DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 30 Samhain 2016

Wednesday, 30 November 2016

The Select Committee met at 9 a.m.

MEMBERS PRESENT:

Deputy Mick Barry,	Deputy Billy Kelleher,
Deputy John Brassil,	Deputy Josepha Madigan,
Deputy James Browne,	Deputy Hildegarde Naughton,
Deputy Pat Buckley,	Deputy Kate O'Connell,
Deputy Joan Collins,	Deputy Louise O'Reilly.
Deputy Michael Harty,	

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

The select committee met in private session until 9.40 a.m.

Health Service Reform: HSE

Chairman: I welcome all of those who are watching the live stream of proceedings, everyone in the Gallery, our witnesses and members to the meeting. In particular, I welcome Mr. Tony O'Brien, director general of the Health Service Executive, and Mr. Liam Woods, national director of the acute hospitals division.

I wish to advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. If they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I thank Mr. O'Brien for his response to several questions that we submitted last week. I invite him to make his opening statement.

Mr. Tony O'Brien: I thank the Chairman and members. I appreciate the opportunity to be here. I am joined by my colleague, Liam Woods.

Approximately one year ago, *The Sunday Business Post* ran an extensive article, entitled "Inside the HSE", in which I was quoted as saying that we do not have a single collective national understanding of what we want from health care, particularly when it comes to how much we want to spend and invest in our system. One year later, I am genuinely delighted to be before this Oireachtas committee to provide input on what I hope will be a major step in developing clarity for the first time in terms of what we, as a nation, wish to achieve, how much of our overall Exchequer funding we are willing to invest and what we can realistically expect from our health services.

To my mind, this clarity and consensus has never really been achieved at societal, political or health service level. This has resulted in the progressive evolution of a platform whereby health has become a political football - political in the sense of using both a small and a big P. Fully 80% of services are of a very high standard, such as those seen recently on the RTE documentary "Keeping Ireland Alive". However, these services are often overshadowed by the 20% of services that are not delivered as well as we would all like. This arises to the extent that many people describe our health services as third-world in nature without stopping to consider the excellent services that are delivered day in and day out by staff in hospitals and in communities throughout the country. It is important to acknowledge today what is working well. I am keen to step beyond the usual headlines - to use RTE's strap-line from the programme – and paint a picture of our health care as it is delivered currently and the positive impact it is having on patients, service users and staff.

My focus today is not on structures. I am of a view that over the decades there has been an overemphasis on the importance of structures to the detriment of putting the patient at the centre of all we do, integrating how we deliver care and ensuring that patient safety and care quality is our utmost priority. My focus today is more on a number of important themes, principles and considerations, such as the need for a decisive shift from the acute hospital sector to the primary and social care setting due to changing demographic profiles, the impact on our health services if we fail to make this shift and some suggestions on how such a significant shift could be funded.

As I mentioned earlier, 80% of our health system is of a very high standard. Despite the resource constraints faced by the health services over the past six years, numerous improvements - too numerous to mention today - have occurred throughout all areas of the health services. Stroke treatment is an excellent example. Each year, more than 500 stroke patients receive thrombolysis to dissolve clots in arteries that cause strokes. In addition, some 150 people have had thrombectomy procedures, whereby obstructing clots were removed from large brain arteries to prevent devastating strokes. This places Ireland in the top three countries in Europe delivering acute stroke therapies. We are seeing similar positive outcomes for people with major heart attacks. Approximately 85% of patients received primary angioplasty within 90 minutes. This compares singularly well internationally.

Our success in diagnosing and treating cancer is well known and follows a difficult centralisation programme that, like many other areas in health care, became a political football for many years. However, thankfully, the views of the clinical experts prevailed and the outcomes are positive today. I have no doubt that we will face other decisions in health care very soon that will be equally contentious and will involve situations where local views diverge from those of clinical experts.

Another major success in the Irish health service is the improved uptake of childhood and school immunisation programmes. The figures compare well with World Health Organization targets. For example, in 2015 over 65,000 children were immunised. For the 6-in-1 childhood vaccine, there is a 95% uptake. For the MMR vaccine at 24 months, the uptake is 93%.

While we continually hear and read criticism of our mental health services, significant improvements are seldom mentioned. For example, the numbers on the child and adolescent mental health services waiting lists continue to decrease. Furthermore, in 2015, 95% children were admitted to age-appropriate child and adolescent inpatient units, compared with 25% in 2008. Moreover, one in every 100 adults in Ireland is estimated to have received suicide prevention training through applied suicide intervention skills training and safeTALK.

I could spend the entire 20 minutes discussing other improvements, such as the success of the quit smoking initiative, the increase in numbers of community intervention teams throughout the country and so on. However, I wish to move my focus to the horizon and to the future of health care in the country.

The positive examples I have outlined show that despite the challenges faced by our health services over the past six years, which was a recessionary period, there has been a positive trend in awareness, early detection and the provision of the right care in the right place at the right time. This means we are living longer, ageing better and learning to live with ill-health. In fact, these improvements to our health care system in recent years mean that we are adding approximately 20,000 people over 65 years of age per annum to our population. This figure is projected to increase by 4%, or approximately 188,000 people, between now and 2021.

Furthermore, the Irish longitudinal study on ageing, TILDA, reports that 64.8% of this over-65 age cohort live with multi-morbidity. This is defined as the presence of two or more chronic conditions. Treating an older population with the presence of chronic disease is costly and getting more costly. A graph in my written submission shows the relative cost of inpatient treatment by age category last year and projected to 2022.

While it is good news that we are likely to live longer, it carries with it new challenges in the required changes to our health service. Unless we plan for these changes now, we are going to run into significant difficulties in ten years' time. In fact, we are facing those difficulties already, as we can see in the 5% to 6% increase in the presentations to our emergency departments year on year and the impact that this is having on our acute hospital system and, in particular, available bed capacity for elective work. Our data show that we are doing more emergency work and less elective work each year. It goes without saying that, as the number of emergency admissions increases, there is reducing space for elective activity. This trend is set to continue unless something changes. If it continues, all work will be emergency work and we will be unable to accommodate elective work.

Committee members will have heard many times in the course of their work witnesses highlighting the need for us to shift our planning away from the acute hospital setting towards primary care. However, this necessitates a "decisive" shift towards primary care and for us to be clear about what we actually mean when we say this. To me, this means doing things in acute care settings that can, and should, only be done in acute care settings. Historically, we would have engaged in a simplistic restructuring exercise to achieve this.

As we are all well aware, the HSE was created with a big bang. Politically and legislatively, it was easy, but it was not necessarily a good idea and not well thought through. The rationale behind the establishment of the HSE was to centralise operations. This type of structure, coupled with an unexpected economic recession, led to a command and control-type system that disempowered those tasked with service delivery. It also tended to stifle the creativity and innovation required of a sustainable, adaptive organisation. Overall, we have learned that 105,000 staff cannot be managed from a central location.

Following a decision by the Government in 2011, we are now at a stage of advanced progress in slowly unwinding much of that. Seven hospital groups, nine community health organisations and the National Ambulance Service have been established. While not a perfect structure, significant consideration has been given to these new health care delivery organisations, which are premised primarily on patient population flows. These new organisations now require to be left alone and given time to embed and grow as the main operational delivery arm of the health service. Whether these structures are the most optimal has become less important than the need to implement them fully, including by providing them with sufficient management capacity and then allowing them a period of at least five to seven years to bed down properly before evaluating them and considering any further change.

In much the same way that restructuring does not provide the easy solution, simply increasing the numbers of acute hospital beds is not the easy solution either. The committee will have heard many people, including representative bodies, calling for an increase in our acute bed stock. If I may, I will put this in context. The health system uses 3.5 million bed days per annum. When adjusted only for demographics for the next 30 years, this number of bed days will have to grow to 6.4 million. That would be unsustainable in cost and staffing terms. There would be a requirement to add in excess of 300 beds per year. The current cost of the public hospital system is €5.3 billion per annum and we would require double this spend to deliver a

doubling of capacity as well as providing capital funding for new facilities. We would do far better to invest in the development of primary and social care services to support people in their communities.

To achieve the decisive shift away from the acute hospital setting to primary care and social care, a significant additional resource is required. However, such a resource will take time to develop, given how we are funded currently. To overcome this, a considerable rethink is needed of some of our existing policies, particularly in terms of how to fund sustainably the type of supports that we need as we grow older, whether that be long-term care, home care packages, home help hours or aids and appliances. It will also require a rethink of our capital funding investment. A change to multi-annual service planning and budgeting would also assist in supporting longer-term planning for the demands on our resources.

Currently, we have a health planning environment that is tied to an electoral cycle as well as a 12-month fiscal public service budgeting cycle. Both of these factors essentially drive short-term decision making and their resultant outcomes. The change cycle in health is longer than 12 months. An annual budget-service plan cycle hampers, rather than facilitates, improvement and reform. Instead, we need a capacity to plan that allows and supports longer-term decision making and promotes an environment of strategic thought based on evidence.

Closely aligned to this, and a matter on which I have commented publicly in the past, is the need to build a general public consensus concerning the maximum appropriate and feasible investment in health and social care for the next 15 to 20 years. In other words, how much are taxpayers willing to hand over for the health service they want? This consensus would have to bear in mind the realities of the economic cycle at any given point in time and competing pressures for Government funding.

I will turn to the issue of a fair deal for primary care. Our population is getting older and their care needs are becoming significantly more expensive. How do we sustainably resource this into the future? We tackled part of this problem a number of years ago through the introduction of a successful scheme that gave a good degree of assurance for the older population around their long-term care, namely, the nursing homes support scheme, or fair deal. It is a fair question to ask why we do not have such a scheme or level of assurance around care that is not long term.

One of the policy issues that should be considered as we examine the future of health care is whether we are going to put in place a demand-led funded environment that guarantees the supports for people moving on from the acute phase of their care to live their lives where they wish to, which by and large is in their own homes. Such a scheme would allow the likes of expensive home care packages to be funded into the future, but we need to reach a settled view on that. Otherwise, our system will become increasingly unsustainable.

The HSE's programme for health services improvement has 12 major programmes under way, constituting in the order of 500 subprogrammes. For the most part, these are patient-centred projects that will happen over three to five years and are designed to enhance service delivery to patients and service users.

There exists a perception that the health services can undertake these major improvement programmes for free or, to put it another way, carry out such major transformation while continuing to provide the same level of services as last year without getting any extra money. This does not happen in large industry, and it has dawned on health systems internationally that

transformation programmes need to be funded.

The committee will have heard from many witnesses about the number of transformative processes that are under way in our health services with varying degrees of success. To date, all of these programmes have been funded from within existing resources, but then we question why we have not seen a quantum shift in health care performance in Ireland. This is one of the reasons that we have been talking for decades about a decisive shift towards primary and social care, but not actually achieving it.

I wish to tell members about a health service where this issue is being taken seriously. In the state of New York, a major health service reform, called the delivery system reform incentive payment programme, DSRIP, is being undertaken. The aim of DSRIP is to improve significantly the way Medicaid beneficiaries receive their health care in order to reduce that cost and deal with the issue of chronic disease through integration and the avoidance of hospitals. The aim over the five-year implementation period is to cut costs by $17 billion. However, it is recognised that, in order to make that saving, there must first be investment. An overstretched system cannot easily move resources from one part of its service to another in order to effect change. We know that we must move resources and spend out of the acute sector and into primary care, but if we were simply to do that now, we would probably collapse our overall system.

New York calculated the saving over time and decided to invest up front part of that saving against a clear roadmap and clear deliverables, as a result of which the service providers in the state participating in this programme have been provided over the five years with $8.5 billion to fund the cost of transformation. This is the reality of health care transformation. DSRIP will promote community-level collaborations and focus on system reform, specifically on a goal to achieve a 25% reduction in avoidable hospital use over five years. All DSRIP funds will be based on performance linked to achievement of project milestones, thus paying for value.

In the UK, the King's Fund reached similar conclusions about what was necessary to effect effective transformation in the NHS. In Northern Ireland, a recently published expert panel report, entitled "Systems, Not Structures - Changing Health and Social Care", recommended that a ring-fenced transformation fund be established to ensure its transformation process was appropriately resourced. I make no apology for saying that if ongoing and future transformation is not funded in this jurisdiction, particularly in an overstretched and growing health care economy, we will not achieve the transformation which members expect or desire. It is as simple as that.

Another important consideration that is often overlooked when we discuss deficiencies in our health service is the level of annual capital funding. Members will be aware of some of the mega-projects in health such as the children's hospital. Through other committees, many will be aware of some of the lesser-known capital projects, including the upkeep and repair of many existing buildings and pieces of equipment in the health sector. We will spend approximately €375 million on capital developments in health this year across primary care, mental health, acute care and a wide other variety of services. Of great concern to me is the amount of money available to us between 2017 and 2021 in the capital space to pay for our ambulances, x-ray machines, MRIs and all those types of equipment on which we critically depend. That sum is €2.25 billion. However, that sum does not meet the €3.64 billion that is required to meet the long list of priority replacements to maintain safety and quality in our health care system. We have, therefore, an immediate problem. There is a mid-term review of the capital programme in 2017 and health needs to be very high on that agenda. I will seek to ensure that all those who have the responsibility for carrying out that review are aware of this capital challenge.

Looking at the next ten years, we need to be spending in the order of €9 billion in health capital to address issues of infection control and ageing equipment. This takes cognisance of the fact that we replaced a lot of equipment at the height of the economic prosperity, most of which is now ageing very rapidly. This includes critical equipment such as our ambulance fleet. As this exists as a quality and safety concern it becomes even more of a priority.

Often forgotten within our capital budget is the funding of e-health. I will not spend too much time on this as members have previously heard from the CIO, Richard Corbridge. Health, like every other sector, needs ready access to good information to improve and sustainably deliver quality cost-effective services. The delivery of integrated care, with a strong primary care focus, is predicated upon having effective technology to allow for easy access to the appropriate clinical advice independent of the care setting and across care settings. In other industries in Ireland this is a given. The farming sector, for example, has an electronic record to trace animal identification and movement for all sheep, goats, pigs and bovines. We need to redesign our systems at every opportunity to ensure that the true benefits of an e-health programme are available to patients and staff. The current electronic health record business case envisages that, by 2020, clinicians will be able to access digital information about patients appropriately, and by 2025 we will see a digital fabric throughout the health system including a system that is also accessible and in the hands of the people of Ireland.

This is a ten-year journey which will put in place a set of solutions built around the individual health identifier. It is not a big bang but an evolution of today's systems. It is not an immediate large investment but rather a commitment to incrementally evaluate the success of digital over a ten-year period and continue to add to the investment as benefits can be seen and success is clear.

Obviously, health care cannot be provided, nor can space and equipment work, without people. Despite considerable attention, attracting and retaining certain cohorts of our staff remains a considerable challenge at both national and local levels. Recent OECD reports identify that the health system in Ireland has a low number of doctors when compared with other jurisdictions. The work of the clinical programmes within the HSE has demonstrated this at a specialty level in Ireland, in specialties such as orthopaedics, obstetrics, ICU and neurology. Typically, we need to double our number of doctors to deliver on the models of care set out for our population. As part of the development of hospital groups, future recruitment of medical staff will be part of the group structure. This will allow for significant flexibility in the rotation of staff across hospital sites and allow for an enhanced training experience for doctors and will reduce the vacancy level of sites with traditional recruitment difficulties.

A committee appointed by the HSE regarding reform of the processes for creation, approval recruitment and appointment to consultant posts has concluded its work and developed a paper, Successful Consultant Recruitment and Retention, which is available and which we have shared with the committee. Recruitment in the health sector is and will remain an ongoing challenge for the foreseeable future. Policy decisions regarding the level of training places, salaries, terms and conditions for health sector workers are required in order for the Irish health services to remain an attractive destination for our most qualified staff.

In conclusion, I thank all members of the committee for the invaluable work that they have undertaken. I am sure the evidence given to this committee so far has been an eye-opener for some members in terms of how complex and challenging the delivery of health and social care services can be. The simple-fix solution may not be as simple as it first seems. I am of the belief that, with the correct strategic approach and a close re-examination of some of the policy

constraints within which we are obliged to function, we can better meet the challenges that face us with an ever-increasing demand for our services over the next ten years. This is especially so in relation to seed funding for our major transformation programmes to allow us to be able to invest now to generate more efficiencies later. It also applies in relation to the need for multi-annual planning and budgeting. The level of capital investment in the health sector is an area that also requires close consideration. Above all, it is important that we all work together to build the best health service that we can and that we can restore the public's confidence in the services that we deliver.

I will close out by taking the opportunity to thank all of my colleagues who work so diligently delivering services right across the country in such challenging circumstances.

Chairman: Before members come in, I will ask Mr. O'Brien to clarify two points from his opening statement. He posed the question of how much the taxpayer was willing to hand over for the health service at once. Can he address this question in the context of recent OECD figures which show that Ireland is very close to the top in terms of health spending? Even if we just take the taxpayer-funded element of that, we are still very close to the top. Is he saying that we need to spend more than any other OECD country? Is there not an issue about getting much better value for money with the existing spend?

Mr. O'Brien also said that the question of whether the structures were optimal or not has become less important than the need to implement them fully. That remains an open question for this committee, given the frequency with which the issue of structures has come up. It is hard for us to accept the case for implementing and bedding down structures that are not necessarily optimal. Attempting to close off discussion would be an issue for the committee as it is a very live issue for us.

Mr. Tony O'Brien: My comments on the structural issue were not intended to close off discussion but to stimulate it. It is my view, as it would be that of other people in similar roles in other jurisdictions, that there are no perfect structures and that whatever structures we have at any given time, it is always possible to argue that a different structure would be preferable. There is also, however, very significant evidence from restructuring processes around the world of the impact of restructuring. Following a study of the context and processes of the mergers of health care providers in England, Professor Naomi Fulop has produced a report which shows that structural changes typically lead to delays to service improvements of at least 18 months, that there tends to be a loss of managerial focus on services leading to a risk to patient safety and that the expectation of cost savings, generally speaking, are not realised.

A satirical study, A Surrealistic Mega-analysis of Redisorganisation Theories, made the serious point that, around the world, one can observe a pattern across many countries whereby one poorly planned, top-down restructure invariably leads to another. We are well into a process in which the hospital groups, in particular, are beginning to bear fruit in terms of the alignment of services, as are the CHOs. If we decide to stop that there will be a price to be paid, as there was when the eastern regional health authority was stopped before it got to a certain point. We will not necessarily be able to produce a structure to replace it which would be perfect, or less imperfect, than what we currently have.

We are spending a very substantial sum of money on health and there is an opportunity, through some of the processes currently under way involving groups and CHOs, to use the funding better by the realignment of services. I am not saying we need to spend an ever-increasing amount on health care. In order to allow strategic change planning, we need to plan ahead over

a longer time horizon than we do. For example, the HSE did not know what its budget for 2017 would be until budget day, and, as it stands, it will not know its budget for 2018-----

Chairman: With all due respect, multiannual budgeting is a different point. Mr. O'Brien is making the point that the taxpayers must decide how much they are prepared to spend on the health service. Given that the spend is close to the top of OECD spending, is Mr. O'Brien suggesting that we spend more than the existing €19 billion we spend on it?

Mr. Tony O'Brien: No, my central point is encapsulated by the DSRIP example. If we do nothing, based on demographic trends, the requirement for funding the health care system will grow exponentially.

Chairman: We are not suggesting we do nothing.

Mr. Tony O'Brien: There is a need, while making the changes, to fast track the changes by investing some of the future savings.

Chairman: Thank you for the clarification.

Deputy Kate O'Connell: I thank Mr. O'Brien for his presentation. He referred to the cost of equipment and said, to paraphrase, we bought a lot during the boom and it could do with being replaced. Why are we buying equipment? Normal process in businesses is that large plant would be leased and maintained by a service provider. Why is this not common practice in the HSE? I understand some is going on, however it seems we are front-loading money on equipment and then, I assume, the HSE needs to employ engineers to maintain it. It seems completely contrary to how it is done in a normal corporate entity.

It is concerning that we would not set out to have a perfect structure and then, maybe, move back a little from it. We are always using the word "ambitious" in the committee. Would we not try to be ambitious to have the optimum structure? I am probably wearing people out speaking about the alignment of the seven hospital groups and nine CHOs. We have raised it on numerous occasions and examined the structure we have been given in one of the documents. If one does not have a defined population with a person in charge of the population, how, in God's name, can we quantify what we need, audit what is happening and compare with similar defined populations? It seems very strange that we would not have defined borders.

Is there any infographic that shows us how the HSE will get from the current structure to the new structure? What sort of dead wood, for want of a better word, can we get rid of in the process? Are we just, yet again, adding another layer to the administration?

Mr. O'Brien spoke about the positives. I do not see many positives on the ground. Mr. O'Brien mentioned improvements in waiting lists for mental health services for children and adolescents. Could Mr. O'Brien elaborate on where we were and where we are? What would he consider an acceptable time for a child to wait for mental health services during his or her formative years?

Mr. O'Brien said some of the information the committee is receiving might be an eye-opener. None of us needed to join this committee to have our eyes opened, given that we see operations cancelled due to lack of beds and escalating numbers of people on trolleys, and that we hope to God we will get a bad frost so we do not have a major flu epidemic. None of us needed to join this committee to have our eyes opened unless we had been living under our beds.

Deputy Billy Kelleher: I welcome the interesting contributions. Deputy Kate O'Connell raised the issue of lease maintenance contracts for high-value and diagnostic equipment across the HSE. The new children's hospital will be in the frame of lease maintenance contracts. I do not know why it has not percolated beyond in terms of capital spend and capital investment in plant.

I would like to tease out hospital groups. There are various views as to whether they are coalescing properly with the CHOs. The HSE establishes a hospital group and gives it independence. Will there be any overarching national policy that will set down parameters for the hospital group in terms of the type of investment it will make and the services it will provide? For example, if all seven hospitals decide to do left hips very well, who will do the right hips? Will there be a national policy that will filter down to ensure we have adequate services in all specialties across the country and that we do not have unnecessary duplication? Given that we are giving the hospital groups independence and their own decision-making processes and budgets, how can we ensure we have adequate cover, particularly for sub-specialties, across the country?

Mr. O'Brien said we needed to make a decisive shift from acute hospital settings to primary care. Probably one of the key issues in making this decisive shift will be negotiations around the GP contract and the delivery of chronic illness care in the community. What does Mr. O'Brien think would be necessary in the contract, without showing his negotiation hand? What are the broad parameters of what is required regarding the detail of the contract for chronic illness and manpower and manpower planning for this inevitable and decisive shift from acute to primary and community care?

We talk about our aging population and the demographic bulge that is evident a short time down the road. Yet, judging by our investment in geriatric services and specialties, we do not seem to be planning in accordance with what we know is going to happen in training, recruitment, retention, expanding training programmes to ensure we have sufficient capacity and manpower to deal with those challenges.

Do we need a division to oversee the roll-out of primary care, or should it be done by the hospital groups? How should we do it to ensure we get primary care running efficiently in tandem with the acute hospitals? Over the years, we, and everybody else who has examined health systems across the world, have consistently said primary care is the way health care should be delivered in the years ahead. Yet, the minute a budget adjustment is required, primary care always seems to be hit first, and then everything falls back on the acute hospital setting. We have strategies in place to deal with the winter initiative, such as cancellations of elective surgeries when there is overcrowding in hospitals. At what stage do we realise we cannot keep doing this and that primary care has to deal with the capacity issues in the acute hospital system?

Deputy Louise O'Reilly: I thank Mr. O'Brien and Mr. Woods for their attendance and presentation. Mr. O'Brien made many references to the trend that we are moving more towards emergency and away from elective procedures. My position is that the HSE is not serious about tackling this. I see no evidence of a systematic plan to deal with the issue. From the response to a parliamentary question I tabled recently, we learned that, from 1 January to 16 November, Tullamore hospital instigated the full-capacity protocol 511 times. That is a phenomenal figure. It suggests that the full-capacity protocol, which I understood was supposed to be a response to an emergency situation, is now becoming more or less a way of life. I agree that we are heading in the direction of more emergency and less elective care, but I put it to Mr. O'Brien that he is not in any way serious about dealing with that.

In responses to other parliamentary questions I asked, I learned that not one of the 14 primary care centres to be built is to get any additional staff. Everybody talks about the need to invest in primary care. Mr. O'Brien said that a significant resource will be required. How would he quantify a significant resource? What will it be? I am sure he knows. I am disappointed that he did not provide the information earlier but perhaps he would enlighten the committee on what significant resource will be required to begin the move from dealing with emergencies. The full-capacity protocol is a recognition that there is an emergency situation at a hospital and that drastic measures must be taken. It appears that hospitals are in an almost permanent state of full-capacity protocol. I am familiar with the protocol because I worked in the unions when it was first discussed. At the time, we were given to understand that it would seldom be used but now it is almost permanently in use. I do not see a plan to move from emergencies only over to primary care, so I would be interested to hear about that.

There was a reference to 20% of what happens in the health service not being of a high standard. What areas have been identified as not being of a high standard? What plans are in place to bring them to a high standard?

We are all aware of the difficulties with recruiting and retaining staff in our hospitals. We are also aware that a significant amount of money is spent every day on agency staff and outsourcing to the private sector. The Minister has said repeatedly, and I agree, that using agency staff is not good value for money. However, I do not see a plan to convert agency hours into directly employed hours. Is there such a plan? I do not believe there is one but if there is, perhaps the witnesses would share it with us. As part of that plan, has the HSE set targets for the number of hours currently provided by the private sector or by agencies that will be converted into the best value for money, which is direct labour?

Finally, does the HSE have a timeline for the conclusion of the discussions on the GP contract? That will be central to planning for the future. A number of my constituents are GPs and they ask me regularly if there is any news on it and whether there is a timeline. If there is no deadline, it will be an open-ended process. This is being held forth as something that might solve some problems but we are already way behind in those negotiations. We all accept the GP contract is out of date. The negotiating bodies are ready to begin the process. Does the HSE have a timeline for it?

Chairman: I would appreciate it if our guests would respond to that group of questions.

Mr. Tony O'Brien: I will ask Mr. Woods to deal with the issue of capital and equipment leasing.

Mr. Liam Woods: There were a couple of questions about how the HSE acquires capital. The traditional method has been the application of capital in the capital development plan to purchase equipment. Both members referred to what we would call managed equipment service, MES, contracts which are now being examined intensively as part of the national children's hospital proposal, which was mentioned, and also at a wider level for use across the HSE. We have looked at models internationally, such as the Karolinska Institutet, which has entered into a major MES, and into an innovation and joint venture arrangement with the Philips corporation, which was the successful applicant, on the back of that. We have done some assessment of that and we are very open to it. There is a certain amount of equipment leasing within our system at present. The HSE must seek prior approval to borrow, a point that arose previously. Leasing is a form of borrowing and it requires prior approval of the Department of Public Expenditure and Reform. That is not an obstacle. I am just stating that it is part of the process. We

estimate we need approximately €62 million per year in capital to maintain the equipment base of the health environment. If we were to examine that on a funded basis over a five or ten-year period, clearly it is an annual amount which is not a capital sum but which would be required to be an increased revenue sum. The HSE is very open to the idea of considering accessing capital equipment in that way, which is somewhat innovative. It would still require revenue funding instead of capital funding to pay that increased cost.

On maintenance, we have a small number of biomedical engineers who are very capable. Our national lead is based in Cork and is very strong on all of this. It is his data I was quoting when I referred to €62 million. We have a small resource ourselves. Much of the contract maintenance is carried out by the providers of equipment. Some of it, and it is an increasing amount, has been taken on board by us as a cost-efficiency measure. We do not have an excess of such people but we must maintain them because they help us to drive value and drive down the cost of maintenance contracts, which typically can last seven years and can be up to 7% of the cost of the equipment.

We are very open to the MES idea and we are pursuing it. We have carried out research on what is working best internationally. There has been mixed experience with this. In Sweden, when the full appraisals were carried out, they determined that it would make more sense for the county councils, which run the health environment there, to provide the capital but to proceed with an MES without the use of the private sector, because they were avoiding interest costs and a profit charge. There are a few variants regarding what that might look like and we are exploring those at present. The core point is that part of the wider future for the hospital and health environment is that there is a choice between funding a revenue stream or a capital stream, but it needs to be funded. It is not free if we go with MES, but it can prove productive. Typically, those contracts internationally are for two life cycles of equipment.

Mr. Tony O'Brien: I thank the members for the variety of questions. I will attempt to cover all of them by grouping some of the topics together.

Regarding the core relationship between acute and community or primary care, Deputy Kelleher asked an interesting question on whether we should let the hospitals effectively control primary care. To be honest, that is the last thing I would do. These relationships are explored in different ways in different jurisdictions. However, I believe that if we did that, which effectively would be giving hospital groups control of the health care system, we would end up with a more hospital-centric rather than a less hospital-centric care system. To look at that through the lens of the issue of alignment, there is a legitimate discussion about the alignment between those two sets of organisations. My back-stop position is that they should be kept separate. There is a big job of work to be done within hospital groups, whatever boundaries they have, around the relationship between larger and smaller hospitals and more rational use of the resources. There is a separate piece of work to be done to build strength in our community services. If they were put into one place in singular organisations, as happens in some jurisdictions at this point, it would be a retrograde step for the development of community health care services in Ireland, which are coming from a lower base of resource.

The reality is that our hospitals have had more investment and historically have had slightly stronger management processes. If they were given control over primary care, I do not believe it would benefit the long-term aspirations we have for a decisive shift towards primary care.

On the alignment of boundaries, I will tell the committee a short story. Five years ago, when I was in the special delivery unit, all hospitals and community services were organised in what

were called integrated service areas, ISAs, of which there were 17. On a geographical basis, that meant that one person had responsibility for hospitals and community services. Around that time, as we were heading into the winter, with my job being to manage trolley crises, we organised meetings in every ISA. Despite the fact that there were common governance structures and processes and singular management, the first thing representatives of the special delivery unit had to do was introduce community service colleagues to hospital colleagues. The structural approach was not the solution.

I was at a lecture given by Professor Rafael Bengoa who recently led the process in Northern Ireland where they have integrated trust areas. He made the very same point. They have not provided the solution and system issues need to be addressed. I am really dealing with the potential argument that has not been made that what we should do is have singular structures that combine both hospitals and community health organisations. Something like this was tried in the past but was not successful.

Chairman: With all due respect, the hospitals were not fully involved in the 17 ISAs.

Mr. Tony O'Brien: They were.

Chairman: What role did HSE personnel have in what was going on in voluntary hospitals, for example? They had virtually no role.

Mr. Tony O'Brien: They were the budget holders, the contract holders and the funders. The same issue that I have just described arose. The best example was not a voluntary but a statutory hospital, in other words, a HSE hospital.

Deputy Kate O'Connell made a point about ambition. Of course, we should be ambitious. The point I was making was it might have been possible if each citizen stayed within a geographical territory to avail of primary, social, mental health and acute care services. In a country of this size, with its distribution of tertiary and quaternary care services, as is already the case, we can expect to see patients travelling great distances to avail of specialty services. The Deputy suggested it, but if we had as an objective having a full range of services within geographically defined areas or a person receiving all of his or her services within a single-----

Deputy Kate O'Connell: That is not what I am suggesting. We cannot have every hospital group performing complex brain surgery.

Mr. Tony O'Brien: No.

Deputy Kate O'Connell: That is just not possible and we all get it, but Mr. O'Brien has said there were issues in the past. Do we have evidence of this within the 17 groups referred to by the Chairman?

Mr. Tony O'Brien: The ISAs.

Deputy Kate O'Connell: What deficiencies were identified? Perhaps we might look at them to see if we could work through them. The matter has been well discussed at this committee and accepted that we cannot have every service provided in every area. That is the principle behind the hospital trusts. Why is it that the population cannot be defined, with specialist treatment services being provided somewhere else? May we have the evidence which shows where the process broke down? That is critical to the work of the committee.

Mr. Tony O'Brien: Sure.

Chairman: If there were defined geographical areas, the health status of people living in an area could be profiled. Activity levels could be measured, with the transfer of tasks from hospitals to community services and so on. In particular, outcomes could be measured, but there is no opportunity to do this currently.

Mr. Tony O'Brien: As the 90-plus primary care clusters are developed, it will aid that process considerably. I recognise and absolutely accept that there is a concern that when one looks at the hospital groups map, some of them transect great swathes of the country, making a map-based alignment of hospitals and the respective community health care organisations, CHOs, very difficult to conceptualise. The point I made in my opening statement was we were already seeing some benefits from within the groups and although there may be very strong arguments in favour of changing them, we must recognise that will carry a cost also.

Chairman: There is the general view that if there was a properly functioning organisational structure, it could be shown on one page, but that is not possible with the HSE. How many directorates are there?

Mr. Tony O'Brien: We have five service divisions.

Chairman: There are five service divisions, nine CHOs, seven hospital groups and something like 14 mental health teams. Mr. O'Brien has now told us that there are 90 primary care team clusters.

Deputy Louise O'Reilly: Does that mean that there are 19 within each CHO cluster?

Mr. Tony O'Brien: Nationally, it adds up to 96 or 97.

Deputy Louise O'Reilly: They are based within each CHO.

Mr. Tony O'Brien: Yes.

Deputy Louise O'Reilly: Does Mr. O'Brien understand we have been looking at this issue for quite some time and plenty of us have lots of experience? As Deputy Kate O'Connell pointed out, it is not an eye-opener. Nevertheless, it is very confusing. Can Mr. O'Brien imagine what it is like for a patient who is trying to navigate through it? It is next to impossible. It seems that when we look at it from the outside or even close enough to the inside, the structures have been almost deliberately set up to make it difficult to achieve accountability and for patients to access services.

Chairman: That is the issue; it is about measuring activity levels and ensuring there is not a geographical lottery, about which many people complain. It is especially about establishing accountability for what is happening. Currently, it seems there is fog.

Deputy Kate O'Connell: Mr. O'Brien has stated it might be difficult to visualise. None of us has any difficulty in visualising it. Although I do not intend to speak for the committee, we all get the idea that there must be a grade 4 hospital and an academic centre. We cannot just draw straight lines between places. The point is that there is a hospital group, as well as a certain amount of CHOs. The borders are clear. If we divide the number of primary care clusters - 97 - by seven, it comes down to the definition of borders. As the Chairman indicated, it is about accountability and, as Deputy Louise O'Reilly stated, patients having pathways. We are not saying we cannot imagine the reason the borders wiggle; we are asking why they are not defined and clear, or why we cannot quantify exactly what is going on in the case of personnel,

treatment services and what we own as a state in an area.

Chairman: It is also about outcomes.

Mr. Tony O'Brien: I will respond directly to that question in a constructive and engaged way. Patients live in communities. In mapping primary care networks it is envisaged that there will be primary care clusters or networks for populations of between 50,000 and 90,000. They fit within community health organisations and map groups of local authority areas. In other areas they relate to entire counties, which makes much sense vertically. In other words, we start with the patient, look at his or her community and have a primary care focus which fits within community health organisations. It includes other elements such as social care and mental health services and so on. We can all accept that this makes sense. It gets complicated when hospital groups are layered on top.

I will return to an earlier point about the hierarchy I have described to the committee. I am not suggesting the following is in the minds of members, but it is in mine. If it were my choice, the last thing I would do is re-amalgamate the hospital groups.

Chairman: We took that point from Mr. O'Brien's opening statement. We are finding it difficult to understand the rationale behind the current structures, as it is not immediately evident to us.

Mr. Tony O'Brien: The rationale came from different places, as I explained with Mr. Jim Breslin the last time we were here. In 2012 the then Minister initiated a process called the Higgins review which considered a set of criteria for hospital groups but which did not take into account community health services. I will come back to Deputy Billy Kelleher's specific questions about the creation of the hospital groups. As a result of their creation, the ISAs no longer functioned. The HSE sought to deal with the implications for community services, where it had a particular concern and that is where the report on the community healthcare organisations, CHO, which is population and geographically-based, comes from. That then leads to the discordance between the two.

In regard to Deputy Kelleher's specific questions on hospital groups-----

Chairman: Before Mr. O'Brien goes further, he still has not explained the rationale for the two systems. He has given us the background as to how they came about. What is the rationale for operating two separate systems when we are looking for integration and know that integration is so important?

Mr. Tony O'Brien: The rationale that informed the original decision may not be the same as the rationale I will put forward now. I need to own that fact because I was not the person who made those decisions. Let us look at the example of the mid-west, where we have a hospital group and a community health organisation whose boundaries are coterminous. We do not have the complicating factor of boundaries. That previously was an integrated service area. If they were present, the people who now work in that area, one running the hospital group and the other running the community health organisation, would tell the committee that both sets of services are running more effectively under separate management, albeit with coterminous boundaries than used to be the case when they were a single organisation.

Chairman: In fairness, the chief executive officer of that hospital group said that she would like to be in a position where she could transfer some of her budget to the community.

Mr. Tony O'Brien: Yes.

Chairman: It would assist all round, if that could be done.

Mr. Tony O'Brien: There are very effective working relationships there which are going in that direction. Over time we need to see the transfer of the hospital budget into the community, not just in the mid-west but nationally.

Chairman: How does one do that if the areas are not aligned?

Mr. Liam Woods: May I make an observation? Internationally there is a dialogue taking place about funded bundles of care across care locations and population-based funding. Those devices are being used independent of structure to fund the right care pathways for citizens. It is possible to provide a basket.

We have models of care and the committee may have had presentations from some of the clinical programmes already that define the optimal ways to provide care, that is, if our funding environment incentivises such a provision. In the context of the mid-west, for example, if home care packages are available to the hospital or in the community before a person came to a hospital and if that is incentivised in both the service model and financially, it can act structurally independently and can incentivise behaviour.

Chairman: It remains a theoretical point.

Deputy Kate O'Connell: What are the impediments that Mr. O'Brien experiences in his position, as opposed to the views of the person who made the decision? Will he list the impediments to getting the borders aligned as they are in the mid-west? How can one transfer funding from an acute setting to a primary care setting if part of the CHO belongs to somebody else? How does one track that money and make sure it is going to the right place and being used in the right way? It seems clear to me there is some impediment either on the part of the HSE or the hospital groups. I doubt it is in primary care because that service does not have enough power yet. What is the impediment to getting the borders at this point, when we are all working so hard to sort out this situation? Will Mr. O'Brien tell us what we can do and what the impediments are?

Mr. Tony O'Brien: I do not think the impediment to the transfer of funding from the hospital sector to the community sector is the borders because we can do that-----

Deputy Kate O'Connell: That is not the question I asked. I am asking about the impediments to having the borders aligned.

Mr. Tony O'Brien: That would require a change in Government policy. The Government policy is reflected in the Higgins report and the Higgins report determined which hospitals would be in which groups. It was not the HSE that made that decision. One would need a Government decision to change the map in relation to hospital groups.

Deputy Kate O'Connell: It is not the groups that I want to change but the community health organisation borders so that they will fit, like they do in the mid-west, everywhere. Can we not follow the mid-west example everywhere?

Mr. Tony O'Brien: The answer is one simply cannot if one looks at the map. Let us take the Ireland east hospital group, as I think it was discussed here recently and Deputy Kelleher asked a specific question on it. It runs from Wexford to Kilkenny, St. Columcille's, St. Vincent's, the

Mater and then to Navan. There is an articulated rationale for that group but that rationale could not apply in a community setting. One could not have a community health organisation that followed that track and transected Dublin in that way. If one started from a community based approach, one would never draw the map that way for community services.

Chairman: The point that is being made is that the boundaries for the hospital groups were drawn for other reasons, as opposed to service delivery reasons. The HSE were handed those by the Higgins report. I think the point being made is the HSE did not have a say in the composition of the hospital groups but did have a say in terms of organising the community health organisations.

Mr. Tony O'Brien: The community health organisation map was developed and proposed by the HSE after very extensive internal and external consultation, based on what would make sense in terms of what service one would try to provide at community level. Alignment with local government was considered important. Alignment with various other services that are co-dependent were considered.

Chairman: To clarify, the HSE did not have a role in determining the hospital group boundaries, but did decide on the community health organisation boundaries. Is that correct?

Mr. Tony O'Brien: Yes. May I come back to Deputy Kelleher's question?

Deputy Kelleher asked about the independence issue in respect of hospital groups. Independence is a word that has been thrown about a lot in the debate around hospital groups. It is important to stress that there is no definition of what independence means. Some people have perceived it to mean something like a foundation trust status in the NHS. Others simply think it means operational freedom to do a set range of tasks in a way that makes operational sense at local level. The truth is at one end or somewhere in between. It is clear that hospital groups will be funded by a central entity against a set performance set of standards using activity-based funding, which drive behaviours. Mr. Liam Woods has spoken about that and can do so again. We would never go back to the type of thing that happened under the health boards, best illustrated by breast cancer surgery where there were 37 hospitals dabbling in breast cancer surgery resulting in sub-optimal outcomes. At central level, individual hospital groups will have to be authorised to provide services that are evidence based, sensible and meet a population need based on our population size and distribution. They would never have the freedom to go back and reintroduce cancer services of a scale and type that are not appropriate. Some hospital groups get distracted by this notion of trust status, particularly because it has been in the air for such a long time. I do not believe that the public sector environment in Ireland would move in the direction of the types of freedoms that foundation trusts have in the UK, which gives them freedom to decide the number of staff they will have, what they will pay them, to step outside of national procurement contracts and all that type of thing. I do not think that will ever happen and it is something of a distraction. All we are really talking about is the opportunity for a set of hospitals in which it makes some sense to put them together to decide how services will be organised across their sites. An example was given at a previous meeting of the interoperability that is now occurring between the Mater and Navan hospitals and that is making some sense. There are similar examples between Beaumont and Cavan hospitals. While there are those kinds of ground-based operational freedoms, they would not allow hospitals to go off and deliver services, or to use the example, to become left hip specialists. That would not be permitted by the funding model.

In terms of the GP contracts, there is no set timeline for that. I was asked about my ambi-

tions in this regard. My view is that we need to re-establish the primacy of the generalist. In our health system, as in so many, we have tended to make sovereigns of specialists. One GP colleague put it to me in this way. In general practice, the patients stay the same and the conditions change; in specialist hospitals the condition stays the same and the patients keep changing, which can be rather annoying from their point of view. We need to have a health system that over a period of time recognises the specialty that is general practice, puts general practice at the heart of prevention and chronic disease management and gives it a full range of access to diagnostics. The general practitioners who refer patients to hospitals should not be second guessed by junior doctors there with only a fraction of their experience in general practice. We need to fund general practice in order to do that. We must recognise the workforce base, if I can use that term, in general practice right now is stretched. We have not been retaining GP trainees in the numbers we once did. We also have an age profile that is concerning. Consequently, whatever we do or do not agree during the GP contract negotiations, it will not be possible to implement the ideal general practice primary care service in one fell swoop. We have to recognise that there is a workforce development issue which will probably take ten full years to address. This will be a long journey rather than a single event. Those are my broad ambitions and hopes.

Chairman: I presume the skill mix comes in to that.

Mr. Tony O'Brien: Absolutely.

Chairman: And premises.

Mr. Tony O'Brien: Both premises and skill mix come into it. Recognising what is currently a scarce commodity of experienced general practitioners, we need to look at how we can support general practitioners with other allied health professions in order to ensure that they can design processes which work optimally for the populations they are trying to serve. That will require the extraction of resources from the acute sector over time. It will require over time some reconfiguration of the acute sector so that some facilities that we currently regard as acute facilities effectively become primary care facilities. That will be difficult. Local communities may not necessarily be delighted with that.

In regard to the issue of agencies, the only reason the health service depends on agency staff currently is because of its inability to fill permanent posts. No health service manager, apart from in rare exceptional circumstances, wants to have a dependency on agency staff, either in medical or nursing. The Deputy will be aware that currently there is a real challenge in recruiting permanent staff notwithstanding our willingness to give permanent contracts. It is a major difficulty for us. Every conversion improves sustainability and quality and also improves the financial bottom line.

Deputy Louise O'Reilly: Mr. O'Brien does not need to convince me. I am already convinced. I just do not believe that Mr. O'Brien has any plan and I consequently cannot help but come to the conclusion that he has not prioritised the conversion of agency staff into directly employed staff. Mr. O'Brien is presiding over a health service that is a deeply unattractive place for health professionals and support staff to work in. He knows this because they leave the health service. The health service cannot recruit, attract or retain staff.

Chairman: In terms of a plan for converting agency staff to permanent staff-----

Deputy Louise O'Reilly: With targets.

Chairman: -----in both nursing and hospital consultants. We have figures on that.

Deputy Louise O'Reilly: It is right across the health service. It concerns support staff as well.

Chairman: They are two stand-out areas. At the moment, from the point of view of staff, it is much more lucrative to be an agency staff member than a permanent staff member. Does Mr. O'Brien have a plan to convert those posts?

Mr. Tony O'Brien: We are actively recruiting but we are doing so in a very difficult employment market which is not just a domestic market but also an international one. I mentioned earlier the number of recently qualified general practitioners who I see tweeting from Australia and Canada. I am also very much aware of the numbers of our own graduate student nurses who will inevitably seek employment off shore in our nearest neighbour and so on. There has always been a pattern of people adding to their skills and experience by going abroad for a period of time. The difficulty at present is that they are not being attracted back. Part of that is the economic reality. The salary situation and the take-home pay effect of gross salaries, which is very different to our nearest neighbours, is having a significant impact. Unfortunately, that then creates the situation where the staff that we have are working under increased pressure, which makes it even more difficult to persuade others to come and join them.

Chairman: Has Mr. O'Brien done any analysis on that?

Mr. Tony O'Brien: We have a considerable amount. We have shared quite a bit of data with the committee but we can share whatever else we have not shared. I refute the Deputy's point. There is no unwillingness or lack of desire to maximise the number of permanent contracted directly-employed staff versus agency staff. We cannot fill posts with staff that do not exist. We cannot allow services to be less safe by refusing to employ agency staff where we can get them. Even the employment of agency staff is becoming extremely difficult right now for all the same reasons.

Deputy Louise O'Reilly: When the IMO was before the committee, it pointed out to us that money ranked as number four in terms of the issues for doctors. It is not just about money. It cannot be reduced to that.

Chairman: It had surveyed its members to see the reasons why they were leaving Ireland. Has Mr. O'Brien done similar work in that regard? What efforts, if any, has he made to address those underlying reasons?

Mr. Tony O'Brien: We shared the Keane report - which we recently commissioned and received - on streamlining our processes and improving our potential around consultant recruitment with the committee. It is a similar situation with NCHDs. Through our national-----

Chairman: Streamlining recruitment processes is a different issue. We are talking about the reasons why nurses and doctors are leaving the Irish health service to go abroad. What research or analysis has the HSE done on the reasons they are leaving and what efforts has it made to address those reasons?

Mr. Tony O'Brien: I am happy to have our national director of human resources provide the committee with her report on that matter.

Chairman: Can Mr. O'Brien outline for us some of the work he is doing?

Mr. Liam Woods: Perhaps I can make some comment. At local level, hospitals undertake exit surveys so they have some awareness of the reasons. Some of the reasons are things Deputy O'Reilly referred to, such as the desire to travel among younger students and the nature of the work, which can be stressful at times. That has been reported and, in our dialogues with the INMO and our own staff, we are very aware of that. Income and the earnable net income have become a challenge. Opportunities for education and development are also an incentive and are desired by staff so the extent to which we provide that, which is quite extensive, is an attractor.

I will make a point on agency staff. The acute system reduced agency staff in gross terms by €39 million last year, so there has been some success at conversion. It continues to do that this year. We have had some success converting clinical agencies specifically. There is still a very high number of agency staff. It does not negate the discussion. We are making some progress.

Deputy Louise O'Reilly: There are no targets for that. Mr. O'Brien would be very quick to set targets for both accident and emergency department times and existing staff but there are no targets for this.

Chairman: We want to move on and complete the GP contract issue. What kind of timeline is the HSE working to? When does Mr. O'Brien expect negotiations to commence?

Mr. Tony O'Brien: There is currently a broad-based public consultation preceding the commencement of those negotiations. The intention is to get into negotiations very early in the New Year.

Chairman: We will move on to the next group of questioners.

Deputy Louise O'Reilly: My question on the full-capacity protocol was not addressed. I also want to correct a figure I gave. I said the figure for Tullamore hospital was 511 but it is 230.

Chairman: There are a lot of people looking to come in. Will Mr. O'Brien answer briefly on the full capacity protocol and children's mental health services?

Mr. Tony O'Brien: I was confused by the Deputy's question because it implied the hospital had activated it more than once every day.

Deputy Louise O'Reilly: No, the figure is 230 and 511 for the group.

Mr. Tony O'Brien: The Deputy knows what the full-capacity protocol is but, for the benefit of other members, it is a way of ensuring that when emergency departments become overheated that the problem is not contained in the emergency department but is shared across the hospital. It is certainly true that a number of hospitals have been close to or on full capacity protocol for much of the year. That is why they are included in a list of nine priority sites that we are seeking to address this year as part of the winter initiative. This is a symptom of a system that is too acute sector focused and is at the heart of the need to transform the system to a more primary care focused system. What the Deputy is saying is correct. I am not disagreeing with her in any respect but I am saying it is very much a symptom of the way the overall system is functioning, which is not as it needs to function in the future.

Deputy Louise O'Reilly: Does Mr. O'Brien agree that five days a week in Tullamore general hospital since January is not acceptable?

Mr. Tony O'Brien: I do not have those figures in front of me. I accept the Deputy's figures and clearly it is sub-optimal.

Chairman: Can Mr. O'Brien provide us with the figures for the number of occasions on which each hospital invoked the full-capacity protocol over the past year?

Mr. Tony O'Brien: Yes.

Chairman: We would appreciate that.

Mr. Tony O'Brien: We can do that. On the issue of mental health, clearly any period waiting for a vital mental health service is not what we want the health service to be able to provide. In providing a few examples of improvements, I am trying to strike a balance between recognising we have a long journey to make but also acknowledging the significant efforts of the staff who currently work in the system are making.

Chairman: The second question is on children's mental health services.

Deputy Kate O'Connell: The amount of waiting time has been reduced. Will Mr. O'Brien elaborate on that? From where to where has it been reduced and what would Mr. O'Brien see as ideal?

Mr. Tony O'Brien: I will get the exact data because I do not have it with me and I do not want to make a mistake. In an ideal world-----

Deputy Kate O'Connell: Does Mr. O'Brien have a ballpark figure? Have we cut it in half?

Mr. Tony O'Brien: We have cut it substantially but I do not want to give data off the top of my head.

Deputy Kate O'Connell: It seems strange that Mr. O'Brien would cite it as a positive in his opening statement if he does not actually know any-----

Mr. Tony O'Brien: I have given some specific data in the statement. Beyond that, I am not carrying the data with me and, therefore, I will not seek to give it to the Deputy.

Chairman: I ask Mr. O'Brien to provide it to us within the next week.

Deputy Hildegarde Naughton: I thank Mr. O'Brien for his opening statement. I will come back to some of the themes raised by my colleagues.

The restructuring fatigue issue was highlighted by Mr. O'Brien. That matter has come up a number of times with other witnesses who appeared before the committee. When the hospital groups came before us, they said although they are not perfect, they have changed patient pathways for the better but that issues arise with regard to resources, a lack of capacity and inpatient beds. Will Mr. O'Brien outline the steps the committee would need to take to ensure that we have a functioning group system throughout the country? All of the hospitals in the Saolta hospital group in the west are HSE-run hospitals, which is a completely different scenario to what is happening in the east, which has voluntary hospitals. There are challenges in this regard. For us to come forward with a report that works for the health service in Ireland over the next ten years and to have the most effective health system in the short, medium and long term, we need to be able to deal with these challenges if we are seriously looking at a non-restructuring solution or, at least, trying to minimise restructuring. Will Mr. O'Brien go through the steps that need to happen for an effective group system?

Will Mr. O'Brien spell out the link between the acute hospital system and community care?

Who will be responsible for oversight of the step-down facilities required when someone needs to leave hospital when their care comes to an end and they need to go to a step-down facility or a nursing home? What is the governance structure between the hospitals and our primary care centres? Mr. O'Brien needs to elaborate on this.

Mr. O'Brien made reference to acute hospital beds and said that simply increasing their number is not the easy solution. He made reference to the importance of community care and step-down facilities. We are all in agreement that if we had properly functioning community care and primary care centres it would alleviate bed capacity issues in our hospital system. The clinical director of the Saolta group, Dr. Pat Nash, came before the committee. The group stated University Hospital Galway, which is a centre of excellence model 4 hospital for seven counties, is not fit for purpose and cannot expand due to physical space issues. Even if we had functioning community care, we would still need extra bed capacity. The group made reference to the need for a new hospital at Merlin Park on State-owned land. What are Mr. O'Brien's views on this? Improvements in the ability to treat people and medicines mean that we will have an ageing population and that there will be a great need for acute hospitals. We will still have very sick people who will need to go into hospital. Does Mr. O'Brien agree that we need an independent assessment of bed capacity in Ireland? By this I mean independent of the HSE.

Deputy John Brassil: I thank Mr. O'Brien for coming before the committee and for his presentation. He also came before the committee at the start of this process. I am now a hell of a lot more knowledgeable of the system then I was back then and it is very beneficial to have Mr. O'Brien before the committee again. We are focusing on number of areas we see as critical for our report to give the health system an opportunity to succeed.

An issue that keeps arising is the lack of accountability throughout the entire HSE. I will ask Mr. O'Brien a very direct question. In the structures under which he operates, can he bring about accountability? Is the system so far gone that it is impossible for him to do so? What would make it possible? If we do not have accountability in health system we will not solve the problems. This theme has arisen with group after group which has come before the committee over the past four or five months. Is it possible for Mr. O'Brien to do the job he was employed to do in the current circumstances? Do we need to introduce legislation or changes to allow him fulfil his role? For how long has Mr. O'Brien been in his current position?

Mr. Tony O'Brien: Four years.

Deputy John Brassil: In his responses to the questions we sent him on recruitment, Mr. O'Brien stated the HSE is looking for a chief operations officer and a chief strategy and planning officer, and he provided a list of other changes he would like to bring about. He states that both roles mentioned will be filled as soon as is practicable. This is of concern to me. Why is it so difficult to get people in place for such critical roles? The HSE should go about recruiting for a particular critical role and appoint a group to advertise and interview, or do this internally. A working group should be established to acquire these individuals, a timeline should be set and they should be appointed. To state that the positions will be filled as soon as practicable is too open. I would much prefer to see a statement that these roles will be filled by the first quarter of 2017. This would create a target for which somebody would be accountable. If the person is in place, that would be great. If, however, he or she is not, we could ask why that is the case.

I agree with Mr. O'Brien that it is very difficult for anybody to make an assumption on whether the hospital groups are working if they are not working optimally. The seven hospital groups came before the committee. I was very impressed by the set-up in the mid-west and felt

it is working quite well because of the structures in place. It carries out routine procedures in its category 2 hospitals, which frees up capacity in its category 3 hospitals. I thought this was a very simple way to do business which improves efficiency. The next obvious question is why this does not happen in all of the other groups. It should be happening and we should make it happen.

I asked each hospital group whether it recruits as group or individually and I received different answers from the various groups. Recruiting as a group should be the only way it is done. To go back to the area I know best, which is Kerry, it is extremely difficult for Kerry University Hospital to recruit but it is not as difficult for Cork University Hospital. If the group recruited, the doctors, nurses and consultants could be assigned so there would be no cherry-picking by people who want to go to where all the activity is. We would have much more successful outcomes. This system exists in the mid-west where recruitment is done by the group, but the latter is not done in the area from which I come. It should be compulsory. Again I return to the question of whether it is possible to make this happen. Mr. O'Brien mentioned the success of acute stroke units. There is no acute stroke unit in Kerry University Hospital, a category 3 hospital. There is no cardiologist in the hospital. It depends on a phone call up and down from Cork once a week. These are structural issues that can be addressed if tackled properly. The people in Kerry to whom I speak say the people in Cork, if they are of a sympathetic mind, might come down and help us but, if they are not, there is nothing we can do about it. The cost of recruiting staff through agencies is three times that of recruiting staff directly. If a group recruitment system were in place whereby staff were sent to the less attractive areas, this issue would be solved and the less attractive areas would become more attractive with the increased staffing. One problem solves another.

Regarding the shift to primary care, do the witnesses have any figures or data as to what kind of investment is needed in primary care to make it work and subsequently take the pressure off the hospital system down the line? From the first day this committee met, the message of investing in primary care to help solve the issues further up the line has been coming across. Mr. O'Brien mentioned the New York model. New York had a specific savings target and investment budget. Do we have anything like that? If not, we should seek it. If we know what to invest in with a degree of - I will not say certainty - hope that if the work is done, significant moneys will be saved further down the line in the hospital system, then it is worth investing in it. Do the witnesses have any figures that would help us in this area?

Mr. O'Brien mentioned IT although he said he would not spend much time discussing it. It comes across to us that IT is one of the most important areas in which to invest to allow savings to be made and the system to run efficiently. Do the witnesses have any figures as to the amount of money needed to invest in IT to get us to where we want to be? This is critical.

Regarding Mr. O'Brien's issue with 12-month budgets, I do not know of any organisation that does not operate according to such budgets. The whole country operates this way. By what system does Mr. O'Brien suggest we operate? What different model could we consider? Nearly every organisation I know works according to an annual budget. What would Mr. O'Brien like to see done differently to this to help the HSE do its job?

Chairman: For the benefit of members, and following on from Deputy Brassil's question about vacancies at senior management level, I draw the committee's attention to the document we circulated which contains responses that came in to this question. On page 6 of the document there is a management structure diagram. Below the level of director general, DG, there are three senior posts, two of which are vacant at the moment. Are these newly-created posts?

Mr. Tony O'Brien: In effect, one of them is kind of a recycled post, but yes, they are to be newly filled. I can give the Chairman a full-----

Chairman: It strikes me that the HSE has commenced a restructuring programme of its own in this regard because it is quite different to the original structure.

Deputy Michael Harty: I thank Mr. O'Brien, Mr. Woods and Mr. Mitchell for coming before the committee again to see us. I will try to be brief in my comments and questions. The terms of reference of this committee are to provide a single-tier system that provides services in a timely manner based on need rather than ability to pay, which effectively means patient-centred care. In our planning, patient-centred care tends to be forgotten about, unlike structures and governance. My questions therefore concern patient-centred care.

First, what do the witnesses think will trigger the transfer from hospital-centred care to primary-centred care? We have a capacity problem in general practice but also with public health nurses, therapists and psychologists. A range of personnel make up primary care, not just general practitioners.

Second, Mr. O'Brien mentioned transitional funding, which seems to be absolutely essential in any transformation programme. How would such transitional funding be targeted?

Third, there is a problem with integration of GP and hospital services and there is a gap between the two. The trigger of the transfer of people from general practice to hospital services tends to be immediate. There is no transition between hospital and GP services. I would like Mr. O'Brien to comment on how this transition could be filled.

There is a problem with governance in our hospitals and within the hospital groups, and there is very little GP input into governance in the hospital groups, which leads to much frustration among general practitioners. There is also very deep frustration among consultants in the hospital groups that their voice is not heard. There is a gap in the governance between what it is intended to do and how it is delivered.

Finally, regarding bed capacity, I believe 600 beds are occupied by people who are on delayed discharges. This is a huge rate of bed occupancy which does not fulfil an acute need. Perhaps Mr. O'Brien could comment on how delayed discharges and transfer to community services could be bridged. There has been a huge withdrawal of or reduction in publicly-funded chronic care, which has been transferred to privately-funded chronic care, and the gap in this regard needs to be addressed. Publicly-funded chronic care is very important but seems to be decreasing rather than increasing.

Mr. Tony O'Brien: I will respond to Deputy Brassil's questions first, if I may. I was appointed as acting CEO in 2012 and became the director general in 2013 on the passage of the legislation that created those changes. By this stage, if the statements of the time were to be believed, the HSE would not exist. It was my expectation at that time that many of the changes we are discussing around hospital groups would be much more advanced than they currently are. The intention was that each hospital group would have a board appointed to it on an administrative basis, that is, without legislation, and that legislation would follow to create those hospital groups as legal entities. As we know, that has not happened.

At a certain point during my time in the HSE, it appointed boards to two of the hospital groups, namely, mid-west and what we now call Saolta. General practice was well represented on both boards, as were other local and relevant interests. Unfortunately, the process of ap-

pointing other boards has not progressed, although the Minister is currently progressing it and, as recently as last week, on a ministerial basis, appointed or reappointed a board for the mid-west hospital group and is progressively intending to do so for all the other hospital groups.

Chairman: Mr. O'Brien said primary care was represented. How was it represented?

Mr. Tony O'Brien: In both cases a general practitioner from the region was a member of the boards that the HSE appointed, for Saolta and for the mid-west.

Chairman: That person did not have any management role, though.

Mr. Tony O'Brien: No, they were board members.

Chairman: Yes, but in terms of the delivery of primary care through the CHOs, they did not have any decision-making role.

Mr. Tony O'Brien: No, they were leading figures in general practice in the relevant regions. They were non-executive members of a non-executive board.

Chairman: They were GPs.

Mr. Tony O'Brien: Both were GPs.

Deputy John Brassil: There are two hospital groups to which boards have been appointed and five to which none has yet been appointed. In the case of the former, did this just happen because the HSE decided to proceed and form a board-----

Mr. Tony O'Brien: The HSE appointed the boards but was asked not to appoint the remaining boards so that Government could do so. The exception is the Children's Hospital Group, which has a ministerial appointed board. The Children's Hospital Group is in a slightly different position for a variety of reasons. In terms of the six acute hospital groups, two had boards and four did not.

In addition, the process of appointing chief executives for those hospital groups is difficult. The level of interest in those roles was small and the potential to recruit outside of our system or to attract any international interest was adversely affected by the level of remuneration, which was not competitive in terms of those fulfilling similar roles in other jurisdictions. Ultimately, at my request and that of Mr. Woods and his predecessor, the brightest of our own staff were prepared to stand forward and take up those roles. The chief executives we currently have in place were appointed on an interim basis outside of the recruitment process simply because those recruitment processes carried out by the Public Appointments Services had not been successful. That having been said, and the committee having met them all, they are all doing pretty good jobs and making a good contribution.

On the two posts the Deputy asked me about, I used the term as soon as practicable because, contrary to what one might expect, I have very little control over those processes. When the post of deputy director general fell vacant this time last year I commenced a process of seeking the necessary approvals to refill that post and to create the additional post. That led to provisional approval in August which enabled me to engage in the dialogue I needed to engage in with the others who were affected, which included the issue of the communication the Deputy has there. We then had to get into a further process which required the individual job specifications to be signed off, not only by myself and the Department of Health but also by the Department of Public Expenditure and Reform, before we could invite the Public Appointments Service to

proceed with the recruitment process. That is why I was ambiguous about the deadline. I can tell the Deputy, however, that the Public Appointments Service has kicked off that process and we expect to have the individuals in post in the first quarter of 2017. I do not have the level of control over timetabling that one might imagine.

Deputy John Brassil: That goes back to my question as to whether Mr. O'Brien can do the job that he was appointed to do. It would seem, even from the answer on that one issue of some critical positions that need to be filled, by Mr. O'Brien's own admission, it is outside of his control.

Mr. Tony O'Brien: The way the public system is structured in Ireland is particular. Contrary to what might be expected, the head of a public service organisation - this relates to the conversation on Deputy Kelleher's questions about future trusts - does not have control in the formal sense over the numbers of staff that an organisation is able to employ, their rates of remuneration or, ultimately, above a certain grade, the blend of structure of his or her management team where he or she requires levels of approval which go beyond his or her parent Department or the Department under whose aegis he or she operates to the Department of Public Expenditure and Reform, and those processes take a little while. Ultimately, the Public Appointments Service is responsible for carrying out the campaign and it will do so efficiently and effectively, but at the point at which I was telling the management team - which was what that communication was - that this was to happen, which I needed to do in order to involve it in some of the process, I could not be specific about the timetable because I did not have control over when those approvals would come and I used ambiguous language.

Chairman: Is it true to say that Mr. O'Brien is undertaking his own restructuring here because this diagram is very different to the original diagram that was in place when Mr. O'Brien took office?

Mr. Tony O'Brien: When I took office, I was in charge of what was to be a transitional change-oriented HSE for, essentially, a three-year period. When it became clear that I am expected not simply to see through change but to manage the existing system in the long term, when the vacancy arose it was clear looking at any other health system, and irrespective of whatever fundamental decisions would be made, there needs to be a divergence or complementarity between strategy and planning on the one hand and operational management on the other.

Chairman: I am merely making the point that Mr. O'Brien himself is engaging in a restructuring-----

Mr. Tony O'Brien: I would not call it a restructuring.

Chairman: -----in terms of the management team.

Mr. Tony O'Brien: I am reorganising some roles and responsibilities but I am not fundamentally changing structures.

On the issue of beds and acute hospital beds on which I will ask Mr. Woods to say more, there is to be a bed capacity review carried out, not by the HSE but by the Department of Health. In our submissions to the Department when this was being mentioned as part of the Government formation process, our central point was that this should not be an acute bed review; it should be a total bed review taking into account long-term care beds as well rather than only acute hospital beds.

I touched on the governance issues around hospital groups. The delay in the appointment of boards has led to some ambiguity in the sense that we have groups which, by general public comment, are intended to have various operating freedoms but the reality is that the directorate of the HSE remains fully accountable for them and the legal authority that they have currently is through the delegation structure set out in the 2004 Act. I receive a delegation from the directorate and Mr. Wood receives a delegation from me and he parcels that out to the seven group chief executives and their authority is very much HSE authority, but, as was said, there are very different mixtures of underpinning governance in the different hospital groups. Saolta and the mid-west group, with the exception of St. John's, are essentially statutory hospitals where the governance is simple in that sense in that we can give full authority to an individual and state something is his or hers and he or she is accountable for it. In hospital groups which have a mixture of statutory hospitals and voluntary hospitals and the level of control of the group chief executive is through ownership of the budget and the service level arrangement with the voluntary hospitals, that is of a different quality. Obviously, we have had to take the view that we work with the raw material we have. There is no policy direction currently as to what way that will ultimately be resolved and the HSE does not have a position or has not taken a position, one way or the other. In other words, we are not saying they should all be statutory and we are not saying they should all become voluntary. We are saying all these groups are slightly different and there may have to be an eclectic set of arrangements, provided they are effective, clear and straightforward in relation to each group. We are not saying they all have to be exactly the same. There is a diversity in the health system. That is the way it developed. Some of that diversity has been good and some of it not so good. Mr. Woods will address the issue of Saolta and beds, etc.

Mr. Liam Woods: Deputy Brassil asked specific questions about numbers of beds. The Deputy is correct in saying that some hospitals are running at capacity and do not, for example, as referred to by Deputy Harty, have significant delayed discharges. In the context of Galway, there is good access to community services, there are relatively few patients clinically appropriate for discharge who cannot be discharged and the hospital is in that sense running at high capacity. Galway is putting in a 75-bed block which will open in February next and that is replacing existing capacity. We are looking at proposals to see can we also then retain another 30 beds because we see a need in Galway for increased capacity. Those 30 beds would be available within the existing facility and would require some upgrade.

Deputy Brassil mentioned that Dr. Pat Nash had referred to the Merlin Park site as a potential location. In many ways, in Galway it has long been thought that Merlin Park - even parking on the campus in Galway would indicate that it is difficult and challenging - would be a suitable site for another hospital over time. It has not happened yet. Some services, as part of the group's overall service design, are moving to Merlin Park.

Mr. O'Brien addressed the independence issue. On the notion of an independent review, it is already determined to be so. HSE has data that would help inform that but the review itself would be independent.

The Deputy asked how groups could work effectively if there were no restructuring, if I understood the question. In a way, where we see it working well is that there is a strong view of what the appropriate clinical pathways are and that they are adhered to. There are some examples of that working well, for instance, in neurology. I am not sure if Dr. Colin Doherty from St. James's was here but we were at the Joint Committee on Health recently. There is a model working which is connecting GPs, patients and neurologists, freeing up space in St. James's,

providing better care for patients, and linking effectively with GPs and speedily providing GPs with advice online. On the idea of enablement through technology to manage care transitions, there will always be transitions between care locations independent of the structure. The management of those transitions, and the use of technology in that context, is really important.

Chairman: Can Mr. Woods comment on the need for an independent assessment of bed capacity?

Mr. Liam Woods: As that is in the Government programme, the Department of Health is committed to delivering it.

Chairman: Would Mr. Woods agree that it is required?

Mr. Liam Woods: Yes. It is committed to. Obviously, it is a matter that the Government has already determined. We can provide data for that, but it will be done externally.

Deputy Hildegarde Naughton: Who is in charge of the step-down services? Should the groups be managing the link between the primary care unit and the hospital if they had the power to do so? Is that what Mr. Woods is saying? I appreciate that University Hospital Galway has a low rate of overnight stays. I suppose that is a compliment to the hospital authorities. They are managing the capacity issue very well. Who has specific responsibility for the link between the community and the hospital? Are the groups responsible for it?

Mr. Liam Woods: At the moment-----

Deputy Hildegarde Naughton: How is it currently working?

Mr. Liam Woods: As the Deputy rightly understands, the community services are responsible for home help and home care packages and for nursing homes under the fair deal arrangements. Hospitals provide hospital services. There is a connectivity between the hospital and the community when people who are fit for discharge are discharged. This needs to be very effective to ensure there is a smooth transition of payments from hospitals to the community. It works well in Galway.

Deputy Hildegarde Naughton: Is there a single person in charge of and accountable for that? I think this is a challenge across the country. We need accountability and governance.

Mr. Liam Woods: It depends-----

Deputy Hildegarde Naughton: Who is that person? How does it work? Is there any complete and uniform system across the country? Is it an *ad hoc* system depending on where one is going?

Mr. Liam Woods: No.

Deputy Hildegarde Naughton: Are different people in different hospitals and community settings making these decisions?

Mr. Liam Woods: There are people in the hospitals who have a discharge planning and bed management roles. Social workers would perform this role in University Hospital Galway. When patients are returning home, it is organised in connection with community services. This is done by Tony Canavan and his team in Galway. The rules governing movements to nursing homes are prescribed under legislation. The fair deal process comes into operation when

people are in hospitals to oversee their potential transfer to nursing homes. Approximately 60% of those who avail of the fair deal process go from community settings to nursing homes, rather than from hospitals to nursing homes. There are people within the hospitals who have dedicated responsibility for that. They work with the community services. Capacity on the nursing home side in the west is more likely to be owned by the HSE, but the community services identify spaces. There is a bed bureau in place in the north city area of Dublin. Community services advise hospitals of where the spaces are to ensure there is quick movement.

Deputy Hildegarde Naughton: There needs to a better management structure.

Mr. Liam Woods: Yes. Technology could be used to enable it to be more effective. The management of it is a key point of focus for us. There is an active focus on winter planning right now. I am working hand in glove with Mr. Pat Healy, who is the HSE national director of social care, to ensure this works smoothly around the country.

Chairman: Much of what Mr. Woods has said is theoretical. Deputy Harty said "600 beds are occupied by people who are on delayed discharges". The kind of transfer or integration about which Mr. Woods has spoken is not happening throughout the country.

Mr. Tony O'Brien: Integration is not fundamentally the issue. The number was 649 a couple of months ago. I suspect it will be approximately 540 when the weekly census is published today. At any point in time, a number of people will be in this category. That number is too high. Sometimes we hear the argument that it would be better if this were controlled from hospitals or from the community. The net problem is that regardless of who is in control, there are limits on total supply and total capacity. It is for that reason I mentioned in my opening remarks the issue of making non-fair deal as demand-led as fair deal is. If the hospitals controlled it, they would ultimately have exactly the same capacity and the same budget that the communities have now. I would be concerned that this would turn the hospitals into magnets for access to home care. In the past, for various reasons we have sought to prioritise egress from hospitals. This has had the effect of leading to blockages in the community. This has meant that the route to get to home care has been through the hospital. This has had a perverse effect.

Chairman: I will allow Deputy Naughton to make a final point. Other members are waiting to come in.

Deputy Hildegarde Naughton: I want to make a point about the vision, the plan and the management for University Hospital Galway as a centre of excellence. Clinical directors have said here that a plan for a new hospital is needed. The suggestion we have heard that old wards will be opened on a congested site shows a lack of vision, in my view, from the HSE and the Department with regard to the needs of the 800,000 people who live in the hospital's catchment area. This is just one example of where we need governance and management structures and groups that work and are effective.

Mr. Tony O'Brien: The Government decision-----

Chairman: Sorry. We need to move on because other people are waiting to speak. I ask Mr. O'Brien and Mr. Woods to address the specific issue of recruitment within groups and the question of transitional funding as activity is shifted to primary care.

Mr. Liam Woods: Some observations have been made about group-level recruitment. This is probably relevant to the point made by Deputy Brassil about the assignment of individuals across locations within a group to provide care on multiple sites during the training phase or in

permanent employment. The groups are focused on the latter aspect of this issue. I will come to the actual recruitment mechanisms in a moment. Joint appointment across sites is happening and we will see more of that. I think we will be increasingly dependent on rotation from larger to smaller sites to maintain appropriate staff levels and the right kind of clinical input, which is a point that has been mentioned. This is part of group planning. We can give the committee documentation on the recruitment process itself. Voluntary hospitals tend to recruit for themselves. Approximately half of the total acute service resource is in voluntary hospitals. The statutory hospitals recruit through the national recruitment service. Truly national campaigns are sometimes run. A recent campaign to recruit emergency department nurses asked for applications to all points. The recruitment service will support somewhere like Limerick in running its own competitions locally. It does the same in Galway. Local units are supported in running competitions. There can be back-end administration around Garda clearance and contracting that does not necessarily exist on every site. The interviewing and the creation of competitions is done locally.

Chairman: Deputy Harty raised the question of what would trigger a transfer of activity and also asked about the possibility of a transitional fund.

Mr. Tony O'Brien: The questions are linked. I mentioned DSRIP earlier as an example because I do not believe, given the current pressures on the hospital system and the amount of work that is waiting outside the doors of the hospital system, that we can expect any time soon to be able to extract the type of funding from hospitals that is necessary to develop the primary care system to the point where it is viable to do that. I believe it is going to be necessary to pump investment into primary care so that the transition can take place. The negotiations on the GP contract are central to our understanding and conceptualising of that. Just before the economic implosion, efforts were made to remove funding arbitrarily from the hospitals and invest it in primary care. The net effect of this was that the hospitals went into meltdown and all of this was unwound in the course of a year. I think the concept of transitional funding is absolutely central to whatever it is the committee ultimately recommends, or whatever it is that any one of us would like to see by way of transformation in the health system. DSRIP is just one example, but it appears to be a very successful example. I shared a book with the committee earlier that gives details of some other examples in other parts of the world that may be of help.

A couple of Deputies have referred to the governance issue. I sit here in a very unusual position. I occupy a job which, as the Chairman will know, I did not actually apply for. I am both the chief executive and the chairman of the largest organisation in the State, bar none. I took up this position in the expectation that I would probably have it for a shorter period than I have had it for to date. At some point, when there is a settled view about hospital groups and so on, there will need to be legislation so that accountability rests where authority lies, which is not the case at present. I would not wish to see a legislative revision of the health service that does not address the fact that we have one person operating as chairman and chief executive of the largest organisation in the State. It is a very uncomfortable position to be in, as I know the Chairman is aware. This brings me back to the issue of accountability. This year we introduced a new accountability framework for all of those who hold budgets within the system. It has been effective. It has been difficult to do that in the past because - not to put a tooth on it - we have entered a number of years - probably five years of service planning - where everyone has known that the level of funding provided was not equal to the level of service committed to. That recurrent supplementary funding of €500 million or €750 million has had to be provided is evidence of this. In the current year, the Oireachtas voted a revised budget - not a supplementary budget - which was able to bring that cycle to an end. This enabled us to say to all the

budget holders across all of their domains that they can no longer simply say the job is undoable. That has a fundamental impact on the psychology of accountability. I also believe that just as clinicians, nurses and other professionals are accountable for professional standards to professional bodies, we need to recognise that management, administration and leadership in the health system, where it is provided by people who are not members of those professions, should be similarly regulated to prescribed professional standards so that we have an equal playing field in the health care setting. Without it, we are not valuing that discipline in health care to the extent that we should and we are not providing equal accountability.

Chairman: There are major corporate governance issues which were flagged at the time, which remain and need to be addressed. I will bring in the final three speakers, Deputies Madigan, Browne and Barry.

Deputy Josepha Madigan: I thank Mr. O'Brien and Mr. Woods for their presence today. The previous time I met Mr. O'Brien was at the Committee of Public Accounts but he will be glad to hear there will not be the same level of grilling. I welcome the fact there is an accountability framework in place. That was a separate issue in respect of contracts. Notwithstanding the remit of this committee, it is still in the abstract and at present we have to deal with what we have. There is an onus to operate the HSE in the best way possible. I welcome the fact Mr. O'Brien is avidly recruiting.

Does the Keane report, which was mentioned earlier, specifically deal with the retention of staff? Morale is very low and I wonder what plans the HSE has to address staff morale? We have to deal with the here and now and retaining staff is more difficult than recruiting staff. Will he outline his views and suggest a solution?

In his opening statement, Mr. O'Brien mentions multi-morbidity. Does the HSE have a long-term strategy to address that, to examine the change in demographics to see what solutions it has and if there will be a significant cost to the taxpayer on account of that?

Deputy Brassil mentioned IT in regard to health records. What level of investment is required to create electronic health records and how has it progressed?

Chairman: I thank Deputy Madigan. Her brevity is noted with thanks.

Deputy James Browne: I have a number of questions. It was announced in the budget that €35 million would be allocated for mental health services but we found out later that only €15 million would be available to be spent. The reason given by the Department of Health was that it was not possible to spend the other €20 million. Is that a decision of the HSE? Does the HSE stand over that, that is, there is no where to spend €20 million on mental health services, if it had that additional amount this year? When is it expected that the HSE service plan will be delivered?

A motion was passed two weeks ago that stated that any unspent money allocated to mental health would be retained year on year. Has that been communicated to the HSE? Is Mr. O'Brien confident that the €15 million that has been allocated to the HSE will be drawn down and spent on mental health in this 12 months?

Let me describe the morass of trying to get information. I had two people online this week trying to find out the geographic areas of the 14 mental health teams. I went online and spent all day Saturday and Sunday doing research on mental health. It was impossible to find out online where the 14 mental health teams were. This committee has allied health profession-

als, trade union professionals, lawyers and yet six months into this process, we are still finding new layers of structures in the HSE. It is impossible to find out how the system actually works. One example is from the HSE website. If one looks up mental health services, one will see that information is only provided for one area, Limerick, north Tipperary and Clare. If one lives outside those areas, one will not find out anything about the services. The page on infant mental health is blank. There is another page on mental health services in one's area, but it only is corporate waffle. There is a link to more corporate waffle and then it links back to the first page. It is a loop and one cannot find out the structures of the health services in the country. To find out the health services available, one would think that by putting in one's eircode, the website would bring one to the services in that area. Instead, professional researchers cannot find out the information.

Currently the Corporate Manslaughter (No. 2) Bill 2016 is going through the Seanad. When a similar Bill was enacted in the UK, it dramatically changed accountability in the NHS. Is this Bill on the radar of the HSE? Is Mr. O'Brien preparing for the very serious decisions that will fall from it? One of the issues with the HSE is the lack of delineation of people's roles in it. I often find that one gets a commitment from a manager and when the manager moves on, the new manager will say it has nothing to do with him or her. Under the Corporate Manslaughter (No. 2) Bill, management churn would no longer allow staff movement to effectively negative the decision, or the lack of decision-making.

The leader of the mid-west hospital group states she would have no difficulty giving money from her budget to the community. That is because of the incentive. If she transfers money to primary care facilities, they can keep people out of hospital, which drives down the waiting lists. The primary care managers then know they can get people into the hospitals quicker. There is an incentive.

One point that keeps coming up week after week is the perverse incentives in the health care system to encourage people to simply waste money. I have heard the arguments about the different alignments for hospital groups and community health organisations. Let us look at the services in County Wexford. If one has mental health issues in north Wexford, one goes to Wicklow while if one is in south Wexford, one goes to Waterford. We are in the Ireland East Hospitals Group but the county councillors sit on the health committee for the southern group. It is just all over the place. The Wexford manager must be driven demented going from one area to another trying to co-ordinate everything.

Chairman: We all share the frustrations that have been articulated so well by Deputy Browne in terms of Deputies navigating the system, let alone the patients.

Deputy Mick Barry: I have two questions. Our data show that we are doing more emergency and fewer elective procedures each year. If these trends continue all work will be emergency work and we will be unable to accommodate elective work. When do we reach that point? Will Mr. O'Brien indicate whether it will be next year or in five to ten years' time?

I am concerned about the amount of money available between 2017 and 2021 in the capital space to pay for our ambulances, X-ray machines and MRI scanning equipment? The €2.25 billion, however, does not meet the €3.64 billion that is required in order to meet the long list of priority replacements so we have an immediate problem. If there is no additional funding, can Mr. O'Brien give an indication of how that plays out? Will funding be provided for years one to three - 2017 to 2019, inclusive - and then one hits a cliff or is the budget stretched over five years and the problems start kicking in during 2017? Will Mr. O'Brien give the committee

a flavour of the situation?

Chairman: I thank Deputy Barry. I call on Mr. O'Brien to respond.

Mr. Tony O'Brien: I thank the Chairman. I will begin with the more straightforward questions from Deputy Browne. The service plan was approved by the HSE directorate in draft form last Thursday and submitted to the Department of Health on Friday. Under legislation the Minister has 21 days to consider that plan. He does not have to take the full 21 days, so I would expect that within the 21 days the plan will either be approved, rejected or amended, whatever the process is. The normal process is that within a day or so of its approval, it gets published.

In respect of the mental health allocation of €35 million versus €15 million, this is in my view an application of reality. When the development of services is being prioritised, as is being done by that money, and that development is predicated on the recruitment and deployment of staff, as we enter a year and begin the process of recruitment, we need to know that in the second year we will have the full year cost and that we can pay the wages for the full year. There is, however, the reality that with the approval of the budget in November or October or a service plan in December, one will not be able to spend that full year cost in year one. That has been the pattern in recent years. The formula arrived at is that sufficient funding would be made available in 2017 to fund full year expenditure of €35 million in 2018. Experience indicates that this is about the right approach. It is our approach to retain any unspent moneys where they are unspent, which includes mental health. I believe that the €15 million that is allocated and which will be addressed in the service plan when published will be appropriately expended in 2017 on mental health.

With regard to structures, I acknowledge that there is an issue with the website. It is not a good website, but there is a national information line on 1850 241 850, from 8 a.m. until 8 p.m. Monday to Saturday, where staff are available to answer such inquiries. As of last week a new live chat feature was introduced on the website which gets through to the same people. We recognise that it is not always the easiest website to navigate and that this is more of a problem with the website than it is with the services. Nonetheless, it needs to be addressed.

Reference was made to a mismatch with the health fora. The community healthcare organisations' report makes clear that they were structured in a way that would align well with the regional assemblies, which were priority policy at that time, and with an expectation - not our decision, of course - that at a future point the health fora would be realigned to those regional assembly boundaries. That speaks to one of the mismatches identified by the committee.

As to when we would run out of elective capacity and the issue of our approach to the multimobility, I will ask my colleague Mr. Woods to address that and then I will come back to the other points.

Mr. Liam Woods: I will take Deputy Barry's question on elective capacity. The HSE undertakes about 94,000 elective inpatient cases per year. In total, the HSE does 1.6 million cases per year. The elective capacity is reducing at around 1,000 to 1,500 per year and it is being replaced by a greater volume of emergency work, and day case volume is growing. That is the trend within the data on what is happening in the current service provision. There was a question about multi-----

Chairman: The specific question was around when we are likely to get to a real crisis point.

Mr. Liam Woods: I would suggest we are already facing a very significant challenge.

Whether we could call it a crisis or not, our capacity to do scheduled care does not match the rate at which we take on people seeking scheduled care. That is a big problem. Some of the things we have already discussed potentially address that in refocusing towards primary care. At the moment, however, we have seen up to a 15% increase in referral from primary care to some specialties since January. We have seen a 5% increase in referrals from community to emergency departments in the current year. To some extent it would be speculating as to what the future rates would be, but certainly we are seeing those kinds of trends. We had 1.3 million attendances at accident and emergency departments per annum, which are up 5%. GPs see about 25 million-----

Chairman: What is the underlying reason for that? Is the increase due to an absence of appropriate services such as out of hours or at community level?

Mr. Liam Woods: We are doing research on that to look at the trends. The commentary that we have shows there is a significant increase in out-of-hours work which is up 11% in the current year in the GP space. That has a higher propensity to give rise to hospital referrals. I would emphasise that only about half of our total attendances at accident and emergency departments first see a GP. Many people are self-referring, are walk-in and are not going the GP route. There are multiple factors there. It could be pressure in the GP environment but also a higher level in the community of people who are self-presenting to hospital. Those are the kinds of drivers for the increase.

Our current capacity is a concern for us and it is a key focus towards the end of this year to try to address some of the longer waiters. Our current capacity in terms of delivering scheduled care is challenged. The committee would have heard some of the hospital groups say they are trying to create dedicated elective space, to protect some space from emergency take, to allow for the rational doing of work on a surgical basis such as day surgery units, for example, on stand-alone sites, and that is happening at the moment.

There was a question on multiple co-morbidities. There is a plan for frail elderly management which is to deal with that issue. There is investment in this, with a number of other programmes in chronic condition management, of about €9 million to do some pilots this year and next year. The plan itself has been documented by Dr. Siobhán Kennelly who is a geriatrician in Connolly Hospital. That would involve moving resources and has involved nurses and geriatricians moving into the community, attending at nursing homes, particularly private nursing homes where there may be limited or no service available, and looking to see to what extent they can reduce presentation at accident and emergency departments resulting from infection or fairly simple health care needs. That plan has started at the moment and work is undertaken in some hospitals. St James's Hospital did some very specific work in addressing the needs of frail elderly last year, and very successfully. There is other work under way specifically in areas such as COPD and cardiology where there are relatively significant numbers attending emergency departments that are potentially avoidable and could be treated in the community, with some support. There is investment going into those areas, but as the discussion here has flagged, it will need to be much greater in the future.

Chairman: What about the Keane report?

Mr. Tony O'Brien: The Keane report, which was circulated to the committee, is primarily around the recruitment of consultants. Retention is an issue for each of the hospital groups. I should have said this in response to the earlier question. One of the primary objectives is to develop a strategic plan for the way services are distributed throughout those groups. There is

guidance issued from the Department of Health relating to each of those. That work has not progressed at the speed originally intended. Some of the issues around retention and recruitment are the way services are distributed across hospitals, the way rotas are structured and, for non-consultant hospital doctors, the extent of Ireland's compliance with the European working time directive. In the past two years we instituted the introduction into every hospital of a lead non-consultant hospital doctor, a bit like one would see in American television programmes of a lead resident or a chief resident, to represent the interests of non-consultant hospital doctors in the management process of the hospitals to ensure their situation is dealt with better.

Deputy Josepha Madigan: I apologise but I have to go to the Dáil Chamber for 12 noon as a Government Deputy.

Mr. Tony O'Brien: I will send Deputy Madigan a written note in answer to her question.

Deputy Josepha Madigan: I thank Mr. O'Brien.

Mr. Tony O'Brien: Reference was made to health records. Ireland is really late to the party on joined-up health records. A decade of not just underinvestment but pretty much no investment in some of our platform systems has resulted in that. As in some other spaces, however, that means we are not in the difficult position of having to rip out recently invested systems. We do not have that legacy systems problem. Two weeks ago I signed the memorandum of agreement with the Department of Social Protection which will allow us to roll out the individual health identifier. This will be rolled out in 2018. The electronic health record business case is under consideration. This will be quite transformative in terms of the systems base which will overcome whatever residual deficiencies in structures there will be at any stage in the future because there will always be some individual-----

Chairman: With all due respect, we have been talking about electronic health records for years.

Mr. Tony O'Brien: We are actually going to do it now.

Mr. Liam Woods: As an observation-----

Chairman: Convince us, please. What sort of timescale is the HSE working towards and is it funded?

Mr. Liam Woods: I would like to convince the Chairman on one aspect of it, if I may. The maternal and infant electronic health record will go live over the weekend as a first instance in Cork and, I believe, in Tralee. This is an electronic health record for mothers and infants, which is a significant success. We have already done significant implementation on the national integrated medical imaging system, NIMIS. It is in 38 sites throughout the State. We are undertaking a programme of work around the national medical laboratory information system, MEDLIS, which is laboratory implementation. To join that all together, and in a way I share the Chairman's frustrations, electronic health records globally are already expressed in the business case and we are very keen to get that moved on. The maternal one will go around all 19 units in the State over the next 30 months.

Chairman: What kind of timescale are we talking about to implement a fully functioning system and what is the price tag for it?

Mr. Tony O'Brien: A fully functioning system, in the absolute sense of the word, is a five to

ten year horizon. Part of the reason for that is we are not going to follow the example of some of the other jurisdictions where they sought to go with big bang implementations which ultimately failed. To use jargon, this is what is known as tactical modular implementation, whereby one builds on things that already work. It is about joining up systems that already exist, for example, Healthlink, which many general practices have, and in-hospital systems, supplementing them and using the individual health identifier to make that information trackable. This is more likely to be successful. We are investing €50 million per year in e-health, but that will need to accelerate because it is not yet fully funded. We will-----

Chairman: How much of that is dedicated to electronic referrals?

Mr. Tony O'Brien: Would the Chairman mind if I followed up with a detailed answer in writing so that I might get the information correct for her?

Chairman: Okay. Mr. O'Brien is saying that €50 million is being spent currently. Do the witnesses have a ballpark figure for the cost of the full implementation of electronic health records?

Mr. Liam Woods: Our business case for the period in question indicates that it would be between €440 million and €500 million. I will give a brief observation on the indicated funding if it is helpful to the committee. Typically, health services across Europe have IT investment of between 3% and 4% of their budgets. The HSE's IT investment is approximately 0.4% of its budget. There is a necessity. Committee members have made points about the need for integration and managing boundaries across care. IT is critical to that. There is a considerable opportunity in that regard.

Chairman: Is the international standard 2% to 3%?

Mr. Liam Woods: Between 3% and 4% at European level. In the US, it is up to 10%.

Chairman: And we are on 0.4%.

Mr. Liam Woods: Yes.

Mr. Tony O'Brien: Deputy Barry asked about capital. The way that it works is that, legally, we submit an annual capital plan at the same time as our service plan. Most of it is now devoted to large projects rather than little ones. I referenced the matter in my opening statement, and I thank the committee for indulging the length of that statement. Without a significant uplift in capital for the next ten years, we will be spending the greater part of our money on the large, Government priority, flagship projects of which the committee is aware. We will not be replacing the bread and butter, day-to-day equipment, which means that the equipment will increasingly fail and not be available and that we will not be operating some of our less fashionable services from environments that are not optimal for patient outcomes.

Chairman: What does that mean?

Mr. Tony O'Brien: Consider the Phoenix Care Centre in Grangegorman. The Chairman is probably familiar with it. It is a new mental health facility. That environment is producing better outcomes for patients in shorter stays compared with a number of old facilities. We have a great deal of health care infrastructure that dates back to the days of the workhouses and needs to be upgraded significantly. Were we to do so, we would have much better outcomes for the equivalent service spend.

The primary point is that, given the age of our X-ray and MRI equipment, ventilators, ambulance fleet and so on, we do not currently see where the money will come from to replace all of that when necessary. This is because so much of the capital envelope is devoted to large projects.

Deputy Mick Barry: How does that play out? Mr. O'Brien pinpointed a period of four to five years.

Mr. Tony O'Brien: Yes.

Deputy Mick Barry: Mr. O'Brien also cited specific examples of ambulances, X-ray machines and MRI equipment and indicated that the HSE had significantly less than the two thirds of the budget that he believed it needed just to maintain those, not improve them. Does that mean that the HSE will spend all of the money in the first two to three years, when everything is grand, only to fall off a cliff unless there is a supplement or will problems with key equipment not being replaced start kicking in next year?

Mr. Tony O'Brien: No. That overall budget is a cash float. We can only spend a certain amount of it each year. One could not frontload it in that way and then run out of money. Rather, year on year, equipment that one would otherwise be replacing would have its life extended to the point that it became unserviceable.

Deputy Mick Barry: Problems will start kicking in as early as next year on that front.

Mr. Tony O'Brien: There is equipment in service now that, ideally, should not be.

Deputy Mick Barry: What kind of equipment?

Mr. Tony O'Brien: A full range - ventilators, X-ray equipment and so on. Each year when we propose our capital plan, we seek to do the best we can for priority replacements, but what is a priority when one has X might not be a priority when one has Y, if the Deputy understands my point.

Deputy Mick Barry: I thank Mr. O'Brien.

Chairman: I will revert to the question on structures. A well-functioning organisation should be able to display its management structure on a one-page diagram. The diagram before me of senior management within the HSE bears no relation to what is happening on the ground in terms of the hospital, community health care organisation, CHO, and mental health service systems or primary care teams. This issue has been raised by many of the groups that have appeared before us, including staff groups represented by their trade unions.

One suggestion has been to consider a geographical division of the country into three or four health authorities, each with defined responsibilities for its senior people in terms of service delivery. Defined responsibility is lacking at the moment, as it is difficult to get to the person who is in charge of something. Deputy Browne mentioned how it might be a different person in charge of something from one month to the next. There is no clear line of sight in terms of accountability or budget spend. Has the HSE given any consideration to a geographical division of the country for its management structures so as to have a clearer line?

Will Mr. O'Brien comment on the level of confidence among staff in the workability of existing structures? We have asked almost every group that has appeared before us about whether it believes that the existing structures could deliver. The answer has generally been "No".

Regarding the delivery of community services, can the HSE provide a management structure diagram in respect of each CHO?

Mr. Tony O'Brien: To answer the last and simplest question first, we can and we will.

Deputy James Browne: That would be important in terms of mental health teams as well.

Mr. Tony O'Brien: We can do that.

Chairman: Just to clarify, if there is a management structure for CHOs, is there a separate management structure for mental health teams? There is a separate structure for hospitals.

Mr. Tony O'Brien: There is. The mental health teams are part of the CHO structure and some CHOs have more than one mental health team. This follows the template laid down in A Vision for Change some years ago. We can show that structure clearly.

Chairman: The areas are not aligned, but each has its own management structure. Is that right?

Mr. Tony O'Brien: No. Each of the mental health areas exists in only one CHO, but some CHOs have more than one of them. There are no transboundary issues in that sense.

Chairman: Okay, but is there a management structure within each mental health team?

Mr. Tony O'Brien: Yes, and it is well defined. We can provide that to the committee and we will do-----

Chairman: It sounds like a great deal of management.

Mr. Tony O'Brien: It is clinical management within mental health, as prescribed in A Vision for Change, with an executive clinical director at its heart. Those teams have 14 geographical boundaries for reasons that are laid out in A Vision for Change.

Regarding the Chairman's larger questions on confidence and geography, in addressing the CHOs, we ensured that they could be grouped in a way that corresponded with regional assembly boundaries, which in turn are groups of local authority boundaries, in recognition of the fact that, when one considers health in its widest sense, there is considerable crossover and a need for correlation between local health services, local authorities and local Garda boundaries. This significant issue was taken into account. From a structural point of view, particularly on the community side, there would be no impediment to organising along those regional lines if that was desired.

Deputy James Browne: Is Mr. O'Brien saying that the hospital CHOs have, in effect, been designed to suit the Department of Housing, Planning, Community and Local Government's notion that the regional assemblies may at some point in the future have more power and influence than they currently have?

Mr. Tony O'Brien: No. I am saying that this is what they can do. As I said earlier, the starting point was primary care. Many of the CHO boundaries correspond quite well with former health board boundaries. There was neither a desire to have that outcome nor a desire to prevent it.

Chairman: That is beside the point in terms of the delivery of services.

Mr. Tony O'Brien: It is beside the point, but I am stating it as a fact. We did not want to break the fundamental unit in the previous environment, which was the local health office. There was no particular need to do so. I will respond to the direct question that was asked by expressing my view that there is a good degree of confidence among staff and managers in CHOs that they can significantly improve the quality, extent and organisation of the services for which they are responsible. I think there is a significant degree of frustration within the hospital groups, particularly at senior level, about the fact that their journey has become unclear. They would have expected that by now, legislation would have been introduced to provide for boards and to make accountability very clear. The hospital groups would have expected to have a degree of freedom they do not currently have. That would be the primary source of frustration.

I am happy to repeat what I said at the time, which is that the hospital groups were not all created equally. Some of them will be more successful than others. At various points in time, their boundaries, organisation and number may need to be revisited, reviewed and changed. I believe that in principle, we are already seeing benefits from the hospital groups. Some of those benefits were referenced previously by some of the chief executives. I return to the Chairman's point that the decisions which were made when the hospital groups were being created came from one place and the decisions which were made when the CHOs were being established came from another place. I believe the boundaries for the CHOs are well evidenced and sustainable.

Chairman: Okay. I think that completes the business of the committee for today. I thank Mr. O'Brien and Mr. Woods for attending the meeting and responding to our questions. It is much appreciated.

Deputy John Brassil: Mr. O'Brien will be glad to learn that the RTE news headline about this meeting says that the HSE boss says the majority of the health service is working well. His attempts to be positive have been heard by somebody.

Mr. Tony O'Brien: I thank the Deputy.

Chairman: Mr. O'Brien should give the press officer a pay rise. He is out of the room at the moment.

The committee adjourned at 12.15 p.m. *sine die*.