamivir (Tamiflu®) which was of serious concern to the HSE (and the HPRA). The issue is being proactively managed with communication between the Marketing Authorisation Holder of Tamiflu®, the HPRA and the HSE. The market authorisation holder has responded proactively to a two fold increase in demand for supply of this product over the previous season and has supplied significantly increased levels of stock to the Irish market.

C) What further action is required to require continuity of supply of all such medicines and pharmaceuticals?

As part of its work in establishing a function to co-ordinate the management of medicines shortages, the HPRA will be looking at a range of measures to help prevent shortages arising and manage them when they do occur. A major part of this is the development of a protocol for a multi-stakeholder approach which should improve the notification of potential or actual shortages to the HSE and the HPRA, the identification and implementation of actions to mitigate their impact and transparency and communication, especially to healthcare professionals and the public.

Additionally, the continued close interaction and collaboration of the HSE with all stakeholders will be required to ensure continuity of adequate supply of authorised medicines at the appropriate price to the patient or the Health Service.

The pricing and reimbursement of medicines marketed in Ireland is underpinned by the Health (Pricing and Supply of Medical Goods) Act 2013 and an Industry framework agreement (2016 IPHA Agreement) to realign, downwards only, the official published list price of medicines to the EU14 average on an annual basis.

The introduction of reference pricing by the HSE, coupled with increased generic and biosimilar uptake and the implementation of the 2016 IPHA agreement has led to significant savings to the HSE whilst leading to pharmaceutical suppliers of the Irish market stating diminishing financial returns. The HSE is very aware of the responsibility under the reference pricing legislation to be cognisant of the ability of suppliers to meet demand when it is setting and reviewing reference prices.

The HSE receives a small number of notifications of discontinuation of low priced (but potentially critical) branded products from IPHA members following on from the implementation of the IPHA Agreement 2016. The HSE has actively engaged in these situations to ensure continuity of supply for Irish patients. On occasion the HSE has agreed price increases for a small number of products to ensure continuity of supply.

The HSE in its engagements with the pharmaceutical industry will remain cognisant of the need for collaborative interaction to help ensure continuity of adequate supply of authorised medicines.

D) What work is being done to plan for the UK exit from the EU in view of the fact that a large proportion of pharmaceuticals and medicines are supplied through the UK?

The Department of Health regards the continued supply of medicines to Irish patients as a key priority in its Brexit planning. To this end, the Department is working with the HSE and the HPRA.

It is important to note that the HPRA is strongly represented at both the European Medicines Agency (EMA) and the Heads of Medicines Agencies (HMA) network, and its input into the Brexit preparations of both these organisations provides an opportunity to ensure that the particular needs of the Irish market are recognised and addressed at European level.

At a national level, the HPRA is taking a proactive approach to Brexit preparations, with a focus on protecting the availability of medicines for Irish patients and the integrity of our medicines market, even in the event of a "hard Brexit". Over the past year and distinct from its new function to coordinate the management of medicines shortages, the HPRA has increased its engagement with pharmaceutical companies and other stakeholders, offering practical support in managing the regulatory challenges of Brexit. Among other measures, the HPRA is exploring opportunities for joint labelling of medicines with other markets, increasing its commitment to medicine assessments within the centralised EU network, and working directly with companies looking to transfer some or all of their operations to Ireland.

The EU's negotiating position also reflects that the Withdrawal Agreement should address issues arising from Ireland's unique geographic situation, including transit of goods (to and from Ireland via the UK). Discussion on the UK land bridge, which is an important issue for the pharmaceutical and medical devices sectors, are continuing during phase 2 of the negotiations as part of the Irish-specific strand of issues, and the Department of Health will continue to play a role in this context.

Q6 –Billy Kelleher- HSE

To ask the Minister for Health if he will detail in tabular format for each voluntary/public hospital the number of bed days lost during 2017 owing to beds being closed in the hospital

Response: HSE

The number of available beds across the acute hospitals can fluctuate greatly from week to week. This can be due to a number of factors including intermittent refurbishments, maintenance works and infection control requirements. Beds may not be available if the beds are not staffed to the required safe levels and with the necessary specialist skills in some cases.

A closed bed report is provided weekly by hospitals to the Business Information Unit for inpatient and day beds closed by hospitals per reason. The total number of inpatient and day beds closed per week is detailed in the report but is not broken down to each day of the week and also not down to speciality level.

The availability of acute hospital beds is clearly an important factor in accommodating acute healthcare demands. In line with International best practice the HSE are implementing new models of healthcare provision with the overall aim of delivering healthcare in the most appropriate setting.

The HSE is continually improving day services and developments that facilitate hospital admission avoidance, rapid assessment and increased ambulatory care.

The latest weekly bed closure report, for the week ending 21st January 2018 indicates that there are 93 beds closed. This is due to infection control, essential refurbishment, staffing shortage issues.

In order to support winter capacity pressures 176 beds have so far opened across the Acute Hospital System and a further 87 are planned to open during the year.

Question 7 (Deputy Billy Kelleher)

To ask the Minister for Health if he will detail in tabular format for each year 2014 to 2017 the number of home help hours provided in each Local Health Office are.

Response:

Table 1: Home Help Hours provided (excluding Home Care Package Hours)

CHO	LHO	2014	2015	2016	2017*
CHO 1	Cavan/Monaghan	331,209	327,103	359,726	369,607
	Donegal	609,783	639,247	669,225	666,181
	Sligo/Leitrim	402,925	441,400	433,067	406,354
	CHO Total	**1,343,917**	**1,407,749**	**1,462,017**	**1,442,142**
CHO 2	Galway	639,502	651,276	735,241	691,096
	Mayo	360,175	402,065	401,447	426,410
	Roscommon	231,948	242,288	247,476	235,882
	CHO Total	**1,231,625**	**1,295,628**	**1,384,165**	**1,353,387**
CHO 3	Clare	195,278	212,098	223,580	193,583
	Limerick	387,381	387,485	389,776	392,134
	North Tipp/East Limerick	312,855	349,491	347,031	336,391
	CHO Total	**895,514**	**949,074**	**960,387**	**922,108**
CHO 4	Kerry	567,300	565,485	517,256	550,888
	North Cork	414,207	380,999	347,110	324,656
	North Lee	461,972	404,340	363,516	349,064
	South Lee	460,385	439,941	448,067	463,446
	West Cork	333,958	314,815	307,195	307,705
	CHO Total	**2,237,822**	**2,105,580**	**1,983,144**	**1,995,759**
CHO 5	Carlow/Kilkenny	305,950	294,883	295,606	274,633
	South Tipperary	294,636	287,524	280,076	259,077
	Waterford	263,245	262,061	274,364	228,844
	Wexford	368,464	360,512	363,522	384,404
	CHO Total	**1,232,295**	**1,204,980**	**1,213,568**	**1,146,958**

CHO 6	Dublin South East	105,585	91,759	91,849	76,154
	Dun Laoghaire	81,002	82,515	87,402	85,835
	Wicklow	216,996	212,127	209,701	175,979
	CHO Total	**403,583**	**386,400**	**388,952**	**337,968**
CHO 7	Dublin South City	111,295	120,643	124,660	105,686
	Dublin South West	146,421	135,807	121,711	103,063
	Dublin West	202,809	173,223	166,471	114,552
	Kildare/West Wicklow	266,157	280,477	302,155	315,300
	CHO Total	**726,682**	**710,151**	**714,997**	**638,601**
CHO 8	Laois/Offaly	263,639	292,369	312,378	297,874
	Longford/ Westmeath	242,426	240,701	254,829	255,136
	Louth	216,265	223,149	226,395	232,091
	Meath	459,639	494,437	500,508	464,255
	CHO Total	**1,181,969**	**1,250,656**	**1,294,111**	**1,249,355**
CHO 9	Dublin North	437,327	469,023	442,311	491,480
	Dublin North Central	361,344	404,137	432,363	465,229
	Dublin North West	246,404	272,073	270,719	342,818
	CHO Total	**1,045,075**	**1,145,233**	**1,145,393**	**1,299,527**
Total		**10,298,481**	**10,455,452**	**10,546,733**	**10,385,804**

Slight variances on totalling due to rounding *Preliminary Data

Question 8 (Deputy Billy Kelleher)

To ask the Minister for Health if he will detail in tabular format for each year 2014 to 2017 the number of home care packages provided in each Local Health Office area.

Response:

Number of persons in receipt of a Home Care Package

CHO	LHO	2014	2015	2016	2017*
CHO 1	Cavan Monaghan	498	557	589	608
	Donegal	366	354	452	469
	Sligo/ Leitrim	322	361	304	301
	CHO Total	**1,186**	**1,272**	**1,345**	**1,378**
CHO 2	Galway	533	578	638	1,039
	Mayo	334	364	491	600
	Roscommon	193	218	246	273
	CHO Total	**1,060**	**1,160**	**1,375**	**1,912**
CHO 3	Clare	126	248	287	380
	Limerick	406	433	498	465
	North Tipp/ East Limerick	191	269	243	304
	CHO Total	**723**	**950**	**1,028**	**1,149**
CHO 4	Kerry	500	515	516	591
	North Cork	176	156	143	139
	North Lee	257	269	299	314
	South Lee	370	353	373	412
	West Cork	121	102	103	101
	CHO Total	**1,424**	**1,395**	**1,434**	**1,557**
CHO 5	Carlow/ Kilkenny	223	213	212	220
	South Tipperary	180	211	309	367
	Waterford	127	126	161	274
	Wexford	264	337	362	381
	CHO Total	**794**	**887**	**1,044**	**1,242**

CHO 6	Dublin South East	448	519	646	841
	Dun Laoghaire	617	652	779	841
	Wicklow	330	387	411	539
	CHO Total	**1,395**	**1,558**	**1,836**	**2,221**
CHO 7	Dublin South City	343	439	420	606
	Dublin South West	538	726	629	1,015
	Dublin West	272	419	427	705
	Kildare/ West Wicklow	345	465	477	734
	CHO Total	**1,498**	**2,049**	**1,953**	**3,060**
CHO 8	Laois/ Offaly	437	558	624	656
	Longford/ Westmeath	229	262	322	468
	Louth	760	811	914	1,061
	Meath	394	460	440	496
	CHO Total	**1,820**	**2,091**	**2,300**	**2,681**
CHO 9	Dublin North	1,584	1,773	1,697	1,853
	Dublin North Central	815	1,053	1,141	1,406
	Dublin North West	900	1,084	1,198	1,348
	CHO Total	**3,299**	**3,910**	**4,036**	**4,607**
	Total	**13,199**	**15,272**	**16,351**	**19,807**

*Preliminary Data

Question 9 (Deputy Billy Kelleher)

To ask the Minister for Health if he will detail in tabular format for each voluntary/public hospital the number of approved consultant positions in whole time equivalent terms in each and the number of which in each hospital are not on the specialist register.

Response:

Table1 below sets out the number of approved Consultant Posts in Voluntary/Public Hospitals.

Table 2 below sets out the number not on the Specialist Register.

Table 1

Approved Consultant Posts in Voluntary/Public Hospitals

Clinical Site	Total Post WTE
Bantry General Hospital	6.21
Beaumont Hospital	178.70
Cappagh National Orthopaedic Hospital	19.70
Cavan General Hospital	33.47
Children's University Hospital, Temple Street	58.73
Connolly Hospital, Blanchardstown	56.16
Coombe Women & Infants University Hospital	27.30
Cork University Hospital	183.46
Ennis Hospital	4.99
Galway University Hospitals	192.88
Incorporated Orthopaedic Hospital	0.90
Letterkenny General Hospital	61.38
Lourdes Orthopaedic Hospital, Kilcreene	1.03
Louth County Hospital, Dundalk	11.94
Mallow General Hospital	8.71
Mater Misericordiae University Hospital	149.53
Mayo University Hospital	41.95
Mercy University Hospital	41.72
Monaghan General Hospital	7.66
MRH Mullingar	35.29
MRH Portlaoise	25.32
MRH Tullamore	44.95
Naas General Hospital	24.90
National Maternity Hospital	23.08
National Paediatric Hospital	0.33
National Rehabilitation Hospital	7.78
Nenagh Hospital	5.81
Our Lady of Lourdes Hospital, Drogheda	76.92

Our Lady's Children's Hospital, Crumlin	**98.31**
Our Lady's Hospital, Navan	**16.14**
Portiuncula Hospital, Ballinasloe	**26.57**
Roscommon County Hospital	**8.27**
Rotunda Hospital	**35.86**
Royal Hospital, Donnybrook	**1.12**
Royal Victoria Eye & Ear Hospital	**18.97**
Sligo Regional Hospital	**65.11**
South Infirmary-Victoria University Hospital	**33.94**
South Tipperary General Hospital	**27.80**
St Columcille's Hospital	**16.44**
St James's Hospital	**170.85**
St John's Hospital	**9.94**
St Luke's General Hospital, Kilkenny	**27.74**
St Luke's Hospital, Rathgar	**17.26**
St Mary's Hospital, Phoenix Park	**1.78**
St Michael's Hospital	**9.73**
St Patrick's University Hospital	**0.62**
St Vincent's University Hospital	**140.12**
St Vincent's, Athy	**0.17**
St Vincent's, Fairview	**4.81**
Stewart's Hospital, Palmerstown	**0.49**
Tallaght Hospital	**131.61**
University Hospital Kerry	**39.77**
University Hospital, Limerick	**125.43**
University Maternity Hospital Limerick	**1.69**
University of Limerick Hospitals Group	**2.56**
Waterford Regional Hospital	**106.71**
Wexford General Hospital	**26.24**
Total	**2,496.85**

Table 2:

Consultants not on Specialist Register

Clinical Site	Total Head/count
Bantry General Hospital	1
Cavan General Hospital	6
Cork University Hospital	4
Ennis Hospital	1
Galway University Hospitals	5
Letterkenny General Hospital	4
Louth County Hospital, Dundalk	1
Mayo University Hospital	1
Monaghan General Hospital	1
MRH Mullingar	2
MRH Portlaoise	3
MRH Tullamore	3
Naas General Hospital	3
Our Lady of Lourdes Hospital, Drogheda	1
Our Lady's Children's Hospital, Crumlin	3
Portiuncula Hospital, Ballinasloe	1
Roscommon County Hospital	1
Sligo Regional Hospital	3
South Infirmary-Victoria University Hospital	2
South Tipperary General Hospital	9
St James's Hospital	4
St John's Hospital	1
Tallaght Hospital	1
University Hospital Kerry	6
University Hospital, Limerick	2
Waterford Regional Hospital	3
Wexford General Hospital	1
Grand Total	**73**

Questions 10 (Deputy Margaret Murphy O'Mahony)

Bantry General Hospital is currently completely hamstrung by the lack of high speed broadband. They are attempting to run high-tech equipment and share data using an IT infrastructure that is entirely unsuitable in 2018. It severely compromises what they can do. What is being done to ensure that all acute hospitals, but particularly rural hospitals are provided with high speed broadband as soon as possible.

Response:

Currently Bantry is served by two high speed optical fibre Ethernet connections (National Health Network). This is configured in a resilient failover architecture. This provides dual 30Mbps connections to the core HSE infrastructure and services. Current monitoring shows average utilisation at about 25% of the available capacity. We believe this will support significant increases in activity for the foreseeable future. We proactively monitor this and plan ahead as part of our capacity planning processes in the technology office of the CIO. As new services come on stream, adjustments are made to ensure effective operations for all clinical services. The hospital is configured with a high-speed internal network in 2017 (1 gigabit to the desktop). This included a fully configured WiFi for all clinical services.

Questions 11 (Deputy Margaret Murphy O'Mahony)

The new extension at Bandon Community Hospital was completed last August and remains closed as a result of staffing issues. Granted this matter lies with the HSE however intervention is now necessary in circumstances where there is a huge shortage in beds in West Cork.

Response:

Cork Kerry Community Healthcare Area have been engaged in discussions with the trade unions and staff regarding the transfer of staff to a newly built 25 Bed Community Nursing Unit in Bandon. At a capital investment of €3.4m, the new building will provide an increased bed capacity from 22 beds to 25 beds as well as providing a physically enhanced residential environment to support the high levels of care being provided to our Residents in the Unit.

The negotiation process with the Staff and Unions has been undertaken in line with the nationally agreed 'Information and Consultation' process and the terms of the Public Service Stability Agreements. Management has identified an increased staffing and skill-mix requirement which represents in excess of a 13% staffing increase. Management has confirmed that the proposed staffing and skill-mix is safe and necessary to maintain a safe and quality service delivery to our Residents.

The negotiations, which initially took place locally and progressed to conciliation under the auspices of the Workplace Relations Commission, have not resulted in agreement and the matter has been referred to the Labour Court for a full hearing on the matter. Management has requested Staff to cooperate with the move to the new Unit which is adjoined to the existing facility. Such a request would be consistent with the aforementioned Public Service Stability Agreement whereby staff agree with the implementation of the changes proposed albeit under protest while the matter progresses to the Labour Court on 7th February 2018.

Requests by management to open the new building with the existing 12 residents, and to re commence the admission of 4 respite residents, pending the outcome of the Labour Court hearing regarding the overall staffing for the 25 bed unit have been unsuccessful to date. The parties are continuing to engage to secure agreement with an interim proposal to secure cooperation with the opening of the additional beds in the context of the current demands for access to community residential care. Should agreement be reached at the Labour Court on February 7th 2018 the HSE will be in a position to move the existing residents into the new building and also commence respite admissions within two weeks.

Question 12 (Deputy Louise O'Reilly)

To ask the Minister for Health the number of patients over 75 years of age who have had to wait more than 24 hours in an accident and emergency department in 2017, by hospital, in tabular form?

Response: HSE

No. of patients over 75 years of age waiting greater than 24 hours in 2017

A total of 148,742 patients over 75 years of age attended Emergency Departments in 2017 and 92.43% of these patients were seen within 24 hours. 7.57% (11,261 patients) of the over 75 year old patients were not seen within 24 hours. The HSE is making every effort to ensure that these patients are given priority in the Emergency Departments.

Q13 – Deputy Louise O'Reilly - HSE

To ask the Minister for Health for an update on the pilot of an integrated hospital waiting list management system?

Reply: HSE

The NTPF was commissioned by the Minister to undertake a study on "the feasibility of progressing to a more integrated approach to Waiting List Management at Hospital Group level". The NTPF report was completed in September 2017 and is currently under review.

Question 14 (Deputy Louise O'Reilly)

To ask the Minister for Health what moves have been put in place to address the situation of doctors who are not on the specialist register but practising as consultants?

HSE Response:

In late 2016 National Doctors Training & Planning (NDTP) rolled out the Consultant Module of DIME (Doctors Integrated Management E-System) to improve the level and quality of information available regarding Consultant posts and Consultants employed in the Irish Health Service. DIME is in use by all public clinical sites that employ Consultants. To date 89% of Consultants employed in the public health services in Ireland have been matched into a post on DIME.

DIME is directly linked to the Irish Medical Council's Register of Medical Practitioners. Thus information on the registration status of 3000 Consultants and 6000 NCHDs is available through the system. Through DIME all clinical sites employing Consultants have access to real time registration information for all their doctors providing them with a tool to more easily identify and report on registration status. In addition the DIME system has a colour coding symbol for each doctor matched to a post to highlight to clinical sites whether a doctor has the correct registration type for the post they are matched to: green = correct registration for the post type, orange = the doctor is registered but does not have the correct registration type for the post they are occupying, red = the doctor is not currently on the register.

Arising from the rollout of DIME, in mid-2017 HSE HR was notified that there were a number of doctors are currently employed as Consultants without specialist registration.

Consultant posts in publicly-funded hospitals, Mental Health Services and health agencies are regulated under law. Between 1971 and 2004 posts were regulated under the Health Act 1970 by Comhairle na nOspidéal, an independent statutory body under the Department of Health.

Taking account of the regulatory functions of the HSE, health service employers are required to seek the prior approval of the HSE before making a Consultant appointment (whether permanent or non-permanent) and comply with the HSE Letter of Approval in making the appointment.

The purpose of regulation is to ensure that persons employed as Consultants in the public health service are appropriately qualified and competent to provide services as Consultants.

A range of controls are currently in place. These include

- Consultant Contract 2008, which specifies required membership on the Specialist Division of the Register of Medical Council,
- Procedures for the regulation of Consultant Appointments issued in October 2009 and was circulated on a regular basis since - sections 2, 3, 4 and 5 refer,
- Further guidance issued attached to Report of Consultant Recruitment Group in February 2017,
- HSE Circular 14/2009,
- HSE HR Circular 008/2009,
- HSE HR Circular 009/2012,

- HSE HR Circular 008/2010,
- HSE HR Circular 021/2015, and
- HSE HR Circular 016/2017.

In response to concerns regarding whether certain Consultants held general division registration, a group was established including the National Director of HR, National Clinical Leads in Acute Hospitals and Mental Health and other key staff to work Hospital Groups and Community Health Organisations to ensure that any risks arising from the process of recruitment of these doctors, be it to permanent, temporary or locum posts, are mitigated and eliminated to the maximum extent.

On 17th July 2017 the National Director of HR issued HR Circular 021/2017 which advised HSE and HSE-funded hospitals and agencies to:

> "immediately take steps to ensure that:
>
> - information regarding each Consultant in the employment of your service / agency is properly recorded on the database. Friday 18th August 2017 personnel in HSE Human Resources will link the relevant HSE national division for resolution to assist during this period of existing applications for new or replacement Consultant posts pending resolution of the matter.
>
> - A risk mitigation plan is in place for each Consultant post where the appointee does not hold the qualifications specified for the appointment by the HSE. This plan should set up access to an appropriate arrangement for senior clinical oversight as required.
>
> - Ensure that specified purpose rather than fixed term contracts are used to engage non-permanent Consultant staff and that such specified purpose contracts are not renewed in a that would create a liability for award of a contract of indefinite duration.
>
> - Identify an early contract end date for those temporary / locum doctors in your employment who do not hold the qualifications required for the post they occupy and ensure that employment is terminated at that point. This applies particularly to doctors employed via an agency). NDTP DIME database to be updated accordingly
>
> - Identify those Consultants engaged prior to March 2008 who do not hold Specialist Division registration and liaise with National Doctors Training and Planning (email: doctors@hse.ie) to support them in achieving same."

A further communication to hospitals and agencies issued on 24th August 2017, noting that

> "two cohorts of doctors have been identified and I am proposing they be dealt with separately on the basis of their employment commencement dates.
>
> a. *Cohort 1: Doctors without specialist registration who commenced employment as a Consultant prior to March 2008 when specialist registration was not mandatory.*
>
> You are requested to invite these doctors to apply to the Irish Medical Council in order to be assessed for a transfer to the specialist division of the register of medical practitioners. The Irish Medical Council has been briefed regarding this proposal and as a once-off measure, the HSE will fund the Medical Council directly for the cost of

each application, such that the doctor involved will not incur any personal expenditure.

b. *Cohort 2: Doctors without specialist registration who commenced employment as a Consultant since March 2008 when specialist registration became mandatory.*

I. A risk mitigation system to be put in place for each doctor to include a risk assessment, proposed restrictions on practice (if any) and a supervision and monitoring process by the Clinical Director or his/her nominee (if necessary).
II. Each doctor to make an application to the Medical Council for assessment for eligibility for specialist registration. The cost of the application will be borne by the HSE."

Arising from the above hospitals are completing an analysis of the various cohorts of consultants not on the Specialist Division of the Medical Council to identify:

- Those who are not on the register due to their own non-compliance,
- Those who are precluded from being on the register due to lack of recognised training in Ireland,
- Those who are not on the register but who would like to achieve compliance if assisted/ supported by HR in doing so,

The Mental Health Division has worked to obtain assurances from the Chief Officers, CHOs that Clinical Directors and ECDs are providing supervision, coaching and mentoring to those consultants within Psychiatry who are not on the Specialist Division of the Medical Council Register.

It is anticipated that it will take to third quarter 2018 before significant numbers of those Consultants currently without specialist registration have achieved same.

Question 15 (Deputy Louise O'Reilly)

To ask the Minister for Health the number of the following recruited in 2017, the sectors of the health service under which they have been recruited, resulting from this recruitment, and the information to be provided in tabular form:

- speech and language therapists
- neurologists
- occupational therapists
- physiotherapists
- dentists
- dental nurses
- mental health nurses
- midwives
- nurses
- NCHD doctors
- consultants doctors
- GP
- psychologists

Response:

Please see table below.

The number of additional WTE by grade group for 2017 is published on our website at the following link:

http://www.hse.ie/eng/staff/resources/our-workforce/health-service-employment-report-dec-2017.pdf

It should be noted that WTE change is not the same as recruited, as staff resign and retire.

Dec 2017 (Dec 2016 figure: 107,085)	WTE Dec	WTE change	% change	WTE change
Overall	**110,795**	**+3,710**	**+3.5%**	**+325**
Consultant Anaesthesia	389	+16	+4.3%	-0
Consultant Dentistry	16	+1	+7.3%	
Consultant Emergency Medicine	98	+6	+6.5%	+1
Consultant Intensive Care Medicine	5	+2	+66.7%	
Consultant Medicine	756	+33	+4.5%	+2
Consultant Obstetrics & Gynaecology	151	+11	+7.9%	-0
Consultant, Other		-1	-100.0%	
Consultant Paediatrics	172	+15	+9.2%	-3
Consultant Pathology	239	+9	+4.1%	-0
Consultant Psychiatry	364	+2	+0.6%	-0
Consultant Radiology	270	+3	+0.9%	-1
Consultant Surgery	511	+12	+2.5%	+3
Consultants	**2,971**	**+109**	**+3.8%**	**+2**
Interns	720	+7	+1.0%	-1

Dec 2017 (Dec 2016 figure: 107,085)	WTE Dec	WTE change	% change	WTE change
Registrar	2,074	+93	+4.7%	-2
Senior House Officer	2,295	+78	+3.5%	+6
Senior Registrar	175	-11	-6.0%	-1
Specialist Registrar	1,067	+104	+10.8%	-4
NCHDs	**6,331**	**+271**	**+4.5%**	**-1**
Dentists	313	-5	-1.5%	-3
Other Medical	507	+23	+4.8%	+1
Medical (other) & Dental	**820**	**+19**	**+2.3%**	**-2**
Medical/ Dental	**10,121**	**+399**	**+4.1%**	**-1**
Clinical Nurse/ Midwife Manager	6,301	+116	+1.9%	+21
Director Nursing/Midwifery, Assistant	864	+35	+4.3%	+14
Director of Nursing/Midwifery	269	+4	+1.4%	+2
Nurse Manager	**7,434**	**+155**	**+2.1%**	**+37**
Advanced Nurse/ Midwife Practitioner	223	+59	+36.2%	+11
Clinical Nurse/ Midwife Specialist	1,483	+68	+4.8%	-8
Nurse Specialist	**1,706**	**+127**	**+8.0%**	**+3**
Nursing Bank	48	+2	+4.9%	+4
Staff Midwives	1,445	-16	-1.1%	-9
Staff Nurse [Intellectual Disability]	1,707	-22	-1.3%	+19
Staff Nurse [Psychiatric]	3,147	-38	-1.2%	+29
Staff Nurses [General/ Children's]	18,968	+620	+3.4%	+150
Staff Nurse	**25,315**	**+547**	**+2.2%**	**+193**
Public Health Nursing	1,514	+15	+1.0%	+1
Public Health Nurse	**1,514**	**+15**	**+1.0%**	**+1**
Post-registration Nurse Students	280	+10	+3.9%	-2
Pre-registration Nurse Students	100	+8	+8.7%	-53
Pre-registration Nursing/ Midwifery	119	+77	+178.0%	-17
Nursing Student	**500**	**+95**	**+23.4%**	**-71**
Nursing Education/Clinical	256	-2	-0.8%	-3
Nursing/Midwifery Other (Corporate)	9	+3	+50.0%	
Other Nursing/ Midwifery	43	+1	+3.6%	+1
Nursing (other)	**308**	**+2**	**+0.8%**	**-2**
Nursing	**36,777**	**+942**	**+2.6%**	**+161**
Occupational Therapists	1,528	+53	+3.6%	-2
Physiotherapists	1,810	+80	+4.6%	+11
Speech & Language Therapists	1,103	+73	+7.1%	+9
Therapists (OT, Physio, SLT)	**4,441**	**+207**	**+4.9%**	**+18**
Audiology	79	+5	+7.1%	+2
Biochemists	70	+4	+6.0%	-1
Clinical Engineering	153	+7	+4.5%	+1
Clinical Measurement	357	+3	+0.7%	-5
Counsellor Therapists	234	+10	+4.3%	+0
Dental Hygienists	55	-1	-1.1%	+0
Dietitians	515	+22	+4.4%	-1
Dosimetrists	9	-2	-14.8%	
Environmental Health Officers	474	+4	+0.8%	-1
HSCP Trainees/Students	86	+6	+6.9%	+9
Medical Laboratory	2,033	+10	+0.5%	-1
Orthoptists	33	+5	+17.0%	+3
Other Health & Social Care	129	+5	+4.1%	+3
Perfusionists	21	+2	+9.7%	-0

Dec 2017 (Dec 2016 figure: 107,085)	WTE Dec	WTE change	% change	WTE change
Pharmacy	899	+45	+5.2%	+6
Phlebotomists	161	+7	+4.3%	+3
Physicists	161	+0	+0.2%	-1
Play Therapists/ Specialists	43	+0	+1.0%	+1
Podiatrists & Chiropodists	69	+1	+2.1%	+3
Psychologists	964	+43	+4.7%	+2
Radiation Therapists	186	-2	-1.2%	+1
Radiographers	1,162	+42	+3.8%	+2
Social Care	2,467	+146	+6.3%	+13
Social Workers	1,148	+18	+1.6%	+2
Health Professionals (other)	**11,509**	**+380**	**+3.4%**	**+39**
Health & Social Care Professionals	**15,950**	**+586**	**+3.8%**	**+58**
Executive Management	299	+30	+11.3%	+4
Senior Management (VIII & GM)	1,310	+134	+11.4%	+3
Management (VIII+)	**1,610**	**+165**	**+11.4%**	**+7**
General Administrative (III & IV)	11,655	+384	+3.4%	+19
Middle Management (V-VII)	4,410	+399	+9.9%	+36
Other Administrative	40	+1	+1.7%	-1
Clerical & Supervisory (III to VII)	**16,105**	**+783**	**+5.1%**	**+54**
Management/ Admin	**17,714**	**+948**	**+5.7%**	**+60**
Catering	860	+6	+0.7%	+5
Household Services	4,277	-27	-0.6%	-8
Maintenance	1,084	-18	-1.7%	+1
Other Labs & Associated	347	+19	+5.7%	-1
Other Support	1,162	+14	+1.2%	+0
Portering	1,630	+7	+0.4%	-2
Technical Services	93	+6	+7.4%	-1
Support	**9,454**	**+6**	**+0.1%**	**-6**
General Support	**9,454**	**+6**	**+0.1%**	**-6**
Ambulance Control	167	+5	+3.3%	-1
Ambulance Education	185	+25	+16.0%	-11
Ambulance Officers	72	+0	+0.3%	+2
Pre-Hospital Care (Ambulance)	1,322	+74	+5.9%	+5
Ambulance	**1,745**	**+105**	**+6.4%**	**-6**
Community Welfare Officers	5	-1	-21.8%	-0
HCA, Nurse's Aide, etc.	16,051	+666	+4.3%	+62
Health & Social Care Assistants	172	+13	+7.9%	-2
Other Care Grades	2,807	+48	+1.7%	-1
Care	**19,034**	**+725**	**+4.0%**	**+59**
Patient & Client Care	**20,779**	**+830**	**+4.2%**	**+53**