DÁIL ÉIREANN

AN COMHCHOISTE UM CHÚRAM MEABHAIRSHLÁINTE SA TODHCHAÍ

JOINT COMMITTEE ON FUTURE OF MENTAL HEALTH CARE

Dé Céadaoin, 13 Meitheamh 2018

Wednesday, 13 June 2018

Tháinig an Comhchoiste le chéile ag 1.30 p.m.

The Joint Committee met at 1.30 p.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
John Brassil,	Gabrielle McFadden.
James Browne,	
Pat Buckley,	
Joe Carey,	
Marcella Corcoran Kennedy,	
Michael Harty,	
Catherine Martin,	
Tom Neville,	
Fiona O'Loughlin,	
Anne Rabbitte.	

I láthair / In attendance: Deputies John Curran and Aindrias Moynihan and Senator Máire Devine.

Seanadóir / Senator Joan Freeman sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: We have received apologies from Deputy Fiona O'Loughlin. I propose that we go into private session to deal with housekeeping matters. Is that agreed? Agreed.

The joint committee went into private session at 1.40 p.m. and resumed in public session at 1.50 p.m.

Mental Health Services Staff: Discussion

Chairman: I welcome the deputations to the meeting. From the HSE we have Ms Rosarii Mannion, national director of human resources, and Ms Eithne Fox, assistant national director, national recruitment service. From the Public Appointments Service we have Ms Fiona Tierney, chief executive officer, and Ms Margaret McCabe, head of recruitment. From the Psychiatric Nurses Association we are joined by Mr. Peter Hughes, general secretary, and Ms Aisling Culhane. From the Irish Hospital Consultants Association we are joined by Dr. Donal O'Hanlon, vice president, and Dr. Kieran Moore. On behalf of the committee I thank you for your attendance today. You will be invited to make a brief opening statement. This will be followed by a question-and-answer session.

I wish to draw the attention of our witnesses to the situation on privilege. Please note that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if witnesses 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 nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members should be aware that under the salient rulings of the Chair they should not comment on, criticise or make charges against a person outside the Houses, or an official either by name in such a way as to make him or her identifiable.

I remind members and witnesses to turn off their mobile phones or switch them to airplane mode because they interfere with the sound system. I advise witnesses that any submission or opening statement made to the committee will be published on the committee website after this meeting.

Before I invite witnesses to make their opening statements, I remind members and witnesses that the purpose of today's meeting is to have a discussion on the processes involved in recruiting clinicians for mental health services. We are all aware of the challenges and the aim of this meeting is to explore options for simplifying the process to make recruiting clinicians more efficient and effective. We have had a couple of submissions that have not answered what we have asked for. We know what the problems are and what we are trying to do at this meeting is to explore options for simplifying the whole process.

I invite each of the witnesses to make an opening statement. We will start with Ms Rosarii Mannion of the HSE.

Ms Rosarii Mannion: I am the national human resources director of the HSE and I am joined by Ms Eithne Fox, assistant national director health business services of the HSE. I begin by thanking the Chairman and the committee for inviting us here today to discuss the processes involved in recruiting clinicians for mental health services. I am conscious that my colleagues were here on 9 May and went through this in some detail, so I will go through my statement fairly quickly, if that is okay. Maybe the Chairman wants to take it as read.

Chairman: If Ms Mannion wishes to add to it or simplify it, that will be fine. Is that all right?

Ms Rosarii Mannion: Perfect.

In terms of background, the public health sector is the largest employer in the country. At the end of December 2017, the census showed a 131,926 headcount, with whole-time equivalents of 114,297, inclusive of directly employed home helps. The workforce is made up of clinical and non-clinical grades, with more than three quarters of it in the former category. In 2017, a turnover rate of 6% was identified, similar to the 2016 rate and up from a rate of 5.8% in 2015 and 5.4% in 2014. There is significant churn within the public health sector's workforce, which places demands on attraction, sourcing, recruitment and retention activity. These activities, however, cannot be carried out in isolation from: workforce planning; training and talent development; staff engagement; performance management; and succession management in respect of the workforce. There are significant interdependencies across all those workforce related activities.

The Irish public health sector, in common with all health systems internationally, is facing significant recruitment and retention challenges generally and, more specifically, with certain grades and categories. The workforce has just come through an extended period of retrenchment and pay reductions. One of the most immediate effects on the workforce from the latter issue has been the ageing of the workforce. At the end of 2017, the percentage of employees of 55 years and older stood at 21%, up from a figure of 13% ten years earlier in 2007.

The recruitment and-or talent pool for many grades within the health sector is now increasingly becoming a global one and even within Ireland there is competition between the private and public health sectors as well as internally between hospital groups and community healthcare organisations. Ireland continues to face significant challenges in retaining its trained health professionals as well as attracting back many who emigrated and took up positions in foreign health industries, particularly in the context of the economic crisis of 2008 to 2014. In addition, sourcing and recruitment blackspots will require new assessments and approaches to address changing roles, skill mix and skill transfers in order to overcome such workforce gaps.

The people strategy 2015-2018 articulates and sets out the overall people management ambition, which is underpinned by an approach to the workforce that derives from human capital management which views people and personnel expenditures as investments in human capital rather than costs. Thus this gives greater credence to the adage that our people are our greatest asset which is perhaps more of an enabler than heretofore. It has been identified that health workforce management needs to focus on four main issues: acquisition; maintenance; motivation; and development of the workforce.

While clearly workforce planning is intrinsically linked to issues being addressed here, suffice to say, it is beyond the issue of numbers. Many activities relevant to the planning and management of the healthcare workforce, such as changing the scope of practices, redesigning jobs and transforming skills and roles of professional groups, are prerequisites to progress on major reforms of health systems.

More sophisticated and integrated models of workforce planning that cut across different professional groups and take account of a greater number of factors, such as skill mix, skill substitution, technologies and working practices, appear to offer a better prospect of contributing to the mission of the health system against a backdrop of continuous change and reform.

The next section is on the challenge with which I am sure the committee is very familiar, so I will move on.

The publication in May 2017 of the report of the Public Service Pay Commission, which was tasked with advising Government on public service pay, devoted a full chapter to recruitment and retention in the public service. This report was used to inform negotiations on a Public Service Stability Agreement 2018-2020, as an extension of the Lansdowne Road agreement. Thus the public health sector is likely to face a changing industrial relations environment that may add to the challenges impacting on the overall attracting, sourcing, recruitment and retention activity within public service.

Another significant emerging issue is the possible fallout from Brexit and analysis and assessments of it are still emerging.

Specifically with regard to the recruitment of consultant staff, the document provided at appendix 2, Towards Successful Consultant Recruitment Appointment and Retention, analyses the operational and administrative barriers in assisting with the efficient work of recruitment of the consultant workforce. The national strategy and framework for recruitment sourcing and retention of health workers is provided in appendix 1.

Specific actions have been taken in the HSE in respect of recruiting clinical staff for mental health services and I will summarise these. We have had the New Year-New Career Christmas campaign; the HSE talent pool, with more than 40,000 applicants; an international recruitment agency framework specifically developed for nursing and clinicians, directly targeting nursing schools and visiting all the nursing training colleges; graduate initiatives to retain our graduates; improved use of social media, particularly LinkedIn; a rolling campaign to allow applications 365 days of the year; the introduction of the psychology grade, where we have recently recruited 110 staff; local recruitment initiatives within the CHOs; investment in online technology; and increased use of Skype interviews.

If it is helpful to the committee, I would like to offer it the opportunity to visit some of the sites and perhaps participate in or observe the working of the consultant appointments approval committee, and visit national recruitment service, which is the shared service for recruitment. Perhaps that might inform the debate. I acknowledge also the work of our colleagues in the Public Appointments Service, who undertake the recruitment of consultants for us.

I thank the committee again for the invitation to be here and I am happy to address any of the member's questions or concerns.

Chairman: I thank Ms Mannion for her invitation. I call Ms Fiona Tierney.

Ms Fiona Tierney: I am the CEO of the Public Appointments Service and I am accompanied by my colleague, Ms Margaret McCabe, who is the head of recruitment. I thank the committee for its invitation to attend here today to discuss our role in the recruitment of consultant psychiatrists for the HSE. By way of assisting the committee, I would like to read this opening statement which explains our role as a recruiter for the Civil Service and the public service but I will concentrate very much on what we do for the HSE; the role of recruitment of medical consultants, including consultant psychiatrists; focus on improving the process and outcomes of medical consultant recruitment; and provide some detail on past and current activity levels in the recruitment of psychiatry posts.

I was struck by the number of submissions the committee has received and the detailed volume of information it has collated around the filling of positions and the length of time taken. There is no point going back through all that detail in our submission to the committee today. I take it as read that most of the members will be familiar with the Public Appointments Service. We are an independent office within the Civil Service, set up in 2004, through the amalgamation of the Civil Service Commission and the Local Appointments Commission, for the purpose of providing an independent, merit-based, transparent recruitment process for appointment to Civil Service and public service jobs. As part of that role, and with a history going back to the foundation of the State, the Public Appointments Service has been involved in recruiting medical consultants on behalf of the HSE and its predecessor organisations. It is only one part of what we do.

We conduct more than 400 recruitment campaigns per year, handling more than 100,000 applications, interviewing more than 15,000 people per year and making about 10,000 appointments to different jobs. I can take any questions about our role subsequently, but I will summarise it to that level. I will talk a little bit about our role in the recruitment of medical consultants. As stated, we work on behalf of the HSE to recruit permanent medical consultants for HSE hospitals and community health organisations, including some academic positions. It is not our role to recruit for section 38 institutions and organisations, voluntary hospitals or any locum consultant posts. We have no role in any of those appointments.

PAS and its predecessor, which, as I said, was the Office of the Civil Service and Local Appointments Commission, have been recruiting medical consultants under the auspices of the Health Act 1970. The function transferred to the HSE in 2005 and the HSE has requested us to continue to carry out recruitment on its behalf. The role of PAS in the recruitment of medical consultants is to undertake the recruitment and selection process as set out under the Commission for Public Service Appointments processes. This includes the advertising of posts; the composition, management and support of interview boards; and all employment checks for successful candidates. We have included a schematic of the activities we undertake as part of that recruitment process at appendix A in order to support the committee in its understanding.

The process is very long and I know that all the members are, at times, very frustrated with the complexity of its overall design. We are a bit player in the middle of a process in which the sanctioning of roles, the design of job descriptions and so on are carried out in the HSE. Once posts are sanctioned they come to us. We advertise and run the selection process, run all of the checks, and then make a recommendation to the HSE which engages in contract negotiations. We currently have 1,618 candidates registered to receive job alerts for medical consultant roles, 260 of whom are registered for the subcategory of psychiatrist.

We want to talk a little bit about the focus on improvement of the process in recruiting medical consultants. PAS is aware that the committee has been briefed previously on the challenges

of recruiting medical consultants in Ireland. Full details of activity levels etc. were provided in the submission by Professor Frank Murray to the meeting of the committee on 9 May 2018. Since 2013, PAS has been working with the HSE to improve the overall recruitment process for medical consultants with a view to increasing success rates in the numbers and quality of medical consultants being recruited.

Over the past five years, our focus has been on four areas. The first is improving the overall quality of the recruitment process. Following an in-house review of the end-to-end recruitment and selection process for medical consultants in 2013-2014 using "lean" techniques, it became clear that constitution of the interview boards was taking a significant period of time. In early 2014, PAS began a process of reviewing the number of board members for medical consultant roles and, following a proposal and consultation with the HSE, it reduced the number of interview board members from ten down to five. This proposal was implemented in February 2015. This change has facilitated a more timely scheduling of interview boards and has reduced the overall time taken to complete the selection process.

The second area is that of consultant psychiatrist posts. In reviewing the outcomes of selection processes that took place in 2014, we identified that there was a significant issue in attracting candidates to apply for psychiatrist posts. In the first and second quarters of that year in excess of €35,000 was spent on focused advertising for psychiatrist posts. Posts were advertised in national newspapers weekly over a two-month period and also in international journals in America, New Zealand, Australia, Canada, the United Kingdom and Africa. At the end of the second quarter of 2015, the services of the executive search function in PAS were engaged to try to improve the numbers and quality of candidate pools for consultant psychiatrist positions. The outcome of this work is in appendix B. This information was forwarded to the HSE and discussed at a number of meetings. I would like to bring the committee's attention to appendix B because, having read some of the deliberations of the committee heretofore, it might be worthwhile spending a few moments going through the outcome.

Chairman: To be honest, Ms Tierney is talking about 2014 and 2015. This meeting is very much about now. I really do not think it is appropriate to speak to that appendix.

Ms Fiona Tierney: I appreciate that view but in the marketplace in which we are hiring, the drivers of and barriers to recruitment in filling these positions have not changed significantly.

Chairman: I think the members are going to ask Ms Tierney specific questions about that.

Ms Fiona Tierney: That is fine. We can come back to it. That is no problem at all.

Chairman: Would Ms Tierney like to just finish what she is reading?

Ms Fiona Tierney: There is no difficulty with that at all.

I will move on to the Keane report on medical consultant recruitment. At the end of 2015, we were invited by the HSE to participate in a group chaired by Professor Frank Keane to review the overall recruitment and retention of medical consultants. Over the course of 2016 we attended a range of meetings, providing knowledge and expertise in recruitment matters with a key recommendation that a comprehensive job analysis be carried out on the role of medical consultants. We were successful in providing this recommendation in the published report in February 2017. We commenced a procurement process to retain an external partner to conduct a job analysis of the role of a medical consultant in the Irish healthcare system in October 2016. The analysis involves a systematic review of the key knowledge, skills and abilities required

for the role. This process is now coming towards a conclusion. I have included in the submission a statement of activity levels which, in the interests of time, I will not go through with the committee.

To conclude, I assure the committee that we are committed to high standards in all of our recruitment work, which includes the recruitment of medical consultants. Should there be any matters relating to recruitment in this area which the committee believes we should address by way of continuous improvement, we will give these our full consideration. I trust this statement is of assistance and I am happy to discuss the issues arising.

Mr. Peter Hughes: I thank the committee for this invitation to look at recruitment processes in the area of mental health. I will be addressing the issue of mental health nurses. By way of background, the committee will be aware that there is a major crisis in the recruitment and retention of nurses in the mental health services. This has had a significant impact on the delivery of services resulting in, for example: inadequate child and adolescent mental health services, which was clearly verified by the Ombudsman for Children in his report this morning; a lack of properly resourced community teams; the absence of 24-7 community crisis teams; and admissions reaching 120% of bed capacity in admission units, resulting in the indignity of service users sleeping on chairs and mattresses in Kilkenny and Waterford services.

A recent survey of Psychiatric Nurses Association, PNA, branches suggests there are approximately 500 nursing vacancies in the mental health services. Services with the highest levels of vacancies, equating to 20% of the nursing staff, include: St. Joseph's in Portrane with 64 vacancies; St. Loman's at Tallaght Hospital with 52 vacancies; the Louth-Meath service with 38 vacancies; and the Waterford service with 26 vacancies. Nursing shortages in mental health services are expected to be exacerbated significantly in the next four years. According to HSE figures in December 2016, 34.2% of the mental health nursing workforce are expected to retire in the next four years, amounting to a total of 1,752 nurses.

Taking into consideration the number of imminent retirements, our understanding of the HSE's convoluted processes is laid out in appendix 1. I will do my best to talk the committee through it but, as the committee can see, there are many boxes. A nurse vacancy arises through retirement or resignation. An employee HR106 form with an agreed end date is signed in consultation with the manager. This form goes to the area director of nursing for sign-off. It then goes on to the assistant director of nursing managing human resources for the nursing leadership team. The HR106 form is then processed by national personnel records. The assistant director of nursing then completes a business case to have the post replaced, this is known as form B. The submission sheet is completed by the assistant director of nursing and signed by a service manager, which is a grade VIII post. Both forms are sent to the service manager's office, where they are logged. The submission sheet is endorsed and signed by the head of mental health services. Form B is signed by the head of mental health service and is sent to the pay and number strategy, PNS, group for the community health organisation, CHO, area, including a risk assessment form. The group generally meets on a monthly basis. There are difficulties with having forms signed due to incomplete forms or whatever. If the application is approved, it is signed by the HR, as chairman of PNS group, and then it is signed by the chief officer.

Approval is returned to the head of mental health, the approval is forwarded to service managers and then it is forwarded to the area director of nursing, ADN. Once approval is received by the ADN who manages HR, the pre-placement assessment form is completed. A job order form is completed next and the documentation forwarded to the job orders section.

The next step of the process commences with a unit called health business services, HBS, recruitment. The HBS deals with the recruitment process, job order and documentation and the post is offered to any existing panels. If no panels exist then one must await a new campaign to commence. The waiting time for new campaigns is significant. The post remains vacant unless covered by a specific purpose contract, agency staff or overtime. Specialist and higher posts, such as a clinical nurse manager 3, an assistant director of nursing or a director of nursing are usually filled through a specific purpose contract, which then depletes front-line staffing. As this process develops at a higher level, a domino effect sets in. The person replacing is often at a higher management level. He or she must be replaced and it can take more than six months for each post to be filled.

This process is only dealt with when the postholder has availed of all of his or her annual leave and remaining time owed, and the position is officially vacant. Let us say a nurse hands in his or her resignation. Due to his or her amount of annual leave or time owed, he or she may not come off the books for six to eight weeks. The process, therefore, cannot start until that happens. The timescales vary considerably. For permanent posts with a live current HBS recruitment panel in place, it will take six months plus from securing approval to a person commencing work.

This is a cumbersome and frustrating process. The feedback from our members, including senior nurse managers, is that it can take between six months and a year to replace a nurse leaving the service. We have evidence from CAMHS in the CHO 8 area that two posts, one of which is a development post, still have not been permanently filled after three years. We are also well aware of the crisis in CAMHS.

In summary, my presentation illustrates that 25 steps must be completed to recruit a nurse for mental health services, with a multitude of signatures required to complete the process. We believe that this system of recruitment is totally unsustainable to ensure the delivery of effective mental health services.

Chairman: I thank Mr. Hughes for his presentation. I thought that there were 27 steps.

Mr. Peter Hughes: We did not count the final two boxes, as outlined in my presentation, because the process is over at that stage. The boxes outline the timeframe, etc.

Chairman: I call on Dr. O'Hanlon to make his presentation.

Dr. Donal O'Hanlon: I thank the Chairman and committee members for the opportunity to address them on the processes involved in recruiting consultants to work in mental health services. The association represents 85% of the hospital consultants who work in acute hospital and mental health services.

It has been recognised for some time that there is a clear need to simplify and speed up the processes involved in recruiting consultants to work in mental health services, and how consultant posts are established, advertised and filled throughout the health service as a whole. It is important to note that complications and difficulties with the recruitment process are not the fundamental problem that causes our current consultant recruitment and retention crisis. This deep-rooted problem is the result of the failure of the State and employers to honour consultant contracts and the imposition of the new terms and conditions placed on new entrant consultants. This has been exacerbated by the FEMPI cuts applied to salaries and systemic funding shortfalls in psychiatry and mental health services over the past decade.

The health service is uncompetitive in recruiting and retaining the number of high calibre consultants that it requires. This sharp decline in competitiveness is evident from data supplied by the Department of Public Expenditure and Reform in a submission to the Public Service Pay Commission last year. The data indicated that psychiatry has 31% of its permanent posts either vacant or filled on a temporary basis, and of the 44 psychiatrist posts advertised in 2015 and 2016, practically a quarter had no applicants and 30% had only one applicant. There were 16 consultant psychiatrist posts interviewed for in 2016, including posts in child and adolescent psychiatry, learning disabilities, forensic psychiatry, general adult psychiatry, and psychiatry of old age, but no applications were received. The competitions that had no applicants were for mental health services posts in Sligo-Leitrim, Cavan-Monaghan, Cork, the Central Mental Hospital, Carlow-Kilkenny, Donegal, Longford-Westmeath, Laois-Offaly, and the Waterford-Wexford. In effect, the health service no longer competes in an internationally competitive recruitment market for specialist medical consultants.

My association's previous submission to the committee highlighted three separate expert reports that were compiled over the past decade or more. They all confirmed that the current number of approved consultant psychiatrist posts is significantly below the level needed to provide safe and effective care to patients. The Hanly report, the HSE national doctors' training and planning unit and the College of Psychiatrists of Ireland report all recommended significant increases and up to as many as 858 consultant psychiatrists by 2020. Of the existing 420 approved consultant psychiatrist posts, only 290 have been permanently filled.

In addition to the overwhelming problem with uncompetitiveness, due to the breach of contract and discriminatory salaries imposed on new entrant consultants, other issues impact on recruitment. These secondary issues have been assessed in the HSE-commissioned report entitled, Towards Successful Consultant Recruitment, Appointment and Retention, which was published in February 2017. Notwithstanding its strict terms of reference set out by the HSE director general, the executive summary stated that, "simply correcting and providing rigour to the recruitment and appointment process was not of itself enough to address the present Consultant recruitment crisis but that other factors also needed to be addressed". These, the report noted, included shortfalls in consultant numbers and the availability of consultants, working conditions and "most particularly, concerns regarding remuneration". The report described the discriminatory new entrant salary scale as a "source of concern to candidates as well as a potential source of intra-departmental disharmony and a disruptive influence on the need for good team-working".

The Keane report also identified deficits in the current recruitment process, including a disconnect between posts approved and training programmes, as well as limited engagement with trainees on forthcoming opportunities. The lengthy periods to progress applications for the approval and advertising of posts were also highlighted, involving multiply bodies such as hospitals or agencies, the consultant appointments advisory committee, CAAC, the national recruitment service and the PAS. The arrangement of interview boards has also caused delays. However, this debate is largely academic if no applicant or just one turns up for an interview.

Some progress has been made on the 38 recommendations in the Keane report but we have yet to see significantly shorter timescales for key aspects of the recruitment process. The reduction in consultant psychiatrist posts advertised – down from 32 in 2015 to 12 in 2016 – is also a significant concern, suggesting that vacant posts were not advertised because the HSE did not anticipate that they would be filled.

The association believes there is an over-reliance on national HSE panels to recruit front-

line mental health staff, rather than creating panels for specific posts. This should ensure a more focused post-specific recruitment process and negate the inherent problems with the formation of national panels. Waiting until a vacancy occurs to begin recruitment is poor practice but all too common. As a result, greater anticipation of the opportunities occurring due to retirement must be built into the recruitment system at a much earlier stage to reduce the gap between a consultant leaving the mental health services and the replacement taking up the post. Proper succession planning is vital in any business or organisation. However, while this would be beneficial in circumstances where we are competitive, in the current breach of contract and new entrant discrimination environment it is expected it would lead to more posts with no applicants.

Data from the World Health Organization, WHO, confirm that Ireland currently has 6.1 consultant psychiatrists per 100,000 population, the fourth lowest out of 26 OECD countries. This is nearly half the EU average number of consultant psychiatrists. Not alone is the psychiatry service unable to fill advertised posts but it appointed 21 non-specialists to consultant psychiatrist posts last year across all psychiatry specialties in ten mental health services. This undermines the safety and quality of patient care and the provision of services.

The failure to fill consultant psychiatrist posts is severely undermining the quality and quantity of the psychiatry service that can be provided to patients. The health service's uncompetitiveness in recruiting and retaining consultant psychiatrists is the fundamental problem that needs to be addressed far more than the recruitment processes. I thank the committee for inviting us to today's discussion.

Chairman: I will briefly outline the process. Several members will have seven minutes to ask questions and receive the answers, if that is possible. Before the witnesses arrived I informed members of the very serious nature of the resignations of several psychiatrists in the south east, meaning that from mid-July onwards, unless they are replaced there will be no services for children in the south east. That includes north Wexford, south Wexford and Waterford. Personally, I find that extremely disturbing. I do not know if Deputy Browne was aware of that.

Deputy James Browne: I put out a press release about it yesterday. Before getting into the substance of this matter, who was responsible for submitting an 80-page document - a report on consultants' recruitment and retention - yesterday evening?

Ms Rosarii Mannion: I was.

Deputy James Browne: Why was it submitted so late?

Ms Rosarii Mannion: I offer my sincere apologies. The document went from me to the parliamentary affairs division and from there to the Deputy. I take full responsibility for the document arriving yesterday.

Deputy James Browne: If this was a once-off and from one person, we would not notice it but I have served on this committee and the Committee on the Future of Healthcare. Trade unions, voluntary groups, individuals, professional representative bodies and everybody else get their stuff in on time but with the HSE it is a common and consistent practice that a massive amount of information is dumped on us the night before. It drowns us in information. It is clearly a systemic policy and deliberate as it happens every time. I am not having a go at Ms Mannion but it is clearly a policy of the HSE. It happens at every committee at which it is to be represented.

It has been stated that recruitment is the single biggest challenge for mental health services

but it is clearly also the biggest failing in mental health services, particularly for children. It is evident right down to basic services, where there is a lack of talk therapy and psychologists, as well as in the acute services such as CAMHS, access to accident and emergency departments, training and awareness of staff. It is a crisis and children are being irrevocably damaged to the point where some are losing their lives. We know this. General staffing levels are approximately at 75% of those recommended in A Vision for Change. The level is at approximately 56% of the recommendations for CAMHS, although it seems to go up and down a small bit, and it is similar for old-age psychiatry. Mental health and intellectual disability staffing is pretty much non-existent. There are consistency problems and there is gatekeeping going on. In some areas if somebody comes in with an autism diagnosis, they are not welcome and have to go somewhere else. Mental health and intellectual disability services are pretty much non-existent.

There are over 100 nurses on panels seeking jobs in CAMHS but they are not being given jobs because they are on general panels. We are consistently told they are seeking jobs where they are not needed, which is amazing. Apparently they will not go where the HSE say they are needed. I am not aware of too many places in mental health where there are too many staff. I would like an explanation again as to why there are so many nurses on panels waiting for jobs.

There is a serious shortage of psychiatrists but the College of Psychiatrists in Ireland sought a 10% increase in the number of training places this year. The HSE only approved a 5% increase. I would like an explanation as to why that is so. The college wants to train more psychiatrists and it has the people but the HSE is refusing to increase the number of places. We heard from Mr. Peter Hughes about the 34% retirement figure but I speak regularly with psychiatric nurses and many of them just want to get out. It is not that pay is not important - it is for everybody - but conditions are intolerable. There is a level of stress and one of the consistent issues that arise is the mental health of psychiatric nurses, psychiatrists and other staff working in the area. They are trying to do the impossible and they are consistently triaging. I am very familiar with Wexford and I know many of the families effectively being triaged. Psychiatrists and other staff in Wexford have my sympathy as it must be horrendous to have to look at families and children, constantly trying to triage and decide who is in the worst position.

It seems such a situation is becoming normalised, with acceptance of the genuine difficulties in recruitment. Mr. Hughes pointed out the number of unnecessary blocks being put in the way, which we saw with psychologists in particular. For a long time anybody not trained as a clinical psychologist was simply being blocked from going into mental health services. They may have been trained in other areas, such as counselling psychology, for example. Last year many *ad hoc* blockages were evident; for example, a person might have been fully qualified but had not done two weeks of training in a particular aspect. Such blocks were seen by people who wanted to enter the mental health area. Everybody is massively frustrated at this stage.

We must deal with this as an emergency. In Waterford and Wexford, by 1 August, as I understand it, there will be no practising psychiatrist. There are 3.6 full-time equivalents down there but one is on sick leave and the other 2.6 are leaving. The non-consultant hospital doctors, psychologists, occupational therapists and all the staff working under psychiatrists can no longer do their jobs effectively because there is nobody to oversee what they do. Will they be redeployed? If they are redeployed, what psychiatrist will come to the area? Speaking with consultants from outside the country looking at coming to Ireland, they say their lack of interest is not just about pay but the lack of an office, secretary or staff. They would spend their first year trying to recruit people. That was probably as much a rant as anything else, but the frustration in this area is real. We experience the frustration daily in our offices when dealing with

the families and trying to represent them to get the supports they need. There are other families effectively competing for the supports, in particular for their children, which is horrendous as well.

Chairman: The Deputy's rant is understandable. However, I heard a question as well. Does the Deputy wish to direct it to anyone in particular?

Deputy James Browne: I am usually criticised for just asking pointed questions and not talking around them. My comments were all directed to the HSE. Perhaps others will have commentary to contribute. In particular, what is being done to address the difficulties recruiting nurses and keeping them in the job, and finding training places for psychiatrists? Clearly, what has happened to date is not working. It is failing the staff and failing service users.

Chairman: It is important to focus on the Deputy's questions and not go through the report or anything like that.

Ms Rosarii Mannion: Yes. That is perfect. I will try to address the points in the order in which the Deputy raised them. He should feel free to interrupt me.

I apologise for the timelines surrounding the documentation. It is not the first time we have heard such criticism. We will bring it back and ensure it is not repeated in future.

It is not the first time I have heard these criticisms about recruitment. I am not here to defend what is indefensible. That would not be constructive. I have been in post since September 2015. On coming into post, I was acutely aware of the recruitment issues in respect of clinicians and nursing. This is why we commissioned Professor Frank Keane to examine the consultant recruitment issues. Clearly, many of these issues are complex, and there is no single thing we can do to address them, but the 38 recommendations we are implementing are improving things. It might not look that way, but they certainly are, and we are making progress on each of them. This is the first step.

Overall, regarding the general recruitment issues, I brought a detailed paper to the leadership team last November. As HR director, I am picking up on these issues across the system. Arising from that paper, I was asked to chair a group which would look at improvements to the way in which we do recruitment across the system. Our recruitment is through a shared service, that is, one national centre for recruitment. There are different views on how we can better do recruitment: whether it can be devolved locally, the fact that large-volume competitions can be done centrally, etc. Committee members are welcome to come and sit in on this process.

Chairman: The committee has gone through this over and over again. The most significant request we have made is to recruit locally. We have had millions of reports and they all come to the same conclusions.

Ms Rosarii Mannion: I agree and I support that thesis.

Chairman: We are not directing this at Ms Mannion. One of the other blockages, especially in respect of Wexford and Waterford, is that the working conditions in the building in which the team in Wexford have to work are appalling. They cannot take medical measurements or carry out risk assessments because of the building. The condition of the building is the biggest block.

I call Deputy Rabbitte.

Deputy Anne Rabbitte: I thank everyone for their presentations. I have a few questions

for Ms Mannion. "Within certain grades" was one of her comments. What grades are the HSE failing to fulfil? She then referred to black spots. Do they relate to sourcing and recruitment? Will she elaborate on that?

Regarding the recruitment of non-national nurses, people who have applied to work in the country but who cannot even get a visa or their qualification certified. Perhaps Ms Mannion or Mr. Hughes could explain. Approximately 100 non-nationals are waiting to come to work in the State.

I do not mean to be flippant in the way I am going to ask this next question. How often do all the witnesses sit in the one room together and thrash out policy and strategy?

I thank Mr. Hughes for his detailed graph regarding the 500 nurses. It is welcome because it gives us a clear understanding of the matter. Does that then go through 25 different hands before the end is reached? Are there 25 different steps to the recruitment process?

Dr. O'Hanlon stated:

> The failure to fill consultant psychiatrist posts is severely undermining the quality and quantity of the psychiatry service that can be provided to patients. The Irish health services' uncompetitiveness in recruiting and retaining consultant psychiatrists is the fundamental problem that needs to be addressed far more than the recruitment processes.

There is a message in that. Will he elaborate?

Finally, he said the number of consultant psychiatrists per 100,000 population was the fourth lowest of 26 OECD countries. Are we still the fourth lowest?

Ms Rosarii Mannion: I thank the Deputy for her questions.

The grades with which we have difficulties are predominantly in mental health nursing, radiography, psychology, paramedics, consultants, psychiatry, and, in some cases, non-consultant hospital doctors, all of which are set out in chapter 6 of the report of the Public Service Pay Commission - Recruitment and Retention in the Public Service. We are engaging with the commission on the next steps regarding that report.

The black spots depend very much on the grade. It is broader than mental health, but, for instance, in public health nursing, we have a specific problem in the east because many people choose to relocate there. There is variation in respect of living conditions, accommodation and education facilities. These factor into the dynamic when people choose to work in specific locations. For public health nursing, the problems are outside of Dublin. There are difficulties with some of the consultant posts in model 2 and model 3 hospitals as well. We have heard from the Chairman about Wexford and Waterford. However, it is important to understand that we are making attempts to address these specific areas. The point I was making to the Deputy Browne is that, as a result of that specific report, we have a group that is looking at designing a better model for recruitment. I am confident that this will deliver options such as more local autonomy within what is a funded workforce plan for each area certainly by July or so of this year. That will then have to be implemented, but we are working towards that.

Regarding the 25 layers and the signatories, recruitment is handled through HBS. This is all determined by the relevant chief officer within the given area. We have had issues with nursing, particularly in the past two years, and arrangements have been put in place whereby

delegated authority has been given to the directors of nursing. This has been enabled across the system as far as practicable to give that delegated authority to nursing in particular. Where this is working, it will be supported. Each chief officer has his or her own budget, and he or she works to a workforce plan. The decisions as to what the layer of delegation is and who signs what are determined locally within the operational system. Centrally, within HR, I specifically do not have involvement in that. I am chair of the group that is going to bring forward a better model but I do not have responsibility for the determination of levels or signatories in regard to operational funding.

Chairman: I thank Ms Mannion.

Ms Rosarii Mannion: I ask Mr. Hughes to address the issue of the layers and how it is working in terms of practical operations on the ground rather than a desktop exercise.

Mr. Peter Hughes: We estimate that recruitment goes through nine pairs of hands and possibly twice through some. I am not aware of delegated authority having been given to a director of nursing. Prior to appearing before the committee, we contacted our branches to get the information used to compile the chart and received an almost identical response from each CHO area. If a person making up one of the layers takes annual leave, the recruitment will not be signed off until that person returns. As was stated, the process does not start until the person leaves. A person may have worked his or her last day six or eight weeks previously but he or she does not come off the books and the process with health business services, HBS, does not begin until he or she leaves. A recruitment retention agreement going back to 2016 states that process should take 28 days but that is not being achieved in any area. It is taking months. As I stated, all it takes to cause a delay is for a person making up one layer to take annual leave.

I am unaware of any director of nursing having been delegated authority. We suggest that directors of nursing be given the authority to recruit because there are significant vacancy rates of up to 20% in several areas. I do not see why one should have to go through a pay bill group on a monthly basis to ascertain whether a nurse is needed and for the related shortage to be dealt with by agency workers and overtime. The HSE has stated that there is a saving of 14% to 16% in having directly employed staff rather than using agency staff. There are similar savings in regard to overtime. When it is very obvious that someone is leaving or indicates an intention to leave, a replacement should be recruited within a very short period of time.

We issued a survey to some of our members in private areas. If a panel is in place, it usually takes a maximum of six weeks for the new recruit to begin work. Issues with Garda clearance, etc. may cause delay in some areas but that is the general timeframe.

On foreign recruitment and foreign nurses, we were recently contacted by a nurse in the United States who has been trying to return to Ireland for a year but is having difficulty getting his or her registration verified. I also received several emails from an Irish nurse who works in Qatar. As Skype is not available in Qatar, the United Arab Emirates and neighbouring countries, there was no facility to interview the nurse, who had nine years of experience in CAMHS and wanted to come back to Ireland to work in CAMHS but is still in Qatar. That Irish-trained nurse was not facilitated with an interview and I have received numerous emails on the matter.

Deputy Anne Rabbitte: Similarly, my office has been contacted on several occasions by people who wish to return here, although that was in regard to nursing homes rather than mental healthcare, which is the focus today. The issue may be the stamp on a person's passport or the reading of his or her qualifications. Is there much of a backlog from a human resources, HR,

point of view?

Chairman: I ask Ms Mannion to be brief in her response as Deputy Neville must leave shortly and would like to put his questions before he does so.

Ms Rosarii Mannion: I am not aware of a backlog in terms of visas but will look into the matter and revert to the committee. The case mentioned by Mr. Hughes was raised with me and arrangements to interview the nurse were made immediately. This is clearly an issue at which we need to look in detail and perhaps furnish the committee with a detailed and considered response if that is acceptable.

Chairman: Absolutely. I thank Ms Mannion and Deputy Rabbitte. I skipped Deputy Neville, for which I apologise.

Deputy Tom Neville: Ms Mannion mentioned the working group on change in the recruitment process. Who signs off on that change? If we had a list of five changes that could speed up the process, what person or position within the HSE would make the final decision on those changes?

Ms Rosarii Mannion: The recommendations of the group go to the leadership team of the HSE and the final decision is made by the director general.

Deputy Tom Neville: The director general will have the final sign off on recommendations.

Ms Rosarii Mannion: Yes.

Deputy Tom Neville: Have any recommendations or other information gone to the director general from the group?

Ms Rosarii Mannion: Yes. We asked for a better focus on devolving recruitment. Staff nurse recruitment is now entirely devolved to local areas.

Deputy Tom Neville: Staff nursing is devolved to local areas.

Ms Rosarii Mannion: It is.

Deputy Tom Neville: Were any other recommendations passed to the director general but not signed off?

Ms Rosarii Mannion: No, absolutely not. I should clarify that I am very happy to own this issue as the director of HR-----

Deputy Tom Neville: I understand that.

Ms Rosarii Mannion: ----and I need to address it. I am not trying to say it is the responsibility of somebody else.

Deputy Tom Neville: That is not what I am saying. The kernel of my question relates to finding out who is accountable and who signs this off and makes the change. We want changes to be made as quickly as possible.

Ms Rosarii Mannion: The director general signs off on the changes.

Deputy Tom Neville: The director general.

Ms Rosarii Mannion: Yes.

Deputy Tom Neville: Has the director general not signed off on any recommendations of the working group?

Ms Rosarii Mannion: No.

Deputy Tom Neville: None whatsoever.

Ms Rosarii Mannion: None.

Deputy Tom Neville: How many recommendations have been made to the director general?

Ms Rosarii Mannion: The options in terms of the different models are set out on three pages which I will furnish to the committee. I should clarify that I am entirely happy to own this issue and I will see it through and address it------

Deputy Tom Neville: That is fine.

Ms Rosarii Mannion: ------but recruitment within the HSE is not within my portfolio because it is part of a shared service. As director of HR, I am looking at the recruitment issue and will address it.

Deputy Tom Neville: Ms Mannion stated that recruitment is a shared service.

Ms Rosarii Mannion: Yes.

Deputy Tom Neville: Who is responsible for recruitment?

Ms Rosarii Mannion: I am responsible for policy direction in regard to all HR matters in the HSE------

Deputy Tom Neville: Who is responsible solely for recruitment rather than all HR matters?

Ms Rosarii Mannion: The national director of HBS is responsible for all processing matters and recruitment is a processing issue.

Deputy Tom Neville: Within that silo, one has recruitment. Is there a position with responsibility for recruitment within the processes that Ms Mannion mentioned?

Ms Rosarii Mannion: Yes, there is.

Deputy Tom Neville: Recruitment comes under that person or position.

Ms Rosarii Mannion: Recruitment comes under HBS because it is a process. However, we obviously need to do better in regard to recruitment and we will do so. We have brought forward the policy paper, established the working group and a recommendation has gone to the director general in regard to devolving the staff nurses. More recommendations will be made and there will be------

Deputy Tom Neville: Okay. I understand that.

Ms Rosarii Mannion: -----a lot of action between now and year end.

Deputy Tom Neville: I am trying to ascertain what efficiencies can be achieved within what Ms Mannion is doing because although all of these groups are meeting, the bottom line is that the process is extremely frustrating, as stated by Deputy Browne. Has there been any pushback from local CHOs in regard to devolved recruitment?

Ms Rosarii Mannion: I would not describe it as pushback. A very reasonable response from local areas has been that appropriate resources must be allocated to a devolved function. The national recruitment service for the HSE is operated by health business services in Manorhamilton. It has a level of resource but we must look at a mechanism whereby locations would be supported to perform any devolved function. As the Deputy is aware, recruitment is a very risky business. We cannot do anything that would compromise the processes. Many of the delays involving various issues and sign-offs or whatever else are for a very good reason.

Deputy Tom Neville: I am sorry to cut across Ms Mannion but I am limited in terms of time.

Ms Rosarii Mannion: I am very happy to have a separate session with members for a day or half a day if that would be helpful because I hear the annoyance and frustration of the committee.

Deputy Tom Neville: Okay. Does Ms Mannion have statistics for the dropout rate within the process?

Ms Rosarii Mannion: Applicants who do not come through to interview. Some 60% of applications come from within the system and in terms of dropout------

Deputy Tom Neville: Some 60% come from within the HSE.

Ms Rosarii Mannion: Within the health service, yes. There is a significant amount of churn.

Deputy Tom Neville: That is fine. Does Ms Mannion have any statistics on how many people have started the process and how many drop out before the end?

Ms Rosarii Mannion: I do not have that to hand but I will check with the recruitment service.

Deputy Tom Neville: I ask Ms Mannion to furnish us with statistics on how many people drop out of the process.

Ms Rosarii Mannion: I will do so.

Deputy Tom Neville: Ms Mannion said 40% of applicants came from outside the HSE.

Ms Rosarii Mannion: Yes.

Deputy Tom Neville: Can she furnish to us the dropout rate both for people within the HSE and those outside?

Ms Rosarii Mannion: Yes. Before close of business on Friday I will be happy to furnish the committee with the exact data. They are all available.

Deputy Tom Neville: Ms Mannion said she was putting recommendations together but I am confused because she has furnished the committee with an 80-page document showing how

things should move.

Ms Rosarii Mannion: The document sets out the policy. Then it has to be implemented and a document is only as good as its implementation.

Deputy Tom Neville: How long have you been meeting?

Ms Rosarii Mannion: We have been meeting since February of this year.

Deputy Tom Neville: When are you hoping to finalise?

Ms Rosarii Mannion: I would hope to do so by the end of June.

Deputy Tom Neville: Is there a term of reference for finishing by June?

Ms Rosarii Mannion: Yes, there is.

Deputy Tom Neville: The deadline is June.

Ms Rosarii Mannion: Yes.

Deputy Tom Neville: Where are you with the recommendations? Are you three quarters of the way there?

Ms Rosarii Mannion: We could have got the recommendations a lot more quickly but there is a process of engagement which is designed to ensure we get something with which people are comfortable and can live. We have to ensure it is lined up with resourcing, funding and so on. One cannot go from one situation to another which makes it worse. Our difficulty was in getting all the pieces lined up. I will be going to the leadership team in July with my recommendations. It has been a painful enough process and I am hopeful they will be supported so that we can have a more efficient model.

Deputy Tom Neville: The service is a shared service, as is finance. Does a member of finance, or someone with responsibility for financial decisions, sit on the working group?

Ms Rosarii Mannion: Yes. I am not a shared service. The shared service for HR is within HBS.

Deputy Tom Neville: That is the business process.

Ms Rosarii Mannion: It is health business services.

Deputy Tom Neville: In the working group which Ms Mannion has put together, is there a member for finance?

Ms Rosarii Mannion: Yes, there are two.

Deputy Tom Neville: Are they there in a decision-making capacity?

Ms Rosarii Mannion: Absolutely, yes.

Chairman: All the questions seem to be focused on Ms Mannion at the moment.

Deputy John Brassil: The committee has felt very strongly from the first meeting that if the recruitment issues were resolved and positions filled that were funded and available, includ-

ing CAMHS teams and psychiatric nurses, we would go a long way to resolving a lot of the issues. Recruitment is an issue which will go a long way to solving what is a very complex service. Anyone listening to Mr. Peter Hughes's explanation of how one person is recruited would see that something was certainly amiss in how we do our business. I have experience in the private sector, with the local authority and with the Kerry Education and Training Board, all of whom recruit a lot of people. Many teachers are recruited annually in this country and many local authority staff are recruited but the process is nowhere near as complex as what has been outlined here.

Ms Mannion has been in the job for nearly three years. Is what she is trying to achieve doable? Can she unravel it to make it as simple as possible and make it work or is the whole thing so complex that she cannot? If all 36 recommendations were implemented, would she have a system that operated to some level of efficiency? It is not there at present.

Are all the positions we are trying to fill funded or, if she fills a post, does she have to look for the finance? Does the HSE have to say it will only give a person a job when it has got funding for them? If the level of complexity in the system is not simplified Ms Mannion's job is impossible, as is ours. One of the first recommendations in our report will be to resolve the recruitment issue within the HSE. If what Ms Mannion is trying to unravel is not possible, we have to go about it another way and build a new system from the bottom up. Dr. O'Hanlon outlined the issue with consultants and Mr. Hughes spoke about the issues with nurses and other staff. What is there at the moment is absolutely unworkable.

Ms Rosarii Mannion: I have a people's strategy and I go around presenting on it a lot. I always say that if we get it right for staff we get it right for patients. The Deputy's question was if it was doable and my answer is that we do not have the staff and are not getting it right for patients. I absolutely believe it is doable, however, and we have to do better. Looking at how we got to where we are, we moved from health boards to get efficiencies and synergies and that is a good thing. There is a role for a health business service, a national recruitment service, for large-volume competitions and setting up staff on point of scale, contract management, quality assurance etc. but there are other things where it does not make sense to leave a location and go to a processing centre and where it can be done much more quickly and safely locally. One size does not fit all and there is room for both approaches.

I would not like to be overly critical of the national recruitment service, NRS, or to say people are not doing it. There was an issue around resourcing NRS appropriately when it was established. We need safe systems, safe places of work and safe and effective staffing to be able to deliver safer and better healthcare. I am totally committed to this and I am happy to come back in July or August when I have moved forward with these recommendations.

Deputy John Brassil: I ask Ms Mannion to look at how the education and local authority systems operate because they do a very good job. Local authorities advertise for general operatives, drivers etc. and people apply. They interview people, set up a panel and fill the jobs that are available. If there are other vacancies they can call on the panel for up to two years. I know that safety is important but a six-month or 12-month probation period can be built into any job.

Ms Rosarii Mannion: Absolutely.

Deputy John Brassil: If it does not work out, one can go to the next person on the list.

Ms Rosarii Mannion: If there are learnings we will take them on board. There are many

areas which do things better than we do and there are areas where we are stronger. Health is a complex environment and there is a scarcity of skills, with a global shortage at a lot of staff grades. I take the Deputy's point, however, and we are happy to examine local authorities, education or any area where they are doing things better.

The Deputy asked if all the posts were funded. Every year we have a pay and number process, setting out what we can afford to add to staffing and for agency and overtime conversion, which also includes what is new in the budget for development funding. It will also show where we expect to be by the end of the year. It is difficult but we are working away on our 2018 pay and numbers. For mental health, anything that is requested to be filled through NRS is funded. In my view the issue for mental health is not funding. Mental health posts are funded. Indeed, additional development funding has been provided to facilitate the recruitment of the 110 assistant psychologists and other grades. It is not a funding issue in mental health.

Deputy John Brassil: Does the witness have a figure for positions that were funded but not filled in 2017? What happened with that money?

Ms Rosarii Mannion: I have it, but not to hand.

Chairman: Perhaps you could provide that to us.

Ms Rosarii Mannion: I will.

Chairman: Before I call Deputy Buckley I have two brief questions for Dr. Moore. I know he is a child psychiatrist. Has he ever been consulted in the recruitment process by HR? Has he been asked for his advice as a child psychiatrist? Second, what blockages does he see in recruiting consultants?

Dr. Kieran Moore: I have a slight throat infection so my voice is a little low. Before the HSE was set up I was directly involved in recruiting people on the team. That was very helpful. I have had no say whatsoever since then. The consultant contract is very clear that the consultant should be involved in the recruitment and retention of staff on the team. That has been flagrantly breached by the employer because we are never involved. People are recruited nationally and put on the team. Sometimes people are fantastic but sometimes they are not and the fit does not work.

Second, I could speak forever about the barriers but I am aware of time. I will take a slightly different angle to it, as a human being. I was in Galway recently for my nephew's holy communion and one of the things the children were being taught about was carthanacht agus cúram - care and love. It was in the Gaeltacht so it was all in Irish. Without going overboard, that is what we are supposed to be doing. We are supposed to be caring for patients. I have heard almost nothing about patients in all of this. With due respect, and this is not directed at any person, we are talking about complex situations and all sorts of barriers that are put in place. Ultimately, all of us who work in the health service need to see patients all the time. I am not blaming individuals but there is a management structure and the system does not work.

In Wexford, where I work, there are five managers. None of them is clear about what they do. I asked them but there are no job descriptions, or if there are I am not allowed to ask. I have asked them numerous times to come and meet the team, which is one sixth of what it should be, but they have not done so. When there are questions from patients they come to me. I tell them to ring the parents and ask them. I ask them to come and meet some of the patients. If that were done we would all realise what the situation is. What I hear at national level is so far removed

that I do not have a clue. It is never sent down to me. In terms of budgets, I have heard there is no issue with funding. That is absolutely not true. Whatever the issue is, decisions are made by people who have no expertise in the area and we are told after the fact, if we are even told.

They are the barriers. Fundamentally, most of the different people who work in the health sector care when they go into it. It is not just consultants but also doctors. We go into it because we care, but much of the time we are treated with contempt. There is no understanding. We get misses after misses. I work in a place where there was a fastened noose left behind after an IT refurbishment. It was a piece of wire fastened in a noose, although not deliberately. It was left there for weeks. I asked numerous times for it to be removed. I would have done it but I probably would have electrocuted myself or caused a health and safety problem. On numerous occasions I let people know about the risk but nothing happened. I even took photographs as well. These are just the elements. Patients are coming into a building that is in a state because staff are burned out. All of us are human beings. Honestly, the one thing that works in staff recruitment and retention is if people feel valued, and they do not. The systems are important as well. Devolving locally would help.

I happen to be one of the people who is resigning. I am resigning from Wexford because it is untenable and unsafe. Two of my colleagues are doing the same. I do not wish to bring it down to one area but there are five managers and I do not know what they are doing, with all due respect. I do not wish to blame the managers alone but if people met patients and understood, we could do things differently.

Chairman: I have a question on two things Dr. Moore said. First, he used the word "contempt". Why is that and where is it? Second, he referred to five managers. What are they managing?

Dr. Kieran Moore: It is not personal to anybody but I am not entirely sure. For example, there is a head of mental health and an executive clinical director. Both appear to be at the same level. I asked both if I could see their job descriptions but I was told I am not allowed to see them. That is either because there is none or I am just not allowed. I am not sure why. In the case of any other medical or nursing professional it is on the website and one can check what the expertise is. As I have said previously, it is like having two taoisigh. If there were two taoisigh and we were required to ask both what we were to do, I doubt that the country would run particularly well. In fairness to both people, they said they do not know and that it has to be resolved at national level. What is the national level? I do not know. There is a huge disconnect between a national level that does not get to see what is happening on the ground and the local level where often the managers do not see it either. Much of that is fear. People are not trained in a particular area. In child psychiatry, which is my area, and adult psychiatry there is still a stigma and a fear of meeting people. There should not be. It should be mandatory that people would meet and understand that people who suffer from mental illness - it is not health - are like the rest of us in every other area.

The State continues to treat people with psychiatric illness as second class citizens. It does so repeatedly. We would not send somebody with asthma to a hospital 400 km away, if they can get into it, with no parents and away from family and home. However, we do it with somebody who has depression. What are we doing?

Chairman: I agree with Dr. Moore. I call Deputy Buckley.

Deputy Pat Buckley: I have heard a great deal in committees over the past two years.

Today, I am just in shock. The opening statement states: "In short, the Irish health service is uncompetitive in recruiting and retaining the number of high calibre consultants it requires." If that is not a red flag, somebody is not doing their job. Last Saturday, hundreds of people marched in Tipperary because they have no mental health services. I had the honour of speaking at an event there a couple of weeks ago. More than 200 pairs of shoes were put on the stage. They represented people, not patients or statistics. If we include Tipperary and work on a 32-county Ireland basis, there are 16 counties that could not hire consultant psychiatrists in 2016. That is 50% of the country.

Mr. Hughes referred to 500 vacancies and the possible 1,700 who will be retiring in the next four or five years. That is a possible deficit of 2,200, or 2,204 if we wish to be politically correct. It is shambolic. I looked at the document on doctors in training and planning. It refers to supply and demand for consultants in the workforce between 2018 and 2028 based on the ratio of 12 consultants per 100,000 of the population. The extra demand to achieve the recommendation for 2028 is an additional 16 each year in 2018, 2019 and 2020. For 2021 to 2027, inclusive, it is an additional 15. Underneath that, however, it tells us that 20 are going to retire in 2018, 20 in 2019, 20 in 2020, 21 in 2021 and 21 in 2022. In other words, the plan is to hire an additional 153 up to 2028, but we are going to lose 207 by 2028. That will leave a gap of 144 consultants. That is a fabulous plan. We then wonder why things are not happening. I am no mathematician, but since I have come here, I have said it is necessary to be an accountant to do the figures. It is not personal, but this has to come out at committees such as this in order that everybody can take it back and take responsibility. I refer to the consultant application process. The current process, following the letter of approval, applies to HSE hospitals. There are 12 stages. After the 12th stage, if someone is picked as a consultant, it takes a year to have the post filled. How long does it take if there are 11 stages before that to go through?

Turning the document over and going to voluntary hospitals, there are five stages. There has to be something wrong and complications. As Dr. Moore mentioned, there are five managers for four staff. A sweet shop, an ice cream parlour or a bakery would not have five managers and four staff. It is not a comprehensive model. Please excuse me - an emotional note can be heard in my voice. I will try to be brief. Again, this is not a personal attack, but I am fed up of listening to talk about the commissioning of reports on recruitment. It is not rocket science. We train them here; we pay them here and we keep them here. That is being lost to society. What is happening is that funds are being diverted into management and it is not patient-centred. Again, it is the patient who is suffering.

Between 2000 and 2002, in my little pocket in east Cork we buried 69 people who died by suicide. It is that serious, which is why I want the delegates to get the picture. Last week I dealt with the case of a mother who had taken her own life, leaving five young children behind. We have mothers who have children with autism spectrum disorder and are suffering from mental health issues. They are making cages to keep their children in their own homes. It is to keep not only the children safe but also the parents. I have dealt with cases at CAMHS in which kids under 16 years of age have pulled all of the hair out of their head, yet they cannot get into the service. They are banging their heads against the wall.

There are two major issues. The plan for recruitment is kerfuffle. That is the word I will use. I love all of the work time equivalents and so on, but there does not seem to be concrete forward planning. It goes back to the numbers of retirements and recruitment. Nobody within the system wants to plan, but there has to be a database containing the dates of birth of staff; therefore, it is known when they are going to retire. However, there is no forward planning.

The HSE waits for staff to retire; then heads are scratched and it is realised, reactively, that there is a post to be filled. We know how toxic it is inside the system.

The staff are the bread and butter of the system. This committee was set up to help the system and service users. I want to ask one more question. I thank Dr. Moore for his honesty and do not want to put him on the spot, but I have to do so. If it is possible to be frank and honest, how bad is the system? I have asked this question before. If we do not have a proper recruitment plan, there is a possibility that in five years we will lose 2,200 staff. In 50% of the country it is a struggle to fill posts. Does Dr. Moore see a national emergency or a national epidemic, as we will call it, of suicides in the next four to five years?

Dr. Kieran Moore: I am not being rude, but I do not want to predict that there will be a raft of suicides. It is, however, the endpoint of severe mental illness that is not treated and sometimes even if it is. That is the reality. There is hope, which is why we all do our job every day. There have been changes and it is also a societal issue. It is for all of us. Every one of us has a brother, or a sister, a son or a relative that suffers from a so-called mental health or mental illness issue. We have to be so careful with the names we use. We do not use the same names for somebody with asthma as if they were different illnesses. For instance, depression is a physical illness, not just a mental illness. It is both. Spokespeople who suffer from it say they suffer huge pain. As I said before, people with a severe mental illness such as bipolar and schizophrenia die 15 years earlier than their peers because of a medical illness. In child and adolescent psychiatry it is nearly impossible to have bloods done on a child and his or her diabetes managed.

To try to answer Deputy Buckley's question, we have to wake up as a society and cop on that this is not just about funding - it is about putting serious money into it - it is also about looking after the people who look after patients. When a person meets a child or an adult who is suffering, he or she gets it. That is what we all need to be doing, not just clinicians. It has to be across the board.

Yes, the prevalence is increasing and the pressures are huge. I refer also to social media. People are moving to self-harm and suicide way before they ever would have before. It is a national emergency. It also links with homelessness. We have to get serious about it and move beyond the stigma. It is like tuberculosis in the past, as if there was something different about it. We are all human and all have it. We all get stressed and suffer from depression at different times. To answer Deputy Buckley's question, it is getting worse. If we are to treat people in trouble, we need to look after those who are treating them, but we are not doing so.

Deputy Pat Buckley: As far as I know, there are two accredited counselling bodies in the country. It was recently brought to my attention that if a person was registered with one, he or she could be employed by the HSE, but if he or she was registered with the other body, he or she could not. Is that true? I do not have the names of the two bodies - I was not given them - but there seems to be a conflict and I do not know why.

Chairman: I will direct that question to Ms Tierney.

Ms Fiona Tierney: I do not have an awareness of counselling, other than having friends or family-----

Deputy Pat Buckley: It has been brought to my attention that one body seems to be able to get on with the HSE and the other one does not.

Chairman: I ask the Deputy to make the request in order that Ms Mannion can follow up on it in her report. I hope Mr. Hughes does not mind, but I also want to ask him a question. We looked at the 25 steps and usually steps are progressive to attain a good level. They do not seem to be 25 progressive steps. From his own experience, why does he think there are those blocks?

Mr. Peter Hughes: There could be elements of trying to save money, which would be false economy because if there is a risk assessment, the person, ultimately, has to be passed. In the higher level positions, if a senior nurse leaves, he or she will be replaced from a panel. If somebody from the same service replaces that person, there is a domino effect that could result in it taking a couple of years to fill the post of the staff nurse, the front-line person-----

Chairman: Will Mr. Hughes give me an example of what he means by that?

Mr. Peter Hughes: If a director of nursing left the service and the person who got the position was an assistant director of nursing who happened to work in the same service, that assistant director of nursing will have to be replaced, so all the steps will have to be gone through again but that cannot be done until the assistant director of nursing moves into the director's role. If the person who gets the assistant director of nursing role happens to be a clinical nurse manager from the service, he or she will go in as the assistant director of nursing and we will then have a vacant clinical nurse manager position. For example, in the geographical area of Donegal most of the people on the panel will live quite near the area, perhaps in Sligo or Donegal, and they may already be part of the Donegal or Sligo service. It may go down as far as replacing the staff nurse. Technically, all of the positions have to be filled. This will have to go to the monthly pay-bill meeting, where a majority will have to agree the risk assessment means the nurse is needed. Why would an area with a significant number of vacancies need to go through a risk assessment at a pay-bill meeting to fill a particular post? It is very obvious the post must be filled if there is a significant number of agency nurses and amount of overtime in the service. Why must it go through that process? It is a layer of bureaucracy that is not required.

Chairman: What does Mr. Hughes think the answer is?

Mr. Peter Hughes: The first page of the two-page graph shows the system, which comprises 15 steps to get it to HBS, which is the national recruiter, to put in the job order to state this is a vacant post. The expression of interest is then signed and it goes out to everyone on the panel, if there is one, and this whole process takes time. We need to look at the local and national processes. Delegated authority needs to come down to the directors of nursing. If there is a need for one other layer that would be it. The director of nursing is the person closest to the people working on the ground who knows a nurse is needed.

We have to plan and not wait until the person leaving is already off the books. The day the person goes out the door is the day he or she needs to be replaced. If that person has time to take or has given six or eight weeks' notice he or she has to be replaced on the day of leaving. This is not happening. The vacancy is often covered with agency staff and overtime but why wait? Why use those resources when we could have someone in permanently? This frustration gets to the nurses.

I will go back to Deputy Buckley's statement on 500 vacancies. We have 500 vacancies at present, with 1,750 retirements in four years.

Deputy Pat Buckley: That is just to maintain what we have.

Mr. Peter Hughes: Between 1,500 and 2,000 nurses are needed to implement A Vision for

Change. Our research has shown that only 30% of the report was implemented but 76% of the beds were taken out of the service. We have minimal community services and I am again alluding to Dr. Moore's area. This is where we have a problem. We have overcapacity and patients are sleeping on mattresses and chairs at night. This is totally unacceptable. If a 24-7 community service was developed, this would not be happening. I believe A Vision for Change and its predecessor, Planning for the Future, were used as cost-saving methods to take beds out of the mental health service. No nurse ever objected to the beds coming out of the system but we wanted community services. We wanted an alternative to hospital admissions and this has not happened. Now we have a serious nursing crisis.

We have a complex and convoluted recruitment system and where are the nurses? They are in the UK, Australia and Canada, where they get far more pay, far better terms and conditions and far better places to work. The stress nurses must endure to go into services that are under-resourced, understaffed and overcrowded is very frightening. It is a crisis at present but it will be exacerbated. There are 24,000 vacant nursing positions in the UK, and the WHO has stated that because of the bilateral agreement we have with the UK, Brexit will mean we will lose more nurses to the UK. It will come looking for our nurses even more that it does at that present because it will not be able to take other EU nurses. The bilateral agreement with Ireland will allow this. This situation will become totally intolerable.

Chairman: As the general secretary of the Psychiatric Nurses Association, has Mr. Hughes been consulted about recruitment?

Mr. Peter Hughes: We had a dispute in 2016 on recruitment and retention of nurses. Eventually, we got an agreement but we had to ballot for industrial action and take industrial action to get it. One of the outcomes was that we were assured the steps outlined on page 1 would take a maximum of 28 days. I assure the committee that those steps take approximately three to four months.

Chairman: Was Mr. Hughes ever consulted about the improvement of recruitment?

Mr. Peter Hughes: Not in a direct way.

Deputy Joe Carey: I will direct my questions to Ms Mannion. What type of approach to succession planning and planning for vacancies that arise in the service is taken? It is very clear that all of these processes take a long time. What type of approach is taken? Is she concerned that a post is left vacant for a year or six months and then the process outlined by Mr. Hughes must be gone through? It is not really acceptable. At the end of the day, it is patients and their families who are suffering as a result, as are the staff who must work in these stressful conditions. It is an obvious problem that has been there for years. What type of policy does the HSE hope to introduce to address this issue with regard to succession planning?

With regard to the working group, Ms Mannion stated she hopes to bring its work to a conclusion at the end of this month and implement recommendations. She stated there has been a devolvement of responsibility locally. When did that happen and what does it mean on the ground for patients? Can nurses be identified and employed locally to fill local posts? Who has responsibility on the ground to make this decision?

Ms Rosarii Mannion: I will pick up a few points made previously, before coming to Deputy Carey's points, if that is okay.

Chairman: We have another speaker to ask questions, and Ms Mannion can come back in

if we have time.

Ms Rosarii Mannion: I will submit it in writing. I thank Deputy Carey for his questions. We identified succession planning and workforce planning as a gap in our people strategy. We have set up a full unit to look at integrated workforce planning. The unit will also deal with some of the points made by Deputy Buckley. We have every piece of data needed to do workforce planning with regard to our consultant workforce. We know that 25% of consultants in psychiatry are over 55 years of age. We have contract type, age profile, gender, tenure, full time or part time and approval status. We did not have this heretofore but we have all of it now. It will only be valuable if we use it effectively. One of the reasons we are in this difficulty is that we have not been doing any integrated workplace planning. That is not a quick fix. We need to build up to integrated workforce planning. It starts with getting the data, the ICT enablers, the systems, etc. I do not want members to think this is not happening; it is happening but it will take time.

The devolvement of decision-making happened in the latter half of 2017. The chief officer has the entire decision-making accountability as to what can be recruited locally and what can be recruited centrally. In doing that, it is important that we do not introduce any risk to the system in respect of medical clearances, occupational health clearances, Garda vetting, contract type, pensions, etc. These are complex issues that are sometimes better done in a central location. The chief officer is the staff member who can make that decision and we are happy to support whatever that is. There is no difficulty; recruitment can happen locally. It is not the case that recruitment is not happening in an effort to save money or that this is a way around saying there is no funding available for these specific posts. Funding is available for posts in mental health.

Deputy Joe Carey: Since the decision to devolve decision-making locally was made, have more people been recruited into the service?

Ms Rosarii Mannion: It has definitely yielded an improvement. Again, I will set this out in the correspondence. The numbers are not enormous, but it has yielded an improvement.

For the third year running, we are offering all our graduates permanent contracts this year. All interviews can be held locally. Heretofore, as the Deputy will recall, graduates became eligible for the register in October or November and interviews started at that point. We have made clear for the past two or three years that interviews need to take place in January with graduates offered contracts before May to ensure they are not headhunted to work in the UK or elsewhere internationally. This approach has been successful. Last year, we retained more than 900 of our graduates. In some areas we are turning the corner and making progress, but it will take time. That is not to say we cannot do better or more. We are committed to doing more. Is that response acceptable to the Deputy?

Deputy Joe Carey: Yes.

Ms Rosarii Mannion: I will respond to some of the points Dr. Moore made on-----

Chairman: I do not think this is the time to do it. I promise I will come back to Ms Mannion at the end.

Ms Rosarii Mannion: I will furnish the job descriptions this evening.

Chairman: That is fine.

Ms Rosarii Mannion: They are readily available.

Chairman: That would be great.

I know Ms Mannion has a timeframe in which she hopes things will happen. I know what time is like. The good news is that I had a meeting with the Taoiseach a couple of weeks ago and he has agreed to the establishment of a permanent mental health committee in November, which will have the power to oversee the mental health services and mental health legislation. That is good news. We will be able to keep communicating from now on.

Ms Rosarii Mannion: Great.

Senator Máire Devine: I thank the witnesses for their presentations. Maybe some of this was covered while I was in the Seanad for a vote. On the retention of staff, recruiting from abroad and attracting nurses and medics to return home, the World Health Organization has suggested we should not rob Peter to pay Paul. We need to refocus on how we provide our indigenous healthcare staff. We have the youngest population in Europe, yet we have a dearth of health service staff. What does that say? It is more than a crisis. If we have the youngest population, obviously everyone will try to pinch our staff, as they have done worldwide. We need to tap into that youth factor and try to mould it for our services. How can we do that?

We need large-scale change within the HSE and the health service. The position is especially poignant at the moment. There may be barriers preventing people from coming back. Staff are offered an adaptation course. How many hospitals are offering adaptation courses and how many courses are running at any particular time?

I wish to ask Ms Tierney about the recruitment process for the chief executive of the HSE. On 30 May last, I received a letter from the Minister for Health, Deputy Harris, stating that the post would be advertised shortly. I do not know if it is in the remit of the Public Appointments Service to include an executive search. It is hoped that by the end of the year a Bill will be introduced to legislate for a board for the HSE. Based on the heads of Bill I have seen, we will table many amendments to the legislation. Does Ms Tierney believe clinical experience along with managerial experience is essential for the chief executive of the HSE? We need to eliminate political appointments to the board. Appointments should be based on experience alone. We need different people in there to represent the people and not just vested interests. I ask for an update on that.

I have some questions for the Psychiatric Nurses Association, PNA. Yesterday the INMO warned that our health services face a winter of discontent. We have had several winters of discontent. We seem to be continually in discontent and it has become normal. The INMO's point was that a report on pay and conditions was supposed to have been completed by the end of June. This has now been pushed out to later in the summer. I know members of the PNA in Tipperary, Galway and Waterford. That 98% of nurses are voting for industrial action speaks volumes not only regarding issues with pay but also the risks to nursing staff, other staff and patients using HSE premises. This is not just a case of a winter of discontent. What the PNA described is the tsunami that awaits us, if it has not already reached our shores.

I have repeatedly asked An Bord Altranais agus Cnáimhseachais na hÉireann, the Nursing and Midwifery Board of Ireland, to be more accountable and inform us of the criteria for and process of registering nurses. We need 100 to 200 nurses. The board is finding blocks and barriers, although it has tweaked matters somewhat following my nagging. Some 30% of graduate

student nurses will leave within a year of qualifying. Child and adolescent mental health services, CAMHS, and services such as those provided in Cherry Orchard and the Central Mental Hospital, which opened five extra beds last week, depend on the September graduates to staff some of the units, CAMHS units in particular. Forgetting the 30% who will leave within a year, 60% or 70% of these graduates have spoken of their intention to move abroad, if they have not already secured jobs abroad. Can the PNA confirm or deny that?

I would have liked a written submission from An Bord Altranais agus Cnáimhseachais na hÉireann because many nurses coming home through the Bringing Them Home campaign or trying to gain entry to the registration process here describe it as a bureaucratic nightmare. It is a pity that representatives of An Bord Altranais agus Cnáimhseachais na hÉireann are not here.

Chairman: To whom is the Senator's question directed?

Senator Máire Devine: Mr. Hughes.

Mr. Peter Hughes: I do not have the figures for graduates with me. Despite 420 nurses having been trained in 2016, I am almost certain there were 180 new registrants, probably including new registrants coming from overseas. That is a very low number registering. It is indicative of the number moving on. There were 1,700 people looking for verification of their registration.

Senator Máire Devine: Seven hundred.

Mr. Peter Hughes: No. There were 1,700. They were going to emigrate and were looking for verification of their registration so they could do so.

We are finding that some young graduates are leaving early and some are staying for a year or so and then moving abroad. A key element is the pay. If the issue of nurses' pay is not addressed by the commission, circumstances will continue to get worse. We will not get back the people who have emigrated unless we change the pay and conditions. There is a double-edged sword in that we need the staff to provide the services to make the workplace better but we are not retaining them. Despite what Ms Mannion says about graduates being offered permanent contracts, which is acknowledged, the take-up is not as good as it might be. If positions are taken up, they are taken up for a short period. As I pointed out with regard to retirements due and the development of services, we just do not have enough staff at present. The frustration associated with the recruitment process does not help matters either. I refer to all the steps when one goes for a higher-grade post.

The CAMH services seem to be particularly affected. Many of the young graduates go to work in those services but do not stay. We saw last year in Linn Dara, Cherry Orchard, that the service closed for the whole of the summer because 50% of the nurses were gone. They needed 34 nurses. They had only 17 and half the beds had to be closed down. We are not sure about how this will develop but it is correct that the service providers are waiting for the graduates to come out in October. At present, there is firefighting to keep the beds open. Agency overtime is just not sustainable. There will be extra CAMH service beds in the new children's hospital. They need to be staffed. The move of the forensic service to Portrane will require 74 extra beds. At the moment, there is difficulty maintaining the staffing level in the Central Mental Hospital.

We are in a crisis. We are moving into a major crisis. The issue needs to be addressed in a number of areas. Nurses' pay will have to be addressed through the pay commission. If it is not, an autumn of discontent might be better than a winter of one, or might be more accurate.

Chairman: It must have been very difficult for Ms Mannion today. I commend her on her dignity and calmness. We have come to the end.

Senator Máire Devine: Gabh mo leithscéal but I wish to ask Ms Tierney about the director general. It is the hottest topic, I would imagine, apart from the failing of services we are unable to provide. When will the advertisement for the director general be placed? Is the Public Appointments Service involved? What are the criteria?

Ms Fiona Tierney: I thank the Senator for the question. She also mentioned the chairperson of the board. Could I start with that?

Senator Máire Devine: Okay.

Ms Fiona Tierney: From a good governance perspective, we were very keen to ensure the Minister's vision for a new governance structure of the HSE would be clear to us. We are happy to see that the position of chairperson of the new board of the HSE was to be advertised. If I am correct, we did this almost two weeks ago. It is currently advertised on the website *www.stateboards.ie* and the closure date is in July. We hope to have quite a wide range and number of applications. We are using our own executive search services to reach out to potential candidates to make them aware of this very important role.

We are, as the Senator knows, currently working with the Department of Health on the development of the job description for the director general of the HSE, which will change, as proposed, and the CEO. The Senator asked a specific question with regard to whether the person had to be a clinician. That is not a question I can answer directly for her today. I just do not have sufficient recall of the job description as it is currently-----

Senator Máire Devine: Could Ms Tierney send us the job description when it is complete?

Ms Fiona Tierney: As soon as it is completed, it will be advertised on *www.publicjobs.ie*. The position will be filled through the Public Appointments Service. There will be an open, competitive process. Notwithstanding that we do not have a finalised job specification, we have already commenced the process of executive search for the role on a global basis, having engaged an executive search firm to undertake the international search part of what is required to be done. It is already warming up potentially passive candidates or seeking to come up with longlists of potential people who could be approached to fill the vacancy when we have greater clarity on the detail of the role.

Senator Máire Devine: Transparency is vital to the public.

Ms Fiona Tierney: Absolutely.

Senator Máire Devine: There should be no helicoptering in because we need to be accountable and responsible for transparency in the appointment.

Ms Fiona Tierney: I was saying earlier that, in everything we do in the Public Appointments Service, we seek to deliver transparency and merit-based, open, competitive recruitment. That is the process we will oversee.

Senator Máire Devine: The establishment of the board requires legislation. We will scrutinise it, amend it and vote for or against the various proposals. Previously, appointments to the board were made by-----

Ms Fiona Tierney: The last board of the HSE was appointed prior to my taking up the role in the Public Appointments Service.

Senator Máire Devine: Were there political appointments?

Ms Fiona Tierney: I do not think there was an open, transparent appointments process for State boards at that point in time.

Senator Máire Devine: Let us hope there is now. We will try to ensure it. We will see what the legislation looks like. I thank Ms Tierney.

Chairman: Our fear is that someone within the HSE will be appointed to the role.

Ms Fiona Tierney: To which role?

Chairman: To the role of director general. I acknowledge Ms Tierney is saying she will be looking globally.

Senator Máire Devine: It is not even about the HSE. It just seems that if somebody is in favour, he or she might be slotted in. That has happened before.

Ms Fiona Tierney: I suppose we all come to these recruitment campaigns with varying perspectives, depending on where we stand. All I can seek to assure the committee is that there will be a global search with very targeted approaches to individuals who would be competent and capable of taking on the role. It will be an open, advertised recruitment process. I hope we have applicants from within the system. It would not be a merit-based, transparent process if people did not come into the system so I would not want to discourage anybody from putting his or her name forward. It is a matter of having a competitive field to come out with the best candidates at the end of the day.

Chairman: I have been asked by the clerk to clarify whether, when Ms Mannion refers to "local development", she means approval of the position or the person who is to be recruited.

Ms Rosarii Mannion: The entire process.

Chairman: It is the approval of the position and the person.

Ms Rosarii Mannion: Yes.

Chairman: Is that part of the national panel's remit?

Ms Rosarii Mannion: No, it is not.

Chairman: I thank everybody. The meeting has been quite difficult at many points. The honesty of Mr. Hughes and Dr. Moore has been extraordinary. It will be recorded in our report. We are in a wonderful position in that, in November, we will have a brand-new mental health committee that will follow up on everything we have heard over the past few months. I thank the delegates again for participating in what has been such an awfully difficult afternoon.

The joint committee adjourned at 3.50 p.m. until 1.30 p.m. on Wednesday, 20 June 2018.