

DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Dé Céadaoin, 1 Feabhra 2017

Wednesday, 1 February 2017

The Select Committee met at 9 a.m.

MEMBERS PRESENT:

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

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

The select committee met in private session until 9.20 a.m.

Health Service Reform: Health Information and Quality Authority

Chairman: I remind everybody to ensure their mobile phones are either turned off or on aeroplane mode so there is no interference with the recording and broadcasting system.

I welcome our witnesses and those watching our proceedings, as well as committee members. In this morning's session we will receive evidence from HIQA, the Health Information and Quality Authority, with a focus on health service reform. HIQA has also made a written submission to the committee. I welcome Mr. Phelim Quinn, chief executive officer, Dr. Máirín Ryan, deputy chief executive and director of health technology assessment, Ms Mary Dunnion, chief inspector of social services and director of regulation, and Ms Rachel Flynn, director of health information.

I invite Mr. Phelim Quinn to make his opening statement.

Mr. Phelim Quinn: On behalf of HIQA, I thank the Committee on the Future of Healthcare for the opportunity to address it this morning.

In the conduct of our work, we witness at first hand the significant pressures and challenges facing the health and social care system. These range from familiar demographic and fiscal stresses to workforce and infrastructural issues. From HIQA's point of view, the disjointed and reactionary approach to health service reform is leading to increasing instability in the system. There is a failure to assess current requirements and plan for the future health and social care needs of the population. There is also a reticence to actually recalibrate the current focus on acute hospital services to the provision of health and social care services in more appropriate ways such as through primary and community care.

HIQA believes a ten-year plan for health policy creates an opportunity to include a vision not only for health services, but for an integrated health and social care system. In my opening statement, I will outline what we believe to be the main priorities for inclusion in the strategy.

Starting with the concept of commissioning, many of the major problems currently evident in our health and social care system could be addressed through the introduction of a strong commissioning model. Good commissioning puts people using services first and, at a local level, involves them, their families and carers in the decisions that affect them. Effective commissioning arrangements at both local and national levels not only ensure services are designed and delivered to meet the needs of individuals and communities, but also instil a culture of accountability in the health and social care system.

Commissioning is only at a developmental stage in Ireland, but is already well established in other jurisdictions, including Northern Ireland and England. While I acknowledge these jurisdictions have their challenges and there are significant structural and policy differences compared to health and social care in Ireland, commissioning has improved strategic planning of services based on population need, strengthened performance management arrangements, placed protection of vulnerable individuals at the centre of service design, improved governance and accountability arrangements, enhanced financial efficiency and maintained a focus on the physical infrastructure needed for the delivery of 21st century services design and provision.

Commissioning arrangements explicitly define and separate the roles of purchaser and provider of services. Currently, both of these functions are usually performed by the Health Service Executive, HSE. An effective commissioning body is responsible for purchasing health and social care services from providers. Procurement in this model is always based on an agreed strategy, assessed need, best available evidence of service efficacy, value for money, and the capacity and capability to deliver a safe and effective service. While recognising that resources are finite, quality and the delivery of safe services should be the primary goals.

Implementing a national commissioning approach would involve a radical review of the current health and social care service funding model and allow for the discontinuation of the ineffective practice of legacy block funding. Commissioning frameworks can provide for national, regional and local procurement arrangements which are person-centred and address local needs. While procurement decisions are made locally, the service itself is delivered in the most effective, efficient manner, whether in the community or at a national level. This means that some commissioning decisions will result in the rationalisation of services and will require courageous choices.

Local commissioning involves community and primary care professionals and, most important, people who use services. Local commissioning in turn informs national commissioning arrangements. A strong, national commissioning model would contribute to effective medium to long-term planning by gathering evidence of current and future service needs. The introduction of a standardised framework to commission services would help, by way of example, with the implementation of national clinical care programmes and strategies such as the national maternity strategy.

Such a framework would allow for effective oversight of service provision and hold providers accountable for the delivery of safe quality services. Strong and clearly defined performance management structures, as well as clear accountability arrangements, are essential components of good commissioning models. Critically from HIQA's perspective, the emphasis of these structures would not only be on financial or activity metrics but on metrics that reflect the quality and safety of services.

The committee has already heard from other contributors about the importance of moving to an integrated health and social care model. Integrated care takes a holistic approach to a person's health and delivers care in a co-ordinated, person-centred fashion as close to their home as possible. Similar models across the world have led to improved efficiencies, better health outcomes and lower costs. One important element of ensuring more seamless integration of care between primary and secondary services is geographical and service alignment. Aligning primary and secondary services will ensure care is co-ordinated, managed and comprehensible for patients in terms of care pathways. There is a consensus that Ireland needs to move away from the current hospital-centric model of care and to introduce integrated care pathways across primary, community and secondary health and social care structures. HIQA believes this should be expedited.

HIQA's primary aim as a regulator is to protect the most vulnerable in our society. We believe now is the right time to introduce safeguarding legislation to protect at-risk adults from abuse and neglect. While national safeguarding protocols are in place following recent high profile revelations of abuse, these do not go far enough to ensure the safety and rights of vulnerable people. In developing a ten-year strategic plan, we must grasp the opportunity to introduce statutory measures to protect the health, human rights and well-being of individuals who are at risk of abuse, neglect or harm. While HIQA currently has statutory powers of enforcement and

prosecution, other health authorities do not have statutory powers to protect vulnerable adults from abuse. The introduction of safeguarding legislation will provide for explicit powers of investigation and prosecution, define the roles for statutory agencies and give clear definitions of offences in respect of abuse of vulnerable adults.

An effective commissioning model can be used to support safeguarding. As commissioning is person centred, it can help ensure that the rights of vulnerable people are respected. In England, the Care Act 2014, which is concerned with the provision of social care, places a statutory duty on local authorities to promote the health and well-being of individuals. This pertains to commissioning as well as care and support and safeguarding and it means that any decision a local authority makes about an adult must promote that adult's well-being.

HIQA also supports and will contribute to the work of the national inter-sectoral safeguarding committee and is committed to working with the Department of Health and the Oireachtas to drive forward safeguarding legislation and the promotion of awareness within civil society about the nature of vulnerable adult abuse and how and when to intervene.

Closely related to safeguarding is the protection of people being cared for in their own homes. HIQA believes measures need to be taken to ensure people being cared for at home are receiving safe and high quality care. The Minister of State with responsibility for mental health and older people recently announced a consultation process on establishing a new statutory home care scheme. Moreover, a Private Members' Bill debated in the Dáil last week sought to expand the provision of home care services. While HIQA advocates the extension of home care packages, we are aware of the specific vulnerabilities of people in receipt of personal care and support services in their homes. Therefore, we must extend statutory regulation to cover all domiciliary care services and other community based social services to ensure vulnerable people are safe and receiving the best possible support.

In recognition of our ageing population, the rapid increase in chronic conditions and the health care costs associated with these developments, society needs to explore alternative models for the delivery of social care services. Consideration must also be given to ways of supporting older people and people with disabilities to remain in or as close as possible to their homes. These alternative models for the delivery of services for older people and people with disabilities would potentially provide incremental pathways of support and care aligned with the changing needs of the person, thereby allowing him or her to be supported to stay longer living at home and nearer family and friends. This process would be supported by local commissioning arrangements.

The rationing of care is an inevitable consequence of a fixed health care budget. Finite health care resources means choices must be made. Owing to opportunity cost, deciding to invest in a new drug may mean the health care service cannot provide another intervention for patients. Currently, we have a system characterised by rationing by delay, crudely manifested in the form of waiting lists. Health technology assessment or HTA is evidence based research widely used internationally to assess the costs and benefits of health care treatments. Using the best available evidence on the clinical benefit and cost-effectiveness of technologies, including drugs, medical devices, public health programmes such as cancer screening and the organisation of services, maximises outcomes for the population and health service. The aim of HTA is to guarantee the best use is made of resources through rationing by design. This ensures the right health care is targeted to the right patient at the right time in the right place, delivering the best outcomes for the individual and the most efficient use of the health care budget. Since 2007, HIQA has carried out health technology assessments to inform major health policy and

health service decisions.

If universal health care is to be implemented effectively, agreement must be reached on what treatments and technologies should be included in the standardised basket of care to be provided to all patients. Expanding the use of health technology assessment in the health care system would ensure this decision-making process is independent, rigorous, transparent and based on high quality information. HTA optimises health outcomes for people, enables access to new and better treatments, fosters innovation by the health technology industry and ensures the financial sustainability of the health system.

I note that the committee's second interim report stated that support for the implementation of e-health solutions came through strongly in submissions to the committee. HIQA recognises the role that e-health can play in significantly reducing clinical errors, improving patient safety, creating efficiencies and, if properly implemented, reaping economic benefits. Many of the areas highlighted in the second interim report depend on having e-health solutions in place. For example, integrated care for disease management requires technologies such as individual health identifiers, e-prescribing and electronic health records. In Ireland, health care is delivered through a range of providers that are both public and private. Therefore, when planning e-health solutions, we should take a patient centred, standards based approach to enable interoperability.

While there are many benefits to implementing e-health solutions, there are also challenges, particularly in terms of information governance and upholding the privacy of individuals. Good information governance practices and effective legislation are needed to support the sharing of information and enhance patient safety. The ten-year strategy should include a commitment to furthering and adequately resourcing Ireland's e-health strategy to help achieve these goals. In addition, further legislation is required to enable the sharing of electronic health records and to advance the e-health agenda in Ireland. Progress will also require the buy-in from front-line staff and senior health care management. Both evidence based decision-making and e-health are essential components of effective commissioning.

We have an opportunity to transform our health and social care system into one that truly serves the Irish people. Central to any new strategy must be evidence based decision-making; the use of e-health systems; the protection of vulnerable people; the introduction of integrated care; and the use of alternative care models that allow people to stay in their homes. Moreover, the development of a strong commissioning model will help ensure that our health and social care system cost-effectively delivers safe and high quality care. If these proposals are implemented, it will lead to better decisions, safer services and better care. I thank members of the committee for listening to us. We will be pleased to answer any questions they may have.

Chairman: I thank Mr. Quinn for his comprehensive presentation on the work of the Health Information and Quality Authority. I invite members to ask questions. As I propose to take three members at a time, I ask the witnesses to record the questions.

Deputy John Brassil: I thank Mr. Quinn for his comprehensive presentation. I will focus briefly on two areas. On commissioning, the Health Service Executive acts as the purchaser and provider. Will Mr. Quinn explain who the purchaser would be in the model he envisages?

Mr. Quinn spoke about home care, which is an issue that is raised consistently with Deputies in their constituencies. The vast majority of people who are unwell desire to be cared for at home. Deputies spend a great deal of time trying to secure home care packages and assistance

for such persons and, as my colleagues will agree, this is always a struggle.

My concern in respect of HIQA is that it has very high standards, which is appropriate, but if are to increase the number of people who are cared for at home, I doubt that many homes would meet the standards that HIQA would require. This would exclude home care as an option in many cases. It will be against the desire of the person and the family. One is looking at the practicality of door widths, bathroom access and so on in respect of which most people will say “We will be fine and will manage”, but HIQA will not accept that. It will say that for a home care package, a €20,000 modification to the house is required which the person will not have. I envisage huge practical problems here. Does HIQA envisage the same? HIQA is a standards authority and has high standards, which is the way it should be, but from a practical perspective on the ground, I wonder if the whole home care idea will unravel because of this. I would be very interested in the opinions and comments of the witnesses on that.

Deputy Louise O’Reilly: I thank Mr. Quinn and the team for the presentation. Commissioning formed a substantial part of the submission. I have an issue with that. I do not see that the creation of internal markets is anything other than the last thing one does before one goes to full privatisation. I note all of the publicity, not only recently but over many years, on the lack of control we have when public money goes to a private or quasi-private organisation for the specific delivery of public services. We seem to lose all control. In a model of commissioning where the HSE or its offshoot, whichever is the commissioning body, is the purchaser of those services, once the service is purchased, how does HIQA envisage us controlling and maintaining standards? To be frank, we have not exactly covered ourselves in glory in that area up until now. I doubt the capacity exists to do that.

Mr. Quinn mentioned the need to statutorily protect health and human rights. Does he have a view as to whether there should be a statutory entitlement to the basket of goods and services he outlined? He mentioned England and the North, but I would also favour looking at Scotland where they have managed to hang on to a great deal more of the NHS than England has. The Minister there is the person who has ultimate responsibility and that is laid down in law. Does Mr. Quinn see us needing that in a model that focuses on commissioning?

Something that did not come up in the course of the presentation but which has come up when we have been discussing the perpetual emergency department crisis is the inappropriate, in some instances, transfer of elderly people to accident and emergency departments. It has been said to me anecdotally that there is a fear that when an elderly person dies in a nursing home, an inspection by HIQA will commence and a certain amount of reporting must take place. That burden is alleviated for the nursing home if the person breathes his or her last in an emergency department. I make no comment as to whether it is true. I have never seen that and I do not know if it is true, but it has been said to me on a number of occasions. While that was not part of Mr. Quinn’s submission, demographic pressures were mentioned and the fact that we are all getting older, which is good, and living longer, which is also good. However, I ask to what extent Mr. Quinn believes that is happening and if he could comment on it. It has come up in other areas.

Deputy Josepha Madigan: I thank Mr. Quinn and his team for coming in today. I found the presentation very helpful. HIQA and its role are very important. Mr. Quinn referred to integrated care and said there were other models throughout the world. I am not saying that they are in any way utopian, but Mr. Quinn said they improve efficiencies and cut down on costs. Could he specify for me a particular country that he sees as one whose model we could try to replicate in this jurisdiction?

Mr. Quinn referred to safeguarding legislation and said it did not go far enough. He also said HIQA had statutory powers of enforcement and prosecution whereas other health authorities in Ireland do not. Could he specify what he would like to see and what more he would like done in terms of the remit of safeguarding legislation?

How does Mr. Quinn see the extension of statutory regulation in respect of home care being enforced? It could be difficult and I would like to see how Mr. Quinn thinks it could be applied.

How does Mr. Quinn see the health technology assessment being carried out, in particular in light of the ESRI's comments earlier about the collection of data and the big gaps that exist? How is that feasible and how will it be addressed?

Mr. Phelim Quinn: I will start with Deputy Brassil's question on commissioning and cover some of the other questions in that context. One of the questions was who the purchaser would be in that circumstances. Critically, within the Irish context and the proposals we have made, I see the introduction of a commissioning model as very much a longer-term strategy. We could not introduce a commissioning strategy all at once. There are a number of critical elements within that, one of which is around improving accountability. It is interesting that Deputy Louise O'Reilly raised the issue of loss of control in the provision of resources to a private provider. In my opening statement, I referred to the concept of current block funding. In that instance in the current circumstances, we actually do lose some control because the actual block funding itself is not specified to the specific needs of individuals in receipt of services. We see that as an example in the purchasing of services for people with disabilities in residential care. As to who the purchaser would be, I note that if we were to start somewhere within that longer-term strategy, local community health organisations might be purchasing care on behalf of individual service users. In that case, the actual community health organisation would be in the purchaser role based on individual needs assessment.

Chairman: To clarify, is Mr. Quinn talking about one section of the HSE purchasing services from another section?

Mr. Phelim Quinn: It could possibly be purchasing also from the voluntary and, or, private sector because we have a mixed economy of care in Ireland.

Chairman: In the case of a community health organisation, it would be one unit purchasing from another unit.

Mr. Phelim Quinn: That is one example of how it would be organised at the level of the individual service user.

Chairman: Is it the individual service user or the organisation?

Mr. Phelim Quinn: Individual service user. Again, it would be the initial building block of a commissioning model. One would bring about a model such as care management where the specific care and support needs of individuals are assessed and addressed through the commissioning of services for that individual. That can subsequently be escalated into commissioning at local and national level. There would be a requirement at a certain point in time for a national commissioning body as a purchaser.

The other question asked related to home care. In that instance, concerns were raised about the application of standards within the context of the provision of care within a person's own home. From our perspective, we would not be regulating a person's own home. That is an

absolutely critical point in relation to the regulation of home care. What we would regulate would be the care provision into a person's own home. The unit or level at which care is actually being regulated is in the provision of care, which is to say the provider. In that instance we use quality standards to examine the systems care providers have in place to provide safe and effective care, and we examine whether they have systems and safeguards in place to protect the provision of care in a person's own home. We do not look at issues such as the physical environment. This would not be feasible in the context of a home care environment because it is a person's home and private dwelling. What is regulated in that instance is the care and the systems through which it is provided.

Deputy John Brassil: I thank Mr. Quinn for the clarification because it is very important.

Mr. Phelim Quinn: It is borrowed from other models of home care regulation in other jurisdictions.

Deputy John Brassil: HIQA examines the amount of time spent and the number of people providing care.

Mr. Phelim Quinn: Yes, and who provides it. There is also the vetting of individuals and ensuring individuals are appropriately trained for the provision of care and support. These are the types of standards and regulations that are regulated and set.

Deputy John Brassil: I thank Mr. Quinn.

Mr. Phelim Quinn: We are speaking about health and human services and rights to the basket of services, and in our opening statement we made reference to the Care Act in England, which clearly sets out statutory responsibility for social care elements of what the state is required to provide. Something similar to this would be a first-line development in respect of the commissioning service and, more particularly, in respect of the safeguarding of vulnerable individuals. Something that would clearly set out the State's responsibilities for the care of its most vulnerable would be a good first step in recognising people are vulnerable and that the State has responsibility. Ms Dunnion will speak about the question raised about the emergency department crisis and the care of elderly patients being transferred from nursing homes.

Ms Mary Dunnion: I thank Deputy O'Reilly, who is correct that when a person is transferred from a nursing home to an acute hospital HIQA is notified. It is a mandatory notification defined in the regulations to which we adhere, set down by the Department of Health. The regulatory model for nursing homes is based on the concept of a designated centre. What defines this is the premises and the care, and in this context Ireland is an outlier as it does not happen in other jurisdictions. We have done an extensive review of this and are quite happy to share the paper if it is of value to the committee. A change would involve regulating services for older people as opposed to a physical building and the care within it. The definition of a designated centre set out in the Health Act defines the type of services that nursing homes can provide. Sometimes when people deteriorate and require additional care, nursing homes may not be equipped to provide it. Some of what dictates this is the definition of a designated centre. If we had a model that looked at regulating services, it would allow an opportunity for providers to be more innovative in the type of care packages they can deliver and it would be more responsive to Government policy as the ultimate aim is for people to remain in their homes. It is a fair comment and it happens. We look at it, but it is not a matter for HIQA. HIQA is often cited as the cause but the notification-----

Deputy Louise O'Reilly: I suspected that, which is why I asked the question.

Ms Mary Dunion: It is a worry for us with regard to quality and the safety of people, particularly vulnerable people, that perhaps the only view providers have is the emergency department door is the only one through which they can send somebody for care. We strongly believe in considering a change in the policy direction towards regulating services as opposed to a premises.

Chairman: There would be implications for the subvention scheme if nursing homes were to provide more acute care.

Ms Mary Dunion: Yes there would, but it would also allow innovation in other directions. By way of example, it would allow the development of day care services in a wider compass, rehabilitation and the extension of respite care, which is not covered in the definition of designated centres and often becomes a challenge for providers. People use the service because a regulated premises cannot deliver respite care. Many jurisdictions apply a suite of regulations to a particular type of service. This would allow flexibility to be worked into Government policy. At present it mitigates it in some cases.

Mr. Phelim Quinn: I will address Deputy Madigan's question on the legislation in the first instance. She asked about the powers HIQA has and what powers other statutory bodies in Ireland have. HIQA has very specific powers under the office of the chief inspector. These powers span a range of issues, including the registration and inspection of a range of services and the implementation or application of enforcement measures, up to the cancellation of registration and-or the prosecution of individuals for breaches in regulation. In some ways there is a safeguarding element in this suite of powers. However, in Ireland we do not have a similar statutory suite of powers which enable a statutory body, such as a social services unit, to work with the Garda to identify when vulnerable adult abuse has happened, what constitutes vulnerable adult abuse and what process is brought to bear when abuse is being investigated. We have been working with the national safeguarding committee to try to develop a framework to describe the type of legislation required for the protection of vulnerable adults and people who might be exploited. This encompasses not only people in receipt of services but people in civil society. One of the major debates the national safeguarding committee had was on the issue of financial abuse. Sometimes this occurs in the context of a family or someone providing informal care to an individual. The legislation we are describing extends beyond care service provision and into wider civil society. A question was also asked about health technology assessments, and I will ask Dr. Ryan, our technology director, to address it. This also relates to the basket of services.

Dr. Máirín Ryan: I thank the committee members for their questions. I will begin with Deputy O'Reilly's question on entitlement to the content of the basket of care. When we do a health technology assessment what we consider includes the ethical implications of adopting a particular technology, and one of the main areas of focus is equity of access. Tomorrow we will publish a health technology assessment on a groundbreaking treatment for the management of stroke, mechanical thrombectomy, which involves using a device to retrieve the clot from the blood vessel in the brain that is causing the stroke. It can only be provided at very specialised centres with neurosurgery and neurocritical care. The two centres are Beaumont and Cork. In our report we clearly raise an issue with regard to equity of access for patients who live at a distance from these two centres, particularly in a situation where the treatment needs to be provided within six to 12 hours of the onset of a stroke. We are very conscious of addressing equity of access issues, and this is a cornerstone of any programme of universal health care.

Deputy Madigan raised the very pertinent question of the quality of the data available to produce a health technology assessment. To explain how we tackle this particular challenge, the first aspect of the technology we look at is its clinical effectiveness and safety, because if it does not deliver a benefit for patients we do not progress any further. How we do this is on the basis of standard methods to assess the international evidence on clinical effectiveness and safety. It is on the basis of the literature. If there is no evidence of clinical effectiveness we cannot do a health technology assessment. It is as simple as that. If there is evidence we have standard methods to synthesise the data and translate it into benefits for people. Where it becomes a little more challenging with regard to data is when we move onto the next aspect. We construct a model to predict the clinical benefits for patients in Ireland and how much the technology would cost to implement here. This is not only takes account of the purchase price but also what other services are needed to implement the technology and the cost savings. As well as the budget impact we also need to look at the cost effectiveness and how it compares to how we would use the budget to fund other technologies in the Irish health care system. The type of data we need there are the epidemiology data, in other words how many patients have the disease in Ireland and how is it currently treated in Ireland. Sometimes we have difficulties there and we must go to other jurisdictions with similar populations or health care systems to ourselves. We also need cost data from the Irish setting. We have relatively dependable cost data from the hospital setting but not such good data from the community care setting. How we deal with that is if we find that a particular datum is really important for the result of the model - we do that by testing through a sensitivity analysis - we then do extra work to try and get a handle on that cost. That might involve a micro-costing study, for example, to figure out what is the actual cost of a particular service. Any data that go into our model are varied around the plausible limits - how low or high can they possibly be - and what difference that makes to our final result with regard to predicting how many patients will benefit, how much it will cost and whether it is good value for money.

The other quality assurance mechanism we use is that we have an expert advisory group for every piece of work we do. This is made up of expert clinicians in the area, right across the divide of acute services, primary care if it is relevant, public health expertise if that is relevant, hospital managers with responsibility for the delivery of the service, patient representatives, international experts in whatever the clinical area is, and the health technology assessment, HTA, methodologies that have been used elsewhere for that area. We use all of those different quality assurance mechanisms to ensure that what we produce is the best available evidence to guide the final decision.

Deputy Josepha Madigan: What can be done if the data are not there?

Dr. Máirín Ryan: If we were asked, for example, to assess a particular technology where there is no evidence of clinical effectiveness, we cannot do a health technology assessment on it because what we do is evidence-based work. If there is no evidence of a treatment being effective, we cannot provide advice on that. All we can do is state there is no evidence to demonstrate this technology is effective. That has happened occasionally. It is often a case of giving advice in the early stages of the development of a technology where the evidence showing the benefits of it has not been collected yet. If the evidence is there, however, then we have standard methods we can use to pull together all the information to give us the estimate of what benefit it can deliver.

Deputy Josepha Madigan: It is not ideal, is it?

Dr. Máirín Ryan: It is not ideal. It does not actually happen that often, particularly if there

is a commercial sponsor behind a technology which has invested in producing the evidence. We have to be careful that the evidence is reflective of an Irish population, so for example evidence collected in a resource-limited setting might not be transferable to Ireland. Part of the work we do is assessing whether the population on which the technology is tested is sufficiently similar to the Irish population that we can be comfortable using that information.

Chairman: Reference was made to models which are effective in terms of integrated care. Deputy Madigan asked for examples. To what countries would the witnesses point?

Mr. Phelim Quinn: There are a number of models on which we have had information during the development of some of our standards and in the case of our contribution to the development of the strategy on maternity services, for example, we looked at specific models. I do not have the specific information on some of those countries but we can certainly supply that.

Chairman: We would appreciate that. A question was raised in terms of areas where there is no regulation.

Deputy Josepha Madigan: We have spoken about the lack of data already, in light of what the ESRI were saying.

Mr. Phelim Quinn: I think that related to the areas where there were no powers in relation to regulation and safeguarding.

Deputy Josepha Madigan: Yes, we spoke about that already.

Deputy Kate O'Connell: I thank the witnesses for coming in. I think we all rest a little easier after hearing their submissions. Maybe that is just me.

In his opening contribution, Mr. Quinn stated "This means that some commissioning decisions will result in the rationalisation of services and will require courageous choices." Can he elaborate on what those choices would be and what sort of barriers he would envisage encountering while trying to rationalise services? Mr. Quinn went on to state, "The introduction of a standardised framework to commission services would help". Is he stating there is no standardised framework at present and it is all over the place? Have there been moves in recent years to standardise the commissioning framework for services?

To follow on from Deputy Brassil's point about care in the home, I understand that people will not be made to put in new bathrooms if they do not require them. My concern here is that in my experience, many people who may be retired carers or nurses or who have none of those qualifications, have capably cared for people in their homes. Given the advertisements on television and the leaflets on view in doctors' surgeries and pharmacies for private home care providers, I am concerned that in regulating the manpower and womanpower of those coming in, we may exclude the son or the daughter-in-law who have stayed at home or any person who wants to care for an elderly person or disabled family member in the home. I understand we cannot have anyone being abused in their home and terrible things happen in some circumstances but in my experience, the vast majority of people caring for a family member are dedicated and committed and are 24-7 people. Can we achieve a balance where we do not create a situation in which, for example, I could be excluded from minding my sister-in-law in the home on the basis of that I am not a commercial provider - assuming I am not financially abusive or anything like that? It is about the balance of supporting people who want to be cared for in the home and people who may not have particular qualifications but are good people and will mind people in an adequate way. How do we get that balance so that we do not end up privatising

home care provision and excluding the very essence of what we are trying to get at?

Deputy Hildegarde Naughton: I thank the witnesses for their presentation this morning. I seek the views of the witnesses on the issue of duty of disclosure by doctors in hospitals and the idea of open disclosure and a duty of candour in the event of medical negligence. I know this was on the agenda previously but was shelved. In my view it would offer more transparency but do the witnesses think it would lead to better safety standards or is it an insurance-related matter?

Designated centres were mentioned and the focus was on the treatment of patients as opposed to the facilities. I take on board the point with regard to home care. My question pertains to outdated hospital facilities and the witnesses' views on that with regard to standards across the country.

Deputy Bernard J. Durkan: Given the job the Health Information and Quality Authority, HIQA, has to ensure the highest standards possible, what comparison can be made between private and public nursing homes and the quality and standard of care available in each? Are the standards universally applicable? I know that the rules are applied. Are comparisons made between the cost and quality of care in the home? For example, has HIQA studied caring for a cohort of perhaps 25 people in an urban and in a rural area? There are differences in the cost of administration with home care packages and all of the associated respite care etc. To what extent have comparisons been made between those factors with a view to achieving the best possible value for money? I agree with the aim of ensuring that the highest possible standards apply in the home because the person or persons providing the care may not have access to a hoist or assistance that is required to lift a patient, etc. A lack of medical aids or assistance might deprive a patient, through no fault of the carer or relative, of the best care.

I have witnessed very high standards of care being given in some of the older public nursing homes. A de-congregation approach permeates through the entire provision of services for special needs and everywhere else. I wonder where de-congregation will take place next. We want the best quality and care that is available to be given in the most cost effective way while achieving the highest quality and standard of care.

Chairman: I thank all of the Deputies for their questions. I ask the witnesses to respond, please.

Mr. Phelim Quinn: I shall first answer Deputy Naughton's question on open disclosure. HIQA, as an organisation, is supportive of the concept of open disclosure and for having legislation that supports open disclosure. We have recently completed a set of standards on patient safety incident management. As part of the early development of those standards there was discussion on whether to include a reference to open disclosure in the standards. The Department of Justice and Equality has informed us that there is, although I am not sure of the exact name of the Bill, specific reference in legislation to open disclosure and that there are regulations that address some of the issues on open disclosure in the Bill.

Deputy O'Connell asked a question on the reference to the rationalisation of services in HIQA's opening statement. Let me put my comment in the context of the longer-term strategy on commissioning.

At the start I said that commissioning needs to be done in an incremental way and that possibly the best way to commence such work is to consider commissioning for the individual. If we

reach the point of commissioning services for local communities, regions and national services, one of the critical components of a commissioning model is around the needs assessment for a population. We need to discover what nationwide services a population requires. Anything in and around decisions on rationalisation of service and the configuration of services needs to be conducted on the basis of sound evidence and information. It was in that context that we made the statement on rationalisation.

In terms of a standardised framework to commission services, there is a very critical range of specifications that would inform a commissioning decision. Again, they would very much be based on population need. There have to be quality and safety metrics within a commissioning specification as well as financial and activity metrics. At the moment I am not sure whether all of that exists. In our experience, say in the commissioning of services for people with disability, there is block funding available but we would not necessarily see it broken down or know how the money has been assessed in the context of value for money.

I will pass the question on home care regulation to Ms Dunnion. I have experience of regulating home care services in another jurisdiction. Deputy O'Connell mentioned that a definition of a home care or domiciliary care service would be an important factor in new legislation. I do not believe, within new legislation, that one should include some of the informal components of care that she mentioned. This is not about creating a nanny State that regulates care provided by relatives or people on an informal basis as commissioned by families. We must adopt an incremental approach in the first instance. As the Deputy has said, one sees many leaflets and advertisements by large companies that provide home care services. That is one of the first places where we need to start and, similarly, where larger organisations in the public and voluntary services provide services. We must analyse the systems that they have in place in order to ensure that the care provided is safe, effective and that people are safeguarded.

Deputy Kate O'Connell: I do not want to misinterpret Mr. Quinn. Is he saying that the larger providers should be examined first and then we can examine the person minding his or her brother or sister?

Mr. Phelim Quinn: Yes. Let us remember that in some instances one will be unable to capture every form of home care when it is provided on an informal basis. Perhaps when there is public expenditure and a service has been commissioned, that might be one of the elements that enters into the definition of what is within the regulation.

Deputy Kate O'Connell: That is where I am going with my query. Let us say that State provides financial support to me to mind my sister-in-law in my own home.

Mr. Phelim Quinn: Yes.

Deputy Kate O'Connell: Does the State not have a duty in such a case to make sure that I am acting in her best interest?

Mr. Phelim Quinn: Yes.

Deputy Kate O'Connell: Let us say I am the carer.

Mr. Phelim Quinn: I know what the Deputy is saying. Again, I refer to the point that Ms Dunnion made about the regulation of services. We need to consider how our services evolve, especially within the social care sphere. For example, budgets are increasingly being personalised. In other words, people with a disability can purchase care for themselves. That might

involve a mixture of family members, people they trust and-or larger providers. A framework must be built around that concept. I wish to emphasise that the critical issue behind our promotion of home care regulation is to protect vulnerable people in their own homes.

Deputy Durkan asked a number of questions on regulation and I ask Ms Dunnion to deal with some of them.

Ms Mary Dunnion: I concur with Mr. Quinn that it would be a tragic unintended consequence if people felt they could not look after their relatives at home but it is important that people are cared for safely.

If the regulation of home care was introduced the first step would be, not dissimilar to older persons with a disability, that someone must register himself or herself as a provider of home care. Therefore, it already corrals the group that one considers in that context. This aspect reinforces the importance of integrated care because integrated care combines the regulated bit and the integrated care associated with a person's journey from birth to death. There are more controls than just what the regulator does in the context of home care and we must be cognisant of same.

A question was asked about regulating outdated facilities, which was particularly pertinent to the acute sector. From the point of view of regulation, the Health Act makes two differentials. We regulate designated centres for older persons and disability and in that the provider must register and pay a fee. There are enforcement powers and the provider must comply with regulations that have been set by the Department.

There are no enforcement powers in terms of health care and child protection and welfare. HIQA has a monitoring role. HIQA has conducted 156 inspections of acute health care facilities over the past number of years. While we have seen pockets of excellence we have also seen a deterioration in the infrastructure within the hospitals and the acute sector. The reports that we have published have put a focus on them. In the areas that we consider, we would have particularly identified inadequate theatre facilities and an inadequate basic maintenance of many hospital facilities. It is the maintenance budget that is often cut when things get tough. The move immediately opens the door to infections, poor cleanliness, hospital acquired infections and it is a continuum. Yes, we have seen facilities that are outdated and require investment. We have also seen the need, and this is why the committee is so welcome, for a policy direction for acute services and for a definition of the delivery of services pertinent to the type of hospital that can deliver that type of services safely for people using them.

Do we differentiate between public and private providers? No, we do not. In the older persons and disability services, both public and private are under the same regulations. It would be impossible for us to do that and we would not have a desire to do so. There is no differentiation between them. They have to be compliant with the same regulations. We inspect in the same way. We meet residents living in all of these services and we have a standard approach to how we elicit from them what it is like to live in the nursing home or disability centre. We publish all our findings and there would be no inconsistency, whether it be a public or private facility.

As for whether we have looked at the cost, we have not. What we have done to date is look at regulation in other jurisdictions. While we have built a knowledge of regulation in Ireland, to inform and enhance that knowledge, and hopefully, to inform policy, we have looked at what regulation does in other jurisdictions, particularly in the context of older persons and disability service and then in the context of licensing of acute health services. We have not looked at the

cost benefit of any of those models because it would not be within our remit, or in our resources at present, to be able to do that.

Chairman: Is it within HIQA's remit, if it had the resources?

Ms Mary Dunnion: No.

Deputy Michael Harty: I am sorry for being late. Some of my questions may have been answered already.

Some providers have brought to my attention that HIQA imposes almost impossible demands upon them to provide standards of service. They themselves are struggling to provide best service but are chronically underfunded. Does HIQA take underfunding and lack of resources into account in making its assessments because some service providers have to either suspend services or reduce their capacity to provide a service because of the standards that are imposed on them, not in terms of the quality of care but in terms of the physical structure in which they operate? Does HIQA have data on the financial costs that its standards impose on different services? Finally, how consistent is the application of HIQA standards across different geographic areas?

Deputy James Browne: I thank the HIQA representatives for their presentation.

I have two points. First, I was talking to a senior nurse recently who told me that when HIQA first turned up a number of years ago there was a lot of resentment towards it but in hindsight the work that has been achieved as a result of HIQA is immeasurable and fantastic. That highlights the change of mindset and the journey people have been on. We see HIQA working with people.

This point has been touched on a little. Horrendous abuse has happened in individual nursing homes in a setting where there are other staff, there is management and there is potential for others, such as family members, to walk in unannounced. There are a lot of social norms there as well and it is quite unusual that such abuse could still happen in those situations. Obviously, there are rarely such circumstances in people's homes. The person who goes into a home to look after a vulnerable person is in a very powerful position. There is no question that there is abuse going on in homes. Often, the only ones who knows it is going on, other than a family member who may walk in, are other staff working for the agency concerned who may come in. It is quite shocking that there is no enforcement in this area. Obviously, there will be difficulties when enforcement comes in, in terms of the constitutional implications of access to homes. I have two questions. First, what are the barriers to the extension of HIQA's powers to these settings? Is it simply that the focus is not brought onto it or is there a kick-back, or is it a cost issue? Second, where these services providers are putting someone into a home, what is the position on whistleblowers coming to HIQA and telling the authority - maybe, they are not in a position, because they are afraid for their own job to stand up to management - so that they can come to somebody and highlight a situation that they have become aware of?

Chairman: I will take a supplementary from Deputy Madigan.

Deputy Josepha Madigan: I was just curious as to whether HIQA has its own way of collecting information that it receives from the public. I refer to queries. One that has just occurred to me - it is not necessarily something I agree with but it is merely to put it out there - relates to end of life and assisted dying. If HIQA receives queries from the public on that and it must give information on it, does HIQA then self-reflect, collect that data and make a submission in

light of it, or what does HIQA do to collate that? Obviously, legislation has to change with the times. I am not saying I necessarily agree with that matter but it is something that comes up sometimes. I would appreciate their views on that.

Chairman: I have a couple of questions of my own. I was quite surprised that HIQA's opening statement it made such an assumption in relation to the committee pursuing a commissioning model. That took me aback somewhat. Obviously, with the purchaser-provider split, there are different systems that can be used such as the money follows the patient or activity-based funding. I wonder why HIQA made that assumption. What are the main arguments in favour of having that purchaser-provider split and has HIQA an estimate of the additional costs involved, in terms of regulation, if we were to move to a commissioning model?

Another question I have relates to the health technology assessment. In what areas has HIQA done those assessments and are they publicly available?

Finally, on the capital investment programme in health which we have not touched on that much in the context of this session, HIQA might comment on the requirement for capital investment, in particular, in the primary care area.

Mr. Phelim Quinn: In respect of the first point the chairperson raised on the issue in relation to commissioning, I would want to apologise. We have not made an assumption on the committee's commitment to a commissioning model. It is a concept that we are trying to promote to the committee as a potential concept within the development of a ten-year strategy. The chairperson was asking about the potential benefits of that. Our assumptions, from a HIQA perspective, are very much based on our experience of working within some of the services and from the outcome of some of our work, particularly in the area of accountability for the provision of services. In the course of the past number of years, we conducted a number of reviews and investigations within the Irish health care system and at points in time we have been frustrated within those finding around accountability for the provision of safe and effective services. What we have seen, as aligned to some of the comments that Ms Dunnion made here, for example, on matters such as physical infrastructure, is that a commissioning model, in terms of projecting both strategic need and infrastructural need, is contained within some of the observations that we have made as part of that review and investigation model. Our experience in working with the HSE in communicating about services that it currently procures from the voluntary and private sectors also highlights to us the absence of a responsibility for what is being purchased. Our ideas on commissioning emanate from that experience.

Chairman: Is HIQA's emphasis on commissioning by the HSE of private sector or charitable services?

Mr. Phelim Quinn: It is informed by that. If we were to look at commissioning in a longer-term timeframe, any strategy would need to look at who would be the commissioner within that longer-term structure. I certainly mentioned, as an example, commissioning for individuals by current community healthcare organisations, CHOs, but in a longer-term strategy that would need to be further thought through.

Chairman: It surprised me HIQA assumed that was the best model without necessarily providing any evidence to that effect. Experience, for example, in the UK, would indicate that a commissioning model is extremely costly and convoluted and adds another layer where one is into the area of expensive consultancies with all that involves. I want to note that there is no evidence to support that approach over and above any other accountability system.

Mr. Phelim Quinn: I agree that a number of the systems in the UK across the four jurisdictions would have their specific challenges. What we need is a health care strategy that is orientated and focused on need and steered by primary care. The UK has a system of primary care trusts which commission services from the acute sector, for example.

Chairman: The UK is entirely different from Ireland.

Mr. Phelim Quinn: I appreciate that. I am speaking about what the longer-term strategy be or how it might evolve. It is a HIQA proposal.

Chairman: It is not necessarily a longer-term strategy, it is a very different approach which would not necessarily be supported in this committee or by the evidence.

Mr. Phelim Quinn: Deputy Browne raised issues in regard to nursing homes, to which my colleague, Ms Dunnion, will respond.

Ms Mary Dunnion: I thank the Deputy for his questions. We are glad to hear he met somebody who was complimenting HIQA because there is often a healthy tension between those delivering the service and those it regulates. On the Deputy's point regarding whistleblowers, we get a lot of information from service users and people employed by the service. There are a number of examples of where we received information and it instigated an unannounced inspection by us, not because we accepted what the person reported but to investigate whether there was any credence to the issue that he or she raised. In some cases, there has been and in others there has not. We will always follow up on detail like that.

Similarly in the context of any of the groups we regulate and monitor we have a system in place such that all information requested, queries on services or reporting about a service, are taken on board, analysed and used to inform our inspections, to target some of our types of inspections and also to inform policy. For example, the use of restraint is an issue that has been raised with us many times by people working within or using the services. This year, we hope to issue a guidance on restraint, which we hope will inform policy going forward and will be used as best practice in centres for vulnerable people. That is one example of information we received and how we responded to it to inform best practice.

On Deputy Harty's question regarding consistency across geographical areas, the Office of the Chief Inspector is determined by the Health Act. It determines our role, what we do and to what standards a service must be compliant. In that context, we are not cognisant of resources but we are aware of how we manage them. For example, most of the resource implications are in a physical environment. This is coming to the fore now in terms of disability centres. While there is a national policy for people to transition from congregated settings to the community, that process will take a long time. Also, people have lived in these centres for 30 years and so moving them is often not the right thing to do. If a centre requires a considerable investment in resources to improve its structure, we agree to register it with a condition. For example, if the centre can produce a timed plan, say, three years, to improve the environment for people living there then we register it. That is a really important piece for us and the centres. For example, we know of a disability centre that requires a €900,000 investment in order to comply with regulation 15 of the disability regulations. That centre does not have €900,000, nor would one expect it to have it. However, what one hopes for the people living in that centre is that in three years time the physical environment will have improved. We take cognisance in the context of directing them towards a plan to achieve that.

Deputy James Browne: What are the barriers to extending HIQA's role?

Mr. Phelim Quinn: It is an issue of Government priorities, factoring in the legislative timetable. We raise the issue because of our work in terms of safeguarding and also our own exposure to services, recognising the vulnerabilities of people in receipt of home care services.

Chairman: Does Mr. Quinn have information on the additional costs of commissioning?

Mr. Phelim Quinn: I am sorry, we do not have any specific information on additional costs.

Chairman: The final questions relate to health technology assessments, HTAs, and capital investment in primary care.

Dr. Máirín Ryan: All of the reports are publicly available on the website but I am happy to provide the committee with copies of the technical reports, including the advice section which outlines the main findings of each report.

Our role is to provide advice specifically to the Minister and his Department on major national health policy decisions and to the executive of the HSE with regard to national service decisions. In regard to the HTAs that we have done to date, a number of them focus on public health programmes. For example, in regard to cancer screening, we did a HTA that led to the introduction of BowelScreen, the colorectal cancer screening programme. We also did a HTA in relation to breast cancer and surveillance for women who are elevated risk before the age for BreastCheck. We are currently doing a HTA on HPV testing for CervicalCheck. We have also looked at vaccination programmes such as HPV vaccination for girls and BCG for boys. In acute services, I mentioned earlier that the HTA on mechanical thrombectomy will be published tomorrow. We have also looked at other interventions such as robotic surgery and referral thresholds for surgical procedures in terms of the criteria that the surgeon requires a patient to meet before he or she proceeds to surgery, with the view that providing that information means that we will not have patients being referred necessarily to the outpatients, which patients should be more appropriately managed in primary care. We have also looked at a number of interventions in primary care. For example, we have done a HTA on smoking cessation interventions, including drug therapies, counselling, telephone supports and so on. We have also included e-cigarettes. That is the first time this has been done in a national HTA. We have done HTAs in a whole range of areas.

Mr. Phelim Quinn: On capital investments, we have not had any experience of reviewing or regulating within primary care and as such our experience in terms of exposure in relation to capital infrastructure in primary care is very limited.

Chairman: I thank all of the witnesses for being here today. I also thank them for their presentations and their responses to all of the questions.

The select committee adjourned at 12 noon until 2.15 p.m. on Tuesday, 8 February 2017.