DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 25 Eanáir 2017

Wednesday, 25 January 2017

The Joint Committee met at 1.30 p.m.

MEMBERS PRESENT:

Deputy Bernard J. Durkan,	Senator Colm Burke,
Deputy Billy Kelleher,	Senator Keith Swanick.
Deputy Alan Kelly,	
Deputy Kate O'Connell,	
Deputy Margaret Murphy O'Mahony,	
Deputy Louise O'Reilly,	

In attendance: Senators Denis Landy and Kieran O'Donnell.

DEPUTY MICHAEL HARTY IN THE CHAIR.

The joint committee met in private session until 2.20 p.m.

Emergency Department Overcrowding: Discussion

Chairman: This is the first of two sessions on overcrowding in emergency departments, the purpose of which is to engage with the Irish Association of Emergency Medicine, ICTU and Patient Focus. The HSE will attend for the second session.

On behalf of the committee, I welcome Dr. Emily O'Conor of the Irish Association of Emergency Medicine, IAEM, Ms Patricia King, general secretary of ICTU, Mr. Liam Doran, chair of ICTU's health sector committee, and Ms Sheila O'Connor and Ms Brigid Doherty of Patient Focus, who will provide us with their perspectives on the issues that have been rumbling on for many years.

I draw witnesses' attention to the fact that, by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and they continue to do so, 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 are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any submission or opening statement that the witnesses make to the committee may be published on the committee's website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I call on Dr. O'Conor to make her opening statement.

Dr. Emily O'Conor: May I begin with an apology? Despite the committee's invitation being dated 16 December, it got to me at 3 p.m. yesterday. The absence of a more prepared opening statement reflects no disrespect to this committee, but rather reflects the reality that the executive of the IAEM is a voluntary organisation with no administrative support and composed of consultants working full-time in emergency medicine. As I am sure that the committee is aware, it has been a busy few weeks.

I thank the committee for the invitation to speak. There are one or two factual inaccuracies in its draft of my opening statement, but I will submit a corrected version to the secretariat and this will be available to members.

Crowding in emergency departments is caused by the boarding of admitted inpatients on trolleys in those departments because there are no beds available on the wards. These patients have completed their emergency phase of care. They are not so-called inappropriate attenders, drunks or those with minor illnesses or injuries. That group of patients does not need hospital beds. Inpatients on emergency department trolleys cannot be diverted from needing a hospital bed by improving general practitioner, GP, care, at least not in the short or intermediate term. General practice needs investment in its own right and, in the long term, its role in preventative medicine and chronic disease care will reduce the need for hospital care. However, that is in

the future. Patients boarding on emergency department trolleys are not victims of poor care from GP or emergency medicine. Mostly elderly, they are victims of a lack of capacity across the entire health care system. They need hospital beds.

Crowding in emergency departments - the boarding of admitted inpatients on trolleys in emergency departments - is the overflow valve of the Irish health care system. We do not say "No". We do not close our doors. We should not be allowed to become "full". Crowding in emergency departments is not caused by the departments themselves, but by a capacity deficit across the entire health system. Crowding in departments causes significant reputational damage to Irish health care and emergency medicine in particular.

Approximately 1.3 million citizens attended emergency departments in 2015. Last year, the number attending the emergency department that I work in, Connolly Hospital Blanchardstown in west Dublin, rose by 8.7%. That is likely reflected across the system and should come as no surprise. Our population has grown, our people's health care needs have become more complex, we are surviving for longer with conditions that previously would have killed us, and we expect and are told to expect timely care. Adding the 8.7% to which I referred to the 2015 figure of 1.3 million emergency department attendances means an extra 100,000 attendances last year. Approximately one quarter of people attending go on to need hospital beds. In broad terms and based on my calculations, an extra 20,000 to 30,000 patients needed admission from emergency departments to hospital beds last year. We need more beds.

This is not to say that crowding in emergency departments is new. Patients have suffered boarding or warehousing on emergency department trolleys for nearly two decades. I remember statements from Members of the Oireachtas in the past. I believed that the situation would improve. It did not. It is getting worse. There were 520 people on trolleys yesterday. One of the inaccuracies in my submission can be seen here. I wrote "286", but last year's target for the maximum number of patients to be boarded on trolleys during the winter initiative was actually 236. For those patients, even that target was unambitious and posed an unacceptable clinical risk, but did we ever have a hope of meeting it? The answer is not with current bed capacity. We lost so many beds from the acute hospital sector in the 1980s and 1990s that we are now down to 2.8 acute hospital beds per 1,000, which is well below the OECD norm of 4.3.

Over the decades, processes have improved across the system, even if that improvement has been patchy. We tried to cope and keep patients moving through the system, but we failed. We fail patients every day. The UK has approximately the same percentage of acute hospital beds per thousand. There was significant investment in process change in the UK. It started just after I left there in 2000 and saw the introduction of targets, leading to a reduction in trolley waits. However, that improvement has reversed because the UK has run out of bed capacity. The NHS is experiencing crowding in emergency departments because of inadequate bed capacity across its health care system. I have included in my submission a reference to the Royal College of Emergency Medicine, which has a great deal of information on this matter.

Ireland needs capacity built into general practice, community care and home care, but we will see headlines about the trolley crisis again next year unless acute hospital bed capacity is built or commissioned now. Hospital beds must be commissioned, built, opened and staffed. Crowding in emergency departments causes a greater risk of preventable deaths, poorer medical outcomes and longer lengths of stay and lessens the chances of those aged over 75 years returning to their pre-admission health levels. Evidence from high-quality international studies is freely available and widely accepted. I can supply references to committee members if necessary.

Overcrowding is also undignified and uncomfortable. It is noisy and always bright. In one's moment of crisis, imagine giving intimate details to a doctor - me - in a corridor where it is so noisy that one has to shout. Imagine having diarrhoea and queuing for a single toilet cubicle with 20 other admitted patients. This happens. Imagine having an ECG or heart trace done in a public corridor. Imagine being immunocompromised, perhaps post chemotherapy, and sharing a corridor with ten others all coughing loudly. Imagine shouting at the nurses and then feeling guilty because one knows it is not really their fault.

Imagine being a nurse coming onto a night shift to care for ten patients who are over 75 years of age and have all been on trolleys since one left the night before when one promised them that beds were coming. Imagine that feeling of hopelessness that they are still there. Imagine being an enthusiastic doctor who comes on shift every day knowing that there are lots of patients in the waiting room who have been waiting hours to be seen and there is no place to see them. The doctor takes a history in the corridor, but there is no place to lie the patient down for an abdominal exam. The doctor circles the department for any spot that will provide a bit of privacy. He or she finds a space, but before the doctor gets the patient there, another patient takes it, so the doctor starts again. Imagine how enthusiasm wanes. Imagine how relationships turn sour. Spend years doing this and understand how it breaks morale in a department and in a specialty. Are we surprised that recruitment is difficult? We are again going abroad to recruit nurses while we export our own to countries with better resourced emergency medicine.

Ireland has excellent medical schools with large numbers of students interested in emergency medicine. We have excellent core and higher training in emergency medicine, delivered by consultants in emergency medicine, as well as producing high quality consultants in emergency medicine. However, they cannot work in our public system. The conditions for patients are too poor, the environment too hostile. There are more Irish consultant emergency physicians in the Australian state of Victoria than in Ireland. We produce five home-trained consultants in emergency medicine every year, I can only name one or two who have gone through a Public Appointments Service competition over the past several years and have been appointed to a permanent post. Instead, they are going into temporary locum posts, full-time private practice or leaving the country.

Ireland has 80 consultants in emergency medicine spread over 29 emergency departments. Some emergency departments do not have a consultant in emergency medicine on call out of hours. This is not acceptable. The Irish Association for Emergency Medicine, IAEM, has done work on a staffing document showing how appointing consultants in emergency medicine gives breadth and depth of care. With adequate numbers, we can look at extending hours of direct shop floor care and resuscitation. We can have consultant-delivered clinical decision units and ambulatory care to further deliver admission avoidance. Without more consultants in emergency medicine, we will continue to have a pyramidal system with most care delivered by doctors in training rather than fully trained consultants.

Consultants in emergency medicine, both in leadership and direct clinical care, are essential for the running of high-quality emergency medicine care. However, we do not work in isolation. On the shop floor seeing patients and supervising NCHDs, non-consultant hospital doctors, I need diagnostics and not just between nine and five. I need to be able to access community beds and services and not between nine and five, Monday to Friday. We need to move away from pretending that patients come for medical care just between nine o'clock and five o'clock. We must stop making them wait until the next day or the following Monday to get the diagnostics or services they need.

There is hope, if the Government can deliver bed capacity and conditions to allow trained staff to stay. Irish emergency physicians are trained to the highest standards. Irish emergency medicine is delivering on training. We know what good care looks like. Let us keep our doctors at home. Irish nurses are internationally sought after. Let us keep them at home. The Government needs to create capacity by building beds where needed, perhaps modular, and staffing beds where they already exist. We must allow people to get good emergency care, allow them to come in from the waiting room to a vacant cubicle to be seen and allow them flow through into a bed when they need one. We must also allow them home or into other care when they are ready.

Processes need to be efficient and we have done extensive work on this. In 2012, the National Emergency Medicine Clinical Programme published a model of care which describes in some detail the processes needed and our path forward such as trauma networks, emergency care networks, local injury units, clinical decision units, staffing levels and advanced nurse practice. We know where we need to go.

We have leadership in emergency medicine locally and nationally to show the way. The Government must give us space to do our job and allow patients to move on from trolleys in emergency departments so that the incoming patients can be seen. Access to public emergency care is a cornerstone of our society. How we treat our citizens in their moment of crisis marks us. It marks committee members and me. The Government must stop warehousing or boarding inpatients on trolleys in our emergency departments. It risks killing them.

Chairman: I thank Dr. Emily O'Conor for her opening statement. I invite Ms Patricia King of the Irish Congress of Trade Unions to make her opening statement.

Ms Patricia King: The Irish Congress of Trade Unions, ICTU, is pleased to address the Oireachtas Joint Committee on Health on the critical and topical issue of overcrowding in all our hospital emergency departments. This engagement is all the more important days after 612 patients, admitted for inpatient treatment, were left on trolleys in our overcrowded hospitals.

ICTU has monitored with increasing concern the marked increase in hospital overcrowding in recent years. We note that it is the elderly and ordinary workers, as well as their families, who suffer most through that overcrowding and the compromising of care that follows. Congress has also been informed on an ongoing basis of this situation through the work of our health union affiliates and, on a daily basis, by the trolley-ward watch figures released by the Irish Nurses and Midwives Organisation, INMO. In that regard, and to graphically measure the extent of the growing crisis, I draw the committee's attention to appendix 1 in our written submission. This records the unacceptable increase in the number of admitted patients on trolleys in emergency departments or throughout hospitals over the ten-year period from 2006 to 2016. These figures confirm that, notwithstanding the measures taken, the reality is that overcrowding continues, unabated, with a record number of admitted patients on trolleys in 2016 of 93,621.

In terms of a political response, we remind the committee that, in 2006, the then Minister for Health and Children declared that 486 people on trolleys was a national emergency, which required a significant and sustained response. Regrettably, history shows the required response was not forthcoming. After 2008, the economic recession saw our public health service subject to significant contraction in overall financial allocation, staffing numbers through a recruitment embargo and the resultant closure and curtailment of services including the closure of public acute/long-term care beds and the restrictions on community nursing and support services.

This contraction, which was unmanaged and undertaken without any risk assessment or reference to the growing concern of health service staff who saw the implications, has, without doubt, been a major contributory factor to the record levels of emergency department overcrowding now taking place. In addition, and as a direct result of flawed decision-making and policy analysis, emergency department overcrowding was exacerbated under the guise of the reconfiguration of services particularly in such areas as the mid-west and the north east. I refer the committee again to appendix 1 to see the damage done when budget considerations determine health decisions, regardless of their impact upon services, patients or staff, for example, Limerick and Drogheda.

In the context of the current, record, level of overcrowding ICTU believes the problem must be addressed, with both short and medium-term measures, recognising overcrowding in emergency departments is not the fault of emergency departments. It is simply the outward manifestation of a public health service too small to cater for the demands being placed upon it, year on year, through changing demographics, health expectations and scientific developments. Hospital overcrowding cannot be laid at the door of senior managers who are not given the resources, both in terms of acute and community-based services, to adequately respond to the demands being placed upon any given hospital. It is also worth noting that any individual hospital's ability to respond to this ever increasing demand is influenced by its own bed capacity, access to transitional or long-term care beds, access to primary and social care services, including public health nursing or home help and other supports. In other words, capacity, both in terms of capital and human resource, are central to resolving this problem.

Short-term actions must include an immediate requirement that all hospitals roster senior clinical decision makers over the extended day on a seven-day week basis, at least until the end of this winter period. This will aid the speed of decision making in the hospital environment, thereby assisting patient flow as decisions to admit or discharge or refer are made quicker. Special measures must be taken to alleviate the staffing crisis which exists right across our hospital services at this time. This will have to include, at least for a defined period, incentivised measures so that we minimise the impact upon patient care arising from overcrowding. Special measures must also be taken to allow for the re-opening of public acute and long-term care beds, again including incentivised measures where required, so that we make maximum use of all available bed stock.

The committee must note that, as of today, approximately 150 acute beds are closed with hundreds of long-term public beds closed all due to staff shortages. Senior management, who can make resource decisions, must also be present on a seven-over-seven basis until the end of the winter period.

In terms of medium-term solutions, by which we mean a three to five-year period, congress believes the capital and current funding necessary to increase acute bed capacity by at least 1,500 must be provided, with the additional beds being allocated in areas where the need is greatest. We remind the committee that, if one refers to OECD figures, Ireland has 2.8 beds per 1,000 population. The OECD average is 4.8 beds. Congress believes there is also a need for a significant and sustained investment to increase public long-term bed capacity which would have both a capital and ongoing cost. This is in recognition of the massive change in demographics that will occur in the coming years, given the reality that this will see us with an ageing population with co-morbidities requiring high levels of intervention and support to maintain people's quality of life and, where possible, their independence.

There is also a need for investment in primary care-community services, which would see

them operate on an extended day basis in a seven day cycle. This should help to provide access to services and individual care supports, as required, as an active and more effective alternative to attendance at an emergency department. This would also require significant and sustained investment as currently most primary care-community services are available on a Monday to Friday basis, with only urgent and priority cases being serviced at the weekend and on public holidays. This is not a model of delivery which keeps people out of hospital.

ICTU holds the view that the ever increasing levels of overcrowding in hospitals must be viewed as being totally unacceptable and a reality which, notwithstanding the economic constraints, cannot be allowed to continue. No public acute hospital can function safely with bed occupancy rates of up to 100% when anything over 85% is viewed internationally as overcrowding. It can only be addressed, however, by a complete realignment of our current approach to health care which views emergency departments as separate from all other parts of the public health system. The only way in which we can address the overcrowding is by integrating care services through a series of initiatives which include increasing acute bed capacity, transitional-long-term care bed capacity and expanding community nursing and other support services, as well as home care services. ICTU and, in particular, its health union affiliates will fully support all investments and new ways of working designed to increase public health services capacity, ensure full integration of care services, from the home to supported living, long-term care and acute intervention. We reference congress's submission to the special Committee on the Future of Healthcare to demonstrate our commitment to such radical change.

We thank the committee for its time and look forward to engaging with it in order that we can elaborate on this submission or answer other questions it may have. My colleagues, Mr. Doran, will field many of those questions.

Chairman: I thank Ms King. The next speaker is Ms Brigid Doherty from Patient Focus.

Ms Brigid Doherty: We thank the Chairman for the invitation to meet the joint committee. I also thank the staff of the committee who helped us to put this presentation together.

I will begin by telling the committee about Patient Focus. I will then discuss our perspective of overcrowding in emergency departments.

Patient Focus is a national patient advocacy service. It was set up in 1999 and established as a company with charitable status shortly afterwards. It has four staff and is funded by the HSE at the rate of €216,000 per annum. Last year we also received some funding from the national lottery. Each year we provide support for between 500 and 600 new clients who have been damaged in some way in the health care system. Most have suffered damage, much of which is very serious. Some have been damaged in emergency departments, as also happens in all other areas of hospital care.

Our approach to healing hurt caused in the health care system is by means of patient centred advocacy. It is not widely known that many people are hurt, injured or die each year because of the provision of inadequate care. We are best known for our work in supporting and advocating for patients on several major issues. They include baby deaths and injury in Portlaoise and elsewhere; miscarriage misdiagnosis; unnecessary caesarean hysterectomies and ovary removals at Our Lady of Lourdes Hospital; and symphysiotomy.

It seems to our clients and us in Patient Focus that much of the public discourse on emergency departments is about overcrowding and the dangers it undoubtedly creates, particularly

at times of pressure during the winter months, at weekends and during bank holiday weekends. Our clients tell us of a service that is at skeleton levels at these times. They also tell us of a service in which adverse events occur during normal times all too frequently. The examples they have given us in recent years include problems with unborn infants not picked up at birth, despite the mother raising concerns, and with small children who were brought to emergency departments and whose mothers were not listened to when they raised concerns. Examples also include children not being transferred in a timely fashion to specialist centres; misdiagnoses of illnesses leading to a shortening of life and-or permanent injury; a man being found dead in a hospital corridor that was considered to be a "virtual ward"; no staff being available to assist in helping a patient from a trolley to meet their toilet needs, resulting in forced incontinence; and no proper meals. These events are not reported in the media unless they can be linked with a daily trolley count. In our view, this tends to set the media agenda in a way that is not helpful to patients. It is easy for the media to cover issues of quantity, but, in our view, it serves to put the resolution of issues of quality and safety even further down the line. It is our strong feeling that, for these issues to be resolved, every group must buy into the finding of long-term solutions. Problems in emergency department are related to problems in other parts of the system. The dignity and safety of patients are sometimes sacrificed. It is almost as if the system, with its competing vested interests, seeks to maximise the horror at critical periods.

Those who work within the system have a duty to ensure their individual professional approach is patient centred. They also have a duty to insist on their representatives not seeking to maximise the lack of dignity and safety in a way that is ultimately anti a systemic solution. It is hard at times to escape the impression that some interest groups like to use the chaos in unhelpful ways. This is easier than working with others to seek long-term solutions to the chaos. If there are groups within the system which are acting against the interests of patients, it needs to be said. Courage is needed, but sometimes it seems as if it is sadly absent. HIQA made several national recommendations about how emergency departments should be run to ensure the safety and dignity of patients. We believe that where there is a will, there is a way.

We have suggestions for improvements. Community services need to be developed and expanded on a statutory basis as a matter of urgency. Nursing care teams must be extended, including employing more advanced nurse practitioners. Public health nurses must be upskilled to carry out procedures in which some are not currently skilled or do not see as their role. GP services must be more effective such that sending a patient to an emergency department is seen as a last resort. GPs should be able to make direct referrals to the specific specialty and patients should be seen on arrival rather than having to sit for hours in an emergency department waiting for assessment and referral to the specialty. Good social care services independent of the health service need to be set up because there is duplication of assessment procedures. Palliative care services in the community need to be available nationally, including a 24-hour service supported by public health nurses.

Developing medical, nursing and social care services in the community is expensive. However, in the longer term it is cost effective and, most importantly, provides safer care for patients in their preferred place of care - their home.

Chairman: We will group the questions in batches of three. I ask members to be conscious of time as we have fallen a little behind. The first group of three speakers includes Deputy Louise O'Reilly, Senator Colm Burke and Senator Keith Swanick.

Deputy Louise O'Reilly: I will be as brief as I can, but this is an expansive subject. My questions are directed at all of the delegates.

The programme for Government gives a commitment to the establishment of a performance management unit. What are the delegates' views in that regard? Do they think it would have a chance of working or would it just be like the special delivery unit and not deliver anything special or otherwise? On the conversion of agency staff, the first two submissions mentioned the need to recruit additional staff as being central to the creation of more capacity within the system. I have questioned the Minister on this several times, and I am interested to hear from those at the coal face how the job of converting agency staff into directly employed staff is working. It is obviously cheaper to employ direct staff. Is the spare money being used to employ additional staff?

On the bed capacity review, have any of the organisations represented here been involved in that? I understand that it is under way at the moment. I would appreciate a comment on how the Irish Congress of Trade Unions, ICTU, is able to identify that there are a minimum of 150 beds available and yet the Government says we need to have a bed capacity review.

On primary care, there are separate budgets. We have heard this from the HSE many times. The budgets for the acute services and primary services are kept separate. How willing is the system to give up some of the budget in the acute sector in order to fund the primary care sector? How are we going to bridge that gap? To use the phrase that Professor Drumm used to use, everybody is in a big silo. Until people start talking to each other we are not going to be able to see very much progress.

My final question is specifically for ICTU. Special measures were mentioned twice at point number eight. Will ICTU elaborate on the special measures envisaged, and the timeframe for implementing them? What is the ambition for the outcome? If the Minister for Health, Deputy Harris, came in here and granted the special measures, what are they? Will ICTU tell us? How soon are they going to have an effect in terms of bodies physically present and working on the front line?

Senator Colm Burke: I thank the witnesses for their detailed presentations. On the basis of the presentations made, it would appear there are around 26,900 people per week attending accident and emergency departments, or around 3,800 per day. If there is a 20% increase in that there is huge pressure on the system, and a sudden 20% increase would not be unusual. On the 29 units, it was said that some of the units do not have consultants on call at particular times. I recently had a meeting with the Mercy University Hospital. It has a consultant on call for only 55 hours, yet it has a 24/7 accident and emergency department with over 30,000 attendances per annum. How many units do not have a consultant on call, and during what periods are consultants not on call?

An issue was raised with me by young general practitioners recently who are afraid of starting out on their own in general practice because they are afraid of the job insecurity. I recently spoke to a GP working in Canada who works a number of sessions in the local hospital. We do not seem to have that connection. The young GPs said to me that they had no problem starting up a new GP practice if they could also get hours in the local hospital. I came across someone who practised paediatrics for five or six years and then dropped out of the system and went into general practice. That person has huge experience in paediatrics, yet cannot use that experience in a hospital. Has employing GPs ever been looked at from the hospital point of view. I am not saying full time, but rather three or four three-hour sessions a week so that they have security of income.

We speak about the increase in accident and emergency all the time but we have not focused

on the issue of excessive drinking and how that contributes to the increases. What kind of percentage are we talking about? I know that previously 30% of people were attending accident and emergency as a result of accidents related to excessive drinking. While we are focusing on accident and emergency departments, the HSE and the Department, we are not really focusing on people's own responsibilities as well. I would appreciate an outline on that issue, which is an important one.

I agree with Ms King about the number of beds. The Minister was in the Seanad earlier today and said that the last time a major hospital was built in this country was 1988. Even at a time when there was money available we did not focus on this, and we still have 2.8 beds per thousand when the OECD average is 4.3. What type of programme would people like to see over the next ten years with regard to new hospitals, and how many new beds should be created over that time period per annum?

Senator Keith Swanick: I welcome all the contributions. I will start with Dr. O'Conor's comments, which I agree totally with. I worked in Blanchardstown hospital as a senior registrar under Mr. Derek Barton a few years ago, and I know first hand the pressure that doctors are under. Indeed, in my time, the recess room was located in a prefabricated building to the side of the emergency department. I also note the increase in attendances of 8.7% in the last year, and that 25% of these people require admission. Longer delays often lead to poor outcomes, with people failing to return to their pre-admission state.

Opening community beds outside of the nine to five model that we have currently was mentioned. Ms King also touched on the fact that 150 acute beds have been closed and hundreds of long-term public beds have closed. I know first hand from my own experience as I run a small community hospital in Belmullet, and we have had bed closures due to staff shortages. We need to look at the role of the community hospital network in this country. It should not be seen as a relic of a bygone era. I am not talking about nursing homes here. I am talking about community and district hospitals. They truly alleviate the pressures of secondary care insofar as GPs can admit directly to the community hospital for problems such as urinary tract infections and chest infections which do not require admission to acute hospitals, thus preventing admissions to the acute sector. They also facilitate discharges from the acute hospitals, for example, in the case of patients who perhaps after having had a hip replacement can be transferred back to a community hospital post-op and have their rehabilitation carried out with the help of a community physiotherapist. That frees up a bed, which allows an emergency department patient to move into that bed. There is another nuance here in that the community hospital network could act as an interface between the fair deal system and the acute sector. If someone is in an acute bed and applies for the fair deal scheme to enter a nursing home, he or she could be waiting ten to 12 weeks in that acute bed. There is nothing stopping us from transferring that patient to a community facility in the interim, prior to being transferred into a nursing home. I would value any thoughts on that.

On what Ms Doherty said concerning some of the suggestions for improvements and that GP services must be more effective, I am a GP in a rural area and I totally agree with her. On one day over Christmas my two practice nurses and I saw 141 patients, and we referred one patient to the emergency department. That is because I have two practice nurses, who are both excellent. They are both prescribers. However, the system we have at the moment is that the HSE will fund one practice nurse per general practitioner which is insufficient. We have a shortage of GPs. Practice nurses are highly skilled and can carry out many of the roles a GP does. We should look at funding more practice nurses for general practices, especially in rural

locations. I am 50 miles away from my local emergency department so I cannot be referring everything to the emergency department so we deal with it in the surgery.

On the Institute of Community Health Nursing, I am very supportive of that group. I had a Commencement debate today and I asked the Minister for Health to look at the funding for it. They do terrific work and their client base is the community so we should value their role. I would appreciate Dr. O'Conor's views on this and the other matters I have raised.

Dr. Emily O'Conor: Deputy O'Reilly asked about the performance management unit. I understand that it is a continuation, or a remodelling, of the special delivery unit. The Irish Association for Emergency Medicine has not been invited formally and an invitation has not been discussed. I have heard the announcements the Deputy has heard but I do not have any further information.

Another question was on recruitment and on agency versus permanent staff. I have experience of both. Many nurses who came to us as agency nurses, and formed part of our number on a night shift, have been converted to permanent nursing staff following interviews. I am aware of some progress in providing funding for new posts, particularly on the medical side. In my own hospital we have had funding for an extra registrar on a temporary basis, which is an extra body on the payroll. Until very recently there was a ceiling on payroll numbers for new staff. Hospitals took any other means possible to get new staff on board without having to put them on the payroll and the only way we could do this was through agencies. I knew doctors who wanted to do shifts with us as locums but I could not take them on myself. They had to register with an agency and the hospital had to pay hugely inflated fees, both to them and the agency, to get them to come. It is very welcome that the ceiling has been lifted so that we can take on board our own staff and it is really important that the ceiling does not come in again.

I was asked if we were invited to the bed capacity review. No, I did not see a formal invitation and I am the president of the association. We feel that if there is to be a review there should be no delay in starting to make things better. We are not opposed to a review but we do not feel it is necessary before we get the ball rolling. We have a short window of opportunity, whether this involves doing modular builds in certain hospitals which do not have enough beds or recruiting staff to open beds in hospitals that have closed wards. We have a small window to get it started before it is too late to make any difference in time for next Christmas and new year. We will participate in any bed capacity review but not at the expense of starting to commission beds, which needs to happen urgently.

I was asked about the primary care budget being separate and moving money from acute to primary care. Both need funding. We are very interlinked and if we have less money in acute care GPs will not be able to access the service and it will put more pressure on them. Both areas need higher budgets and I am glad I do not have the job of allocating them. The question on special measures was directed at ICTU.

Senator Burke asked about emergency departments. My department saw an increase of approximately 8% last year but I have not seen the HSE increases. I would say the increased attendance at emergency departments will be between 5% and 10% and between 25% and 28% of those patients go on to need an acute hospital bed. I wanted to demonstrate how, based on the numbers alone and not taking into account increasing frailty and the higher complexity of conditions, we will need more hospital beds. He also asked about the number of Departments where there was not a consultant in emergency medicine on call at night. We have 29 departments and 80 consultants, an average of over two consultants per department. I cannot name

them all but we have nine or ten emergency departments which do not have consultants in emergency medicine on call at night, though there may be a consultant surgeon or physician. How would members feel if we ran obstetric units without a consultant obstetrician on call at night? We do not feel this is acceptable.

We do GP working sessions in local hospitals and several GPs work on a sessional basis in our hospital. It is a model that seems to have gone under the radar a little bit but it is in many departments around the country. We have GPs contributing to our minor injuries stream and our ambulatory stream. We cannot, however, give them security. They are not permanent members of staff but come out of our special budget and I cannot say that budget will not be rearranged in the future. Lots of GPs like to get their hands dirty, so to speak, by working in emergency departments but I cannot give them permanent contracts, even those who have been with us for many years. It is extra income for them but is not a source of security.

I was asked about excessive drinking. As an emergency physician, I am entirely non-judgmental as to why patients need to come to an emergency department. There are many societal bad habits that mean people end up in crisis and excessive drinking is one of them, as are drug use and lifestyle and behavioural issues. I have no role in telling people what they should and should not do before they come to the emergency department. I just want to be able to deal with them when they come. I have heard of bad experiences of drunk people being kept in prison cells or Garda stations overnight. If a young person, or an older person, is drunk to the extent that they are not fully conscious they cannot protect their own airway and they need to be in an emergency department. We need to be resourced to look after them so that they do not compromise the care of other patients but it is the right place for them to be.

I was also asked about the type and number of new beds and the community care model. I agree with Senator Swanick about our public care model for beds, not just the private nursing home sector. There has been success in freeing up acute hospital care beds, including such measures as the winter initiative, and in reducing delayed discharges. These people have completed their acute episode of care and need to move on to another type of bed. We may have further improvement as the years go by but I do not know if we can change things for patients on trolleys between now and next Christmas. We need to start opening acute hospital beds because, while process change should continue and there should be a continual improvement in step-down beds, transitional beds, community and nursing home beds, this will not be fast enough for patients lying on trolleys in our department. We need current beds, opened and adequately staffed. Where there is not enough physical bed space new beds need to be commissioned, in whatever form that can be done.

I fully agree with Senator Swanick and would like to see long-term care in community hospitals as well as in private nursing homes. GPs can admit to community hospitals but I do not have much experience of this. I fully agree that GPs should have a role in post-admission and transition care. Transitional-type beds already exist in the system and for patients applying for fair deal there is a system whereby we get funding for these beds while they are waiting for fair deal to come through. I hope the community care hospitals are involved in that. With regard to busy GP practices, I am well aware that our GP colleagues have been absolutely overrun this Christmas. They have felt the pressures as much as the acute hospital sector.

Chairman: I thank the witness-----

Senator Keith Swanick: There is a vote in the Seanad. I must excuse myself.

Chairman: That is fine. Does Mr. Doran wish to make any comments on the questions asked so far?

Mr. Liam Doran: If I may. The fundamental problem is that our health service is too small, too narrow, not integrated and cannot cope with demand - full stop. That has to be acknowledged. It does not matter how we shape it up or talk about process. That is the harsh reality of it. No matter what measure we apply, acute bed, continuing care bed, traditional care bed or community-based services, none of them is sufficiently wide, deep, high or long to meet the demand that is placed upon them. That must be accepted politically if we are to address this problem.

I will run down through the questions. In fairness, my colleague, Dr. Emily O'Conor, has answered some of them on which we would not differ. The programme for Government and the performance management unit was mentioned. The one thing we are not short of with regard to emergency departments and health is management measuring. What we are short of is anyone doing anything about it. We can measure everything with regard to emergency departments now: age profile, length of stay, what colour socks a patient has - you name it, we can measure it. However, it has gotten worse. I will say quite clearly that we would not support more performance management people to oversee managers who oversee front-line staff who are understaffed, overworked and always held accountable when the thing goes wrong. If we are going to empower, we have to empower the front line. We have to address the consultant issue, the nursing numbers and the support staff issue. We do not need more management. We know what the problem is.

With regard to agency staff conversion, the committee should know that the latest figures we received from the HSE just yesterday confirmed, for example, that €80 million was spent on agency employment for nursing staff last year. That is roughly 800 staff per day, every day, for the year. That figure is responding, as we understand it, to approximately 60% or 65% of the calls. That is not the full need of the service. The agencies cannot supply the full need because they do not have enough people on their books to do so. That is-----

Deputy Louise O'Reilly: While the witness is on that subject, is he saying that the request for agencies is only being met about 60% of the time?

Mr. Liam Doran: It is being met 60% to 70% of the time.

Deputy Louise O'Reilly: Does he think that is because the 40% that are absent and not available to turn up for a shift have been converted into direct labour?

Mr. Liam Doran: No. It is because we do not have enough nurses, full stop, to respond.

Deputy Louise O'Reilly: Thank you.

Mr. Liam Doran: When the hospitals apply and go to the agencies, it is a short-term gap measure. We could talk for six or seven years about the recruitment embargo and how that absolutely decimated the workforce, but in terms of managing it now, when a hospital seeks short-term relief, the people are not there. Whatever chance there might be in Dublin, and it is a slim one, there is no chance at all outside of Dublin.

The nursing staff who wish to work are working, and that is good. However, we do not have enough of them to meet service demand. The €80 million is the cost. The conversion of that into permanent employment is an absolute must. There have been repeated efforts to do it.

However, we are then in the arena of employment ceilings, pay ceilings and so on. A hospital is told that, while it needs the staff, it is over the pay budget that it was given or is over its employment ceiling. The only way a hospital has of getting someone in is if a director of nursing feels there is an absolute clinical need to go to the agency. Does that deliver continuity of care and is it the way to staff a service? Absolutely not. In this year's service plan, there is a mention of 1,000 extra nursing posts. I do not mean to be parochial. That is to be funded primarily by that conversion. That is very welcome, but we have to make it happen, and even if it does happen, it does not increase the overall nursing man hours in the system. There will still be shortages and so on.

If I may, I wish to make a straightforward statement on that. There was an outcome of an expert group report from last August that said that at least 107 nurses are required to look after admitted boarded patients in emergency departments on a dedicated permanent basis. The idea of that is that the emergency department staff are then more free to look after their normal emergency department throughput. The admitted patients would have a dedicated cadre of staff. That expert group reported last August. The Department and the HSE met. There was ping pong between the two of them as to which was going to do anything about it. We met them last Friday and were told that there was nothing in the 2017 budget or service plan to allow for the employment of those 107 nurses, end of discussion. That is the reality of emergency department admitted patients and having a dedicated nursing staff for them. There is nothing in the budget or the service plan for them, even though an expert formula has said that at least 107 are need. We would argue that even more are needed. However, nothing is being done about it.

On the bed capacity review, 150 beds is the tip of the iceberg. The health strategy of 2001 called for 3,000 additional acute beds, with 650 of those to be private. That was parked. There was then the co-location idea in the 2006-2007 period, which was supposed to bring on about six hospitals with about 2,500 private beds on a co-located basis. That was parked. Whether one liked or disliked it, it would have meant an increase in our bed capacity in large acute hospitals. However, it was parked. We have done absolutely nothing about our acute bed capacity and our needs. We have particularly done nothing about our continuing care and long-term care bed capacities.

Dr. O'Conor is absolutely right and we have to be very clear here. While we argue with the HSE and so on, the one success story and good thing that has happened this winter is the reduction in the delayed discharges that took place. Roughly 13 or 14 months ago, we had 800 or more people that were discharged but in an acute bed. I think that is down to around 440 at the moment. That is being driven by additional transitional care beds, additional home help under the winter initiative and a de-layering of the bureaucracy in access to the fair deal scheme, for which the waiting time is now about four weeks rather than ten to 12 weeks. That has to be welcomed. It is late, but it has to be welcomed. The difficulty we have is that the demand for those types of beds will continue to increase. Where are we going to get them from? It does not matter how we de-layer the bureaucracy. Where are we going to get the additional transitional and continuing care beds? There is no plan to develop. The capital thing about bed capacity is not just about the attention-seeking acute hospitals. It also has to be about our long-term care. We must remind everyone that 20,000 to 25,000 people will turn 65 every year for the foreseeable future and will increasingly present with comorbidities that will have to be addressed either with supports at home or in some kind of primary or acute care environment. The bed capacity issue is massive and we have to address it.

How willing is the system to share? Deputy O'Reilly asked that question. It is simply not.

My money is mine and the Deputy's is the Deputy's and we do not share.

Deputy Louise O'Reilly: And neither of us has enough anyway. We do not have anything to share.

Mr. Liam Doran: And neither of us has enough. If an initiative might improve the patient flow and patient experience in one area but might incur cost in another area, it does not happen because it does not transfer. This touches on Senator Swanick's comment about properly using district and community hospitals. We have got to develop district and community hospitals in order that they can address a certain level of acute illness in their patient population. That means that they must grow their nursing staff, expand their roles and so on. We are on record of congress as wanting to do that since 2007. The then CEO of the health service called it elder abuse to transfer people from a continuing care setting to an acute hospital when their situation could be managed in that continuing care setting through the expansion of roles. We are still waiting to be engaged by the continuing care setting managers to deliver that, whether it is first-dose antibiotic, fluid balance, phlebotomy or whatever. That has not happened and, recognising reality, it needs to happen. The sharing of budgets is very poor. It is very siloed and there is no integration. The one thing we have done, badly at that, is we were moving towards integrated care structures in the health system and we have gone backwards in the past two years and become more siloed.

A question was asked about special measures in respect of the labour market. Nurses and medical staff are no different to anybody else. They respond to labour market realities. When we talk about special measures, that includes monetary solutions but it is also about terms and conditions of employment and access to continuing education. I am very passionate about developing access to a buddy hospital system whereby if I am a nurse in an emergency department, ED, perhaps I could have a contract which would send me over to the United Kingdom to do a specialist programme in emergency nursing and come back to my permanent job. So it is about monetary compensation but it is also about issues of professional development, which are not available at the moment. I wonder why nursing staff and support staff go in every day to emergency departments. It is an absolute miracle that they go in every day to the same problem and try to cope with it when the situation around them has got worse. We need special measures.

In terms of the numbers presenting, for the record, the national figure for attendances is up by 5.3% year-on-year to the end of December, according to the latest figures from the task force. It is steadily increasing every year. The point is very well made about lack of consultant cover. As to whether the GP system is working, integrated care happens and then it does not happen in some spots.

In terms of causes of attendances, there is a problem undoubtedly about lifestyle. We will not comment on the whys and wherefores of it but in terms of whether emergency departments are staffed to deal with that presentation, I do not think that is the case. Thursday, Friday, Saturday and Sunday nights are very heavily influenced by alcohol and related issues and that presents huge challenges, not just for the staff but for the patients who are there for normal reasons and have to put up with the shouting and so on. Security is very poor.

Bed capacity and timeframe issues will not be solved without the nettle being grasped. We have not been invited to contribute to the bed capacity review from the point of view of either congress or my own house but I do not think it requires much science to work out that we need additional beds. The trick is – this is a political issue – that there are greater needs in some areas

than others. The level of overcrowding has noticeably reduced in Dublin hospitals but outside of Dublin the situation has become significantly worse. I do not say the situation in Dublin is good but it is not as bad as it was, whereas outside of Dublin it is about 20% worse than it was two or three years ago. Hospitals are now experiencing overcrowding that never did before, for example, the level of overcrowding in Kilkenny and Tullamore is very bad. The patient experience time is also very bad and staff are completely overburdened.

We have discussed community district hospitals and we have touched on transitional care. The practice nurse is a vital cog in the wheel. The practice nurse is part of the nursing infrastructure for the community and we hear a lot about primary care and community nursing. For the record, at the end of December 2016, there were three more public health nurses employed than at the end of December 2015 but yet we speak about reorienting care into the community. I listened to the submission by Patient Focus on growing the role of public health nursing and I agree with what was said. A public health nurse is a highly educated professional and currently such nurses are not being properly utilised. We had 1,700 and now we have only 1,500 because of the recruitment moratorium in the past eight years. Only three have been added in the past 12 months. That is not a sign of a commitment to offering an alternative to hospital care and to give a safety valve to the emergency departments and keep the frail elderly in particular out of hospital. The Institute of Community Health Nursing does excellent work and we often work with it. Such entities have a role to play in trying to devise policy but ultimately this problem will not be solved without making the health service bigger.

Chairman: I thank Mr. Doran. I will ask one or two questions before we move on to the next group of speakers. On process and integration, is there a value in integrating primary care and secondary care in a much more active manner? We have a model in Kilkenny where there is a highly developed integration between primary and secondary care which involves the streamlining of the flow of patients both into the hospital and out of the hospital.

Dr. O'Conor might respond to my second question. Are sufficient experienced clinicians and nursing staff involved in making serious managerial decisions that can help to improve patient flow and access to services?

Dr. Emily O'Conor: The Chairman referred to the medical assessment unit, MAU, model in County Kilkenny. No matter how many doors one puts into the acute bed pool, one still needs the same acute bed pool. Whether patients come via GPs directly to wards, via the MAU or through an ED, MAUs are not the solution to overcrowded emergency departments. They offer an alternative process to getting to the acute bed but they will not solve trolley waits. Kilkenny is experiencing significant trolley waits despite having an MAU at the moment. If one only has 20 chairs, and one has 50 patients trying to get into them, it does not matter how many doors one puts into the room; they will not all get a seat. We must remember that when we are talking about processes.

I can only speak for myself and I must be careful because the meeting is in public and my hospital manager probably has access to it. What I experience is a tiered level of management. I may have a good relationship with my local hospital manager but I work in a HSE hospital and much of the real decision making seems to be happening at group level and I have no access to the group CEO. I depend on my voice being transmitted through the management executive team up to where the power and the money seem to be, which is at group level.

I am only one of many problems faced by my hospital manager. She is trying to do the impossible task of managing elective bed capacity versus emergency bed capacity. On some days,

the elective care waiting lists are more of a priority for her boss and sometimes the number of patients on ED trolleys are more of a priority in terms of the pressure coming down from her boss. Sometimes, no matter how loud I shout, the elective care cannot all be accommodated in the same acute bed pool. Sometimes my voice seems to get through and at other times the voice of my surgical colleagues seems to be heard best because the emphasis is on waiting lists. I would love to be more involved in management locally and I would love to have access to the real decision makers who seem to be the CEOs of hospital groups.

Chairman: Is there a lack of consistency in planning? Is Dr. O'Conor saying that week one might be completely different to week two in respect of the emphasis in planning?

Dr. Emily O'Conor: The cycles are longer than that. I am sorry that perhaps I am speaking from cynical experience, but the emphasis will go off trolley waits in the next couple of weeks. We will still have lots of patients on trolleys but the media will stop picking up on it and, without meaning to cause offence, governmental interest will stop focusing on it. Media interest might go onto patients waiting for elective surgery. They are real patients who need to be seen. Hospital management will have to respond to that. We often use our surgical day ward capacity as a safety valve. The surgical day ward does not normally take patients off the waiting list but on occasion, hospital management would close it to the waiting list and open it to the ED and yet that means patients will be off the elective waiting lists. Our management will respond to the directives from above. It is a see-saw and there is simply not enough bed capacity to accommodate both.

Mr. Liam Doran: I can only echo Dr. O'Conor's point about integrated care. Everybody is for integrated care, with GP access to diagnostics and so on. I will give a figure for Kilkenny, although I do not mean to be smart because I come from Kilkenny. It does not please me to have to say this. In 2010, there were 140 people on trolleys there for the whole year. Last year, there were 3,144 people on trolleys. That is in a unit that has really worked hard and that has great people in the clinical arena, including Dr. Garry Courtney. They are just overwhelmed by a lack of beds and so on.

I can give some figures about the level of overcrowding. In Dublin in 2007 we had 27,000 people measured on trolleys and last year we also had approximately 27,000 people measured on trolleys. That number stood still with a growing population. Looking at the hospitals outside Dublin, in 2007 there were 23,000 people on trolleys but last year there were 66,000 people on trolleys. It has become three times worse outside Dublin because of the growth in the population, demographics, demand for services and so on. Even when we have tremendous integrated care and collaboration with the general practitioners, practice nurses, primary care teams and the acute hospital, if we do not have enough beds, the end game is overcrowding because the accident and emergency door can never close.

With regard to clinicians in management, I do not have to choose my words quite as carefully as my colleague, Dr. O'Conor. I do not have to go back to any hospital. We have heard the phrase "clinicians in management" for years and two issues arise, with respect. One is that general management do not like it; for example, they do not like putting nurses and doctors into management roles. It is a case of nurses nursing and managers managing. The other difficulty, with respect, is that clinicians at times find it difficult to move into the arena of the difficult job of management, where one must make choices. Nobody is in any way downsizing the challenges facing a senior general manager, who has not got enough resources to respond to need. It is very difficult. There is a clinical director who is supposed to co-ordinate the work of all consultants and, if we are brutally honest, that can be a difficult job for that consultant, as his

brothers and sisters do not always like him or her because of what they are required to do arising from that management component. Clinicians have a clinical focus and they do not really want to do the management component. Clinicians in management sounds very good but it often does not happen as well and it does not make the material difference one might expect.

Ms Brigid Doherty: We absolutely agree with Mr. Doran's opening statement and Dr. O'Conor echoes how we feel exactly. We do not need another report or review. We must get on with this. Personally, I am passionate about community care. That money must be ring-fenced and we must do something now, even if we start small. It concerns me greatly that there are community intervention teams in some parts of the country but not in others, so if I need antibiotics and I happen to live in Thurles, I will get them if I have a medical card but if I have VHI, I will not. Neither will the VHI cover my patch so I will have to sit in Kilkenny hospital for three weeks purely to get antibiotics. Something must be done about that. It is a two-tier system, with medical card care by the community intervention teams provided by the Health Service Executive, HSE, versus the high subscriptions to private health care where they pick the patches for community care. That is unacceptable and the issue must be examined.

There is the issue of developing community care teams. There are plenty of skilled nurses out there and they need to be developed. Particular care does not need to be provided in the accident and emergency departments. I will go to the basics, like block catheters etc. When a patient arrives, he or she must arrive by ambulance and these people will sit all day in the accident and emergency department before being taken home by ambulance. There are dreadful conditions, with bursting bladders for example. That is very basic but how it is. There are many other aspects to consider but we must get on with it, even if we do it in small patches and not necessarily the whole country together. Palliative care specialists do brilliant work and I ask that they integrate their services with community nurses as well.

Deputy Kate O'Connell: I thank the delegations for coming before us. I almost feel I am friends with them at this stage as I see them at so many committee meetings. I will try to be as quick as possible and I will have to excuse myself immediately because I am supposed to be attending the water committee meeting as well. I must show my face but I will look back at the replies here.

The figures for overcrowding are increasing outside Dublin but in Dublin they have basically remained the same but demand has increased. Could one say things have improved? Is that taking it a bit too far? If capacity has not increased and demand has increased, are people just making this work? Are there efficiencies? I just want to tease out the issue in Dublin. If we had not used private hospitals in the past eight weeks, what would we have been faced with? Is there data on that? Could Mr. Doran say from experience what sort of mess we would have been in if we did not have that capacity or the "valve" to release pressure?

The success of the winter initiative would be a reduction in delayed discharges. Has there been any other success or anything else that was positive? Could we learn something for next year? I worked as a community pharmacist for the Christmas period and I do not think I have ever dealt with as many people in an awful state in that time. I was working until after 8 p.m. on Christmas Eve dealing with people. Is there anything we could do in the view of any of the witnesses to try to improve matters next year? Do we need to examine buffers? This year we had a strain of flu that was particularly difficult for older people so how could we predict that? Taking that to a natural conclusion, what would happen if there was a massive disaster? How would it leave trained clinicians like Dr. O'Conor with what they deal with already?

The comment that illness is a 24-hour phenomenon as opposed to something that happens from 9 a.m. to 5 p.m. is quite interesting. I remember speaking with an accident and emergency consultant one night who explained that a farmer had come in one night with a massive gash on his arm. Instead of being able to deal with it at that point, remedial treatment was given and the fellow was kept stable. There was no capacity to deal with it fully and the doctor had to make a decision based on what was available. There were three or four subsequent operations with multiple doses of intravenous drugs to try to deal with it. I think there were maggots in his arm by the end. When something is not dealt with properly in accident and emergency departments, in the experience of the witnesses, what sort of knock-on effect is there? I realise it is difficult to get metrics on that. Are we constantly in this cycle of causing ourselves more problems?

In a health committee meeting this morning we had an economist who told us there were 3,000 beds taken out of the system in the 1990s. It went from 18,000 to 15,000 beds. Despite demographics and people expecting greater access to health care, are the witnesses saying the imbalance has never been addressed? There is a plus three figure for public health nurses. My mother is a public health nurse who retired last year or the year before that. Is that a pure plus three or does it take into account senior nurses who have been made retire at 65 years of age, even if they do not wish to? Obviously, if they wish to retire it is fine, but I know a number of people who do not wish to retire at 65 years of age.

To return to the management, Ms O'Connor mentioned her experience. I do not wish to get her in trouble at work but could it be said, perhaps, that prioritising of patient need is not being done by clinicians but by management? Is it fair for me to say that? If that is the case, it must be exceptionally challenging for people bound by codes of ethics and registered with the Irish Medical Council and the like.

Finally, if there were three realistic things the witnesses could do tomorrow - I know that Dr. O'Conor's first would be more beds - or that they think could be done to try to fix things, will they say what they are?

I thank the witnesses. I am sorry but I must excuse myself. I will watch the rest of the committee's proceedings tomorrow.

Deputy Billy Kelleher: I welcome the witnesses and thank them for their presentations. The Committee on the Future of Healthcare is working in parallel with this committee and the witnesses have made presentations to that committee in that context.

The big challenge will be whether the State will have the ability to deal with the capacity issue in the health services. That is something we will have to assess both in the political sphere and in society, in terms of how we are willing to fund, and who is willing to pay for, expanding the capacity of the broader health system. When the witnesses talk about bed capacity they are referring to acute bed and intensive care unit bed capacity. Then one moves out to the community care setting and to the home, using that bed capacity in the context of home care, home care packages, home care supports and intensive home care packages. It is not just the acute hospital system - there is a lack of capacity across the system and in the nursing homes.

This meeting is primarily about emergency medicine and the overcrowding in our emergency departments in the last number of years. If memory serves, a previous Minister declared a national emergency in 2006. Then other emergencies were declared. It was seen as the horror of all horrors. There were 612 people on trolleys on the first Tuesday of 2017, so we have not addressed it. I am putting questions so I can get answers or at least opinions on what we must

do, so these are not my stated views but questions to which I wish to get answers. I cannot get my head around the fact that, as an Opposition Deputy, I could have prepared a press release for the first Tuesday in 2017 last October, as a result of the trends over the past seven to ten years. On the first Tuesday of every year there is a spike in the numbers on trolleys. On every Tuesday of every week there is a spike in the number of people waiting on trolleys in emergency departments across the country. While there is a huge capacity issue there is also an inability in the system to anticipate what will come through the front door, even though we all know it will come through that door. In terms of rosters or preparedness to deal with the overcrowding in emergency departments, even on a short-term basis, why are we incapable of just anticipating what will come through the front door next Tuesday in the emergency departments? We all know today that there will be a spike next Tuesday. Why is it that management and stakeholders cannot collectively try to deal with that issue? Why is it that there is a spike in numbers on the first Tuesday of every year and on Tuesday every week and why can we not deal with that?

Regarding Mr. Doran's point about dedicated staff for admitted patients, I have visited emergency departments once or twice myself or to visit a person in an emergency department or as an Opposition Deputy trying to help, or perhaps hinder, but at least to observe. There appears to be no transitional place for patients who have been admitted to the inpatient system. They are warehoused in busy corridors or in nooks and crannies in our emergency departments. I always wonder why there is no capacity to build a proper annexe near the emergency department for people who are assessed, whose emergency treatment is over and who are now awaiting proper admission to the acute hospital system. Why are they still on trolleys in corridors? Could they not be on a trolley in a nice ward area before they go up to the hospital proper?

The reason I raise this is that Mr. Doran says we need dedicated staff. We do not have that capacity in the beds in the acute hospital system. In the meantime, patients on intravenous drips, people who are incontinent and people who are 90 to 100 years of age are waiting in corridors. Is there any transitional place where patients could be put while waiting for acute beds to free up in the hospital proper? I know it has been considered, but why has there not been action on it given that we have the emergency medicine task force? It is a flawed name because the word "emergency" should not be there at all. It has not been an emergency but has been very lethargic in assessing and anticipating potential problems or issues to ensure appropriate structures, processes and controls are in place. Many of the witnesses are familiar with this. There appears to be a neverending language about communication and the exchange of platforms between the HSE and relevant stakeholders, but for the last ten years we have had the most appalling incidents of people waiting inordinate lengths of time just to get to a place that is quiet and peaceful, before they are admitted to the hospital proper.

There was reference to the fact that we have 80 emergency medical consultants. We have 29 hospitals that provide some form of emergency care. Why are there only 80 consultants? Is it because there has been no recruitment effort or because nobody wishes to work in the environment? Is it because it is not remuneratively attractive? What are the reasons for only having 80 emergency medicine consultants?

I seek clarity on another issue. While there is bedlam and chaos in the emergency departments, the other end of the hospital is serene, tranquil and nicely managed. There is 9 a.m. to 5 p.m. discharging and 9 a.m. to 5 p.m. access to diagnostics, five days a week, although I am aware that it has gone to 8 a.m. to 8 p.m. in some places. Is there an onus on the stakeholders at the other end of the hospital, that is, the consultants and union representatives, to promote the concept of moving beyond 9 a.m. to 5 p.m.? Let us be honest, Ms O'Connor has colleagues

who are operating from 9 a.m. to 5 p.m. while she is down in chaos. Why is there not more emphasis on the professional or representative bodies to promote that concept of expanding hospital hours? There was resistance by consultants to nurses being able to discharge, so it is not all just about the elephant in the room, which is the lack of capacity. Are there any opportunities for us to improve and do better with what we have, bearing in mind that everything the witnesses and I have said here today must be funded by taxation? Until recently the State simply did not have the capacity to fund even what we had, so that must be borne in mind.

On the issue of elderly people and nursing homes, Mr. Doran mentioned public health nurses. We know the demographics and the assessments that will confront this nation in the next number of years in terms of the ageing profile, life expectancy and the demographics in age profiles. There will be huge demand in geriatric services and for geriatricians, nurse specialists, community care and so forth. At the same time, if there is a difficulty in a nursing home in the evenings or out of hours it is quite likely that a locum doctor will attend. They might not be familiar with the patient or even with the nursing home. It is inevitable that the elderly person will be transferred by ambulance into an acute hospital, such as the one where Dr. O'Conor is working, in a state or crisis. Why is there not more emphasis on the need to enhance geriatric services to include geriatricians and consultant geriatricians in our public and private nursing homes to ensure there is confidence in the system and to allow older people to stay in the nursing home? Having spoken to representatives, I believe there is a reluctance to allow palliative care in nursing homes because it does not read well if people are passing away in nursing homes and there is the urgency then to move them on. Is this an issue that must be addressed to deal with the points about overcrowding as outlined by Dr. O'Conor?

On the issue of discharging, earlier in the discussion I referred to the lines of demarcation and prescribing. If one mentions to some GPs that nurses might prescribe, those GPs have apoplectic fits because they see it as a complete crossover into their area. It was mentioned that pharmacists should have more of a role in front-line care provision which is another no-no for some people. There is a need within the medical professions to embrace a bit of flexibility in the area of needing to accept that things must change for the betterment of people who avail of the services. This applies also to the stakeholders and workers' representatives,

Deputy Bernard J. Durkan: I welcome our guests and thank them for their interesting presentations. Going back to this morning's discussion, a medical consultant had previously intoned to me that medical economists were the cause of the problem, and he may not be wrong. I recall a different era when it was fashionable to say that we wanted fewer beds. I remember raising that question during the design stage of a hospital and a fairly long argument went on about the issue, an exercise about which I could not see the purpose, but the theory put forward was that people would be staying in beds for shorter periods. That did not work either. There is something in what my consultant friend said and was right about. There is a problem that needs to be dealt with and I agree entirely. We do need more beds.

I had occasion to be in a hospital in recent years and found beds in every corridor, in the waiting areas and at the reception area, with people being fed, bloods being taken and all at the same time and in the same place. I asked why this was happening when a couple of wards were decommissioned around the corner. I was told that it was less expensive to maintain the beds in the corridors. My conclusion was to ask whether it would not be cheaper, or almost free, to have the beds out in the car park. Pardon me for being cynical but these questions must be asked from time to time. My conclusion remains that we need extra accommodation and we need to have it active, available and ready for emergencies. The question then arises about

how to utilise the spare capacity in ordinary time. If we have the adequate capacity to meet the emergencies, and it must be made available, then the hospitals must have some way to deploy that spare capacity in ordinary time.

Will the witnesses explain how they deal with the recruitment issue? For instance, are medical services people paid less in Ireland than in other jurisdictions such as the UK, France or the Middle East, which is the place everybody wants to go to nowadays? Are we paying enough or are we paying less? What is the comparison between rates of pay in the UK and Ireland, for example, for nurses, consultants and doctors, and how do we address the issues emerging from that?

The operation of the fair deal scheme is another issue that drives me up the wall. One of the things that bugs me relates to geriatric care, as my colleague Deputy Kelleher has pointed out. This care is delivered by way of nursing homes and by public, old-fashioned community hospitals. On the one hand we have the Health Information and Quality Authority, HIQA, decommissioning public facilities and reducing bed and ward capacity in accordance with some mysterious policy. I do not know if this makes any difference to some patients. Generally speaking, elderly patients in a nursing home like to be able to talk to each other, their ward neighbours or the people down the corridor. I wonder what exactly the cause is and where the inspiration came from that money should be spent in subdividing wards to create less space at a time when more space is required. It bugs me that in the assessment used by the fair deal scheme, which I understand is being reviewed at the moment, the family home of the person is taken into account, even where the family home is not available for a particular reason. Maybe a person with a disability or a long-term illness has an entitlement to the family home for many years to come or *ad infinitum*, but the home is still taken into account in the assessment of the means of the person concerned, ultimately making it more difficult for the person to gain access to the scheme and so to leave hospital. That is a factor in the blockage in step-down facilities.

In looking at costs and comparisons with EU figures for consultant and GP ratios, I know that Ireland, for example, does not have a similar GP system to Germany as they operate different systems. In the witnesses' opinion, which is the best system operating now and how can Ireland aspire to it? We heard about the Dutch, French and Canadian systems - some magical system somewhere - that is obviously better than ours. Yet Ireland has a reasonably good system. Once upon a time, not so many years ago, a gentleman in this House said that in the days when we had no money there were lots and lots of beds and one could gain access to a hospital anytime one wished. Admittedly, it is true that we had a smaller population then. If the population is growing, however, and it has become fashionable to reduce the number of hospital beds, where do the two meet? What was the purpose of that exercise?

There is something I still cannot understand. I know there are many primary care centres throughout the State now. There should be some indication as to the extent of their intervention in alleviating the overcrowding at accident and emergency departments and in the system generally. How are they operating and gelling into the system? How are they interlinking with the community care system on one side and with the general hospital services on the other side? Are the primary care centres doing the job intended for them? We were informed last week that these centres are state of the art. I am delighted to hear that but we must remember that they are structural edifices within the system and if they do not contribute to alleviating the burden on the community care and general hospital services systems, of which they are part, then I would like to know why the primary care centres do not relieve that burden. Somebody somewhere must be able to tell us this. I have raised questions in the House and with people before this

committee many times about this and I have not yet had an answer. There is, however, an answer to be had. If our health services system is to work, we should see how it works well here. I remember a similar situation in Northern Ireland many years ago when it was quite possible to deal with emergencies in what was called a health centre at the time but which was effectively a primary care centre. They were quite capable of dealing with emergencies without any difficulty at all. What exactly are we doing?

I wish to comment on the cost of medicines. It is only part of the system but the cost affects the extent to which funds are available to run the health services. I have always held the view that we should procure medicines at an EU level where there is a massive market. Ireland is in the Single Market and membership is supposed to carry clout and weight. Modern technology allows countries to transfer money and debt across borders very quickly. I cannot understand why we cannot transmit the necessary messages to avail of the buying power of 500 million people as it carries much greater clout than the Irish population of 4.5 million.

Deputy Margaret Murphy O'Mahony: I will be brief as I am conscious that this meeting has run over time. I thank the guests for attending and for their concise presentations. I have a general question on emergency departments. Does Dr. O'Conor know whether all emergency departments operate a triage policy? If they do, does it operate 24 hours a day? Who oversees or runs it? Does she know how many medical staff, on average, are trainees in the emergency departments? If the percentage is high, does she think it has an effect on emergency departments operating to the necessary standards?

Chairman: Who would like to respond?

Dr. Emily O'Conor: I will start. If I forget anything, members should feel free to remind me as I go along.

In response to Deputy O'Connell, I have no data on how or if private hospitals alleviated pressures over the Christmas period. I do not know whether the HSE has the data. We have a two-tier health service. Private hospitals work hard for the cohort of patients who can pay and provide a service to that population. I believe, having worked in the public sector, that private hospitals cherry-pick non-complex cases that are profitable because of their business model. I do not see private hospitals taking on the complex cases of our frail and elderly population that the public sector takes on every day and every night. We do not run a business. There is absolutely no profit in the vast majority of what I spend my time doing every day. I would never be a profitable investment given what I do with the complex cases of elderly patients. We need to consider this aspect as we move forward.

The Deputy asked whether the winter initiative was successful. The delayed discharge initiative was a success but we need to keep going. If the funding for transitional care beds is stopped then the number of delayed discharges will build up again. The initiative was a win. We do not know yet whether it is a permanent win or only a temporary win while the transitional bed funding was available. The Deputy asked me to identify other wins. Although I am not part of the task force, I know from its meeting after the trolley crisis peaked that of the 55 beds promised to open before the winter, 17 beds had opened. Perhaps more beds had opened that I do not know about.

The Deputy asked whether we could cope with a massive disaster. I have huge concerns about that. In terms of the emergency departments in University Hospital Galway, Cork University Hospital, University Hospital Limerick, the hospital in Drogheda and my department

which copes very well, if there was a massive disaster that generated a sudden influx of hundreds of patients into the system then we would struggle to deliver care. We are already over 100% capacity but we would do our best to cope. We have highly trained people so we would all step up. We would do our best to make the system work but I have grave doubts about how we would cope with a disaster.

The Deputy asked about moving outside of the 9 a.m. to 5 p.m. model, as did a couple of other members. As a society we used to accept that doctors and nurses were just available between 9 a.m. to 5 p.m. Even when I was growing up, one did not wake up the doctor, unless one was half dead. People delivered their babies at home with no help. One accepted that granny died in the corner during the night. One accepted when one's baby died. One accepted that children died. We have moved on as a society. We have much greater expectations from the health service. We are unwilling to wait with our child who has a tummy pain until a doctor wakes up in the morning. We are not going to let granny die in the corner from a chest infection because she is 75 years old and getting on. We want things to be different. We used to have many empty beds but, as a society, we have moved on and have greater expectations. Patients get sick outside of the hours between 9 a.m. and 5 p.m. so we should move towards providing 24-hour care but that comes down to what we can afford as a society.

In response to the comments made by Deputy Kelleher, medical and nursing care is very hands-on and very expensive. We, as a society, must decide how much we can afford. In the interim we are looking at consultant delivered care or consultant shopfloor care operating between the hours of 8 a.m. and 8 p.m. We are actively moving towards that model in emergency medicine. I am not here as an industrial relations representative for emergency medicine so I will not discuss contracts, remuneration, etc. Most consultants working in emergency medicine have moved to working between 8 a.m. and 8 p.m. most days of the week but not all. This was done before contracts were decided or remuneration was agreed simply because we saw a need to do so. There have been variable approaches to working these hours outside of emergency departments.

The hospital system will respond outside of the hours between 9 a.m. to 5 p.m. for critical care. That means if I telephone another service in my hospital and say I think my patient will die before tomorrow morning, of course the system will open up for him or her and on-call services will come in. I cannot open up the system simply because I believe a person could go home on the same night if I got a certain treatment for him or her. The system is so thinly spread that I cannot make such demands at 10 p.m. Most of the services that work until late at night are unavailable the next day due to a lack of resources. Therefore, I must choose carefully which cases I get the radiologist out of bed for at night. My hospital's radiographer travels from her home when I need a CT scan to be done at night. Every time I get her out of bed she cannot work the next morning. We must pick and choose when logistics are at stake. We do not have to choose when a person is critically unwell, has suffered a major trauma, needs acute resuscitation or where I think the person will die before the morning. The service does open up in such cases.

How many beds are required? Do we need 2,000 new beds in our system? I want politicians to tell me how we will fund the provision of 2,000 new beds. We need to be ambitious. I do not think the numbers we have heard so far are adequate.

Deputy O'Connell asked whether the decisions on the prioritisation of clinical need are made by management rather than clinicians. Hospital managers have no choice but to make decisions on whether they are going to bring in elective or acute care. I will always believe

that a patient in an emergency department is in more immediate need of an ICU bed than, for example, a major esophagectomy case that is on a waiting list for cancer treatment who also needs an ICU bed. If it is my patient who is in the emergency department then the surgeon and I will not agree on which patient has greater priority. Therefore, hospital managers must make difficult decisions and bring balance to the situation. The problem is there are not enough ICU beds. The people I feel sorry for in our system are the nursing staff who have moved on to bed management roles. They must telephone people to tell them their operation has been cancelled. They must negotiate with management about whether to bring in electives or whatever. They must also clear emergency department trolleys, which is a horrible job.

Deputy Louise O'Reilly: When we had the HSE representatives here before, the hospital groups described what they called "stretch targets". Based on what patients got from private medicine last year, they would now have a stretch target on top of that from private income. I asked the HSE to explain, if there were two patients on trolleys - one with private health insurance and one without - which one of them would get a bed. Does Dr. O'Conor have any insight into whether or not managers have influence? I think Deputy O'Connell's point was that concern was expressed by members of the committee that in a clinical situation the stretch targets may, in fact, take over. Where there is only one bed, but two patients with competing acuity, what influence do managers have?

Dr. Emily O'Conor: Managers are expected to come in on budget. I cannot say more than that. Thankfully, in the emergency department I do not even look at who has health cover or not. I could not tell, looking around at patients on trolleys in my department, who has got cover. Thankfully, it is something I do not have to deal with. My hospital managers do have to come in on budget and make a certain amount of income, but I cannot give the Deputy any insight into how that is done.

We need to start commissioning modular bills for places that do not have enough acute hospital beds. We need to open every single bed, along with nurses and care assistants, that we have already built in our hospitals. I am not in IR, but from a medical staffing viewpoint, we need to sort out our contracts, conditions and remuneration for consultants or else they will not come home or stay. I would love that to be sorted.

Deputy Kelleher has raised some good societal decisions. We have gone from what Deputy Durkan was describing, which was not needing acute hospital beds, to everybody needing an acute hospital bed. We have huge expectations for what will happen in end-of-life situations. As a society, we have to deal with what we want for ourselves at our end of life. When I am 90, if I get sepsis from a chest infection in a nursing home, I will not want to go to an acute hospital for treatment, even if it means I am going to die. That is happening all the time for patients at the moment, however. It is really difficult. We are coming from a society where Catholicism was prominent and it was God's will. One did not discuss interfering with God's will at the end of life, but I think we have got to start having that discussion. Our age group needs to start doing that so that we do not leave this burden to our children.

At the moment it is hard for nursing homes to hold on to patients. All nursing home deaths are reportable to the coroner. HIQA has strong statutory reporting responsibilities for nursing homes, so the paperwork must be correct. There is really good practice out there. We have an example in my hospital with what is called a nursing home liaison geriatrician who spends half the time in the hospital and the other half seeing patients in nursing homes. It is a fantastic model. I can send someone to a nursing home and say: "It might be a risky discharge. Could you see them in 48 hours in the nursing home?" They will say: "Yes. We'll call in and make

sure everything is okay." If we could expand that model it would really help.

Deputy Billy Kelleher: Who calls into the nursing homes?

Dr. Emily O'Conor: It is a geriatrician and there is a clinical nurse specialist who works with her. It was started off by Siobhán Kennelly, a geriatrician in Connolly hospital. If we could expand that service it would be wonderful. Currently, we cannot give intravenous antibiotics in nursing homes. We need to be able to do that to prevent patients coming in to us with infections.

Geriatricians also introduce good practice for end-of-life planning. They are difficult conversations to have with patients and relatives, but they are bringing in good practice on that. I can only support that model.

As regards the predictability of surges, I could not have said it better myself. We know when the surges happen. Why do they happen on Mondays and Tuesdays? It is because we have peaks in attendance at emergency departments on those days, generated significantly by GP referrals on Mondays because the clinics re-open and, thus, GP referrals increase. In addition, theatre lists for elective surgery open up on Mondays and Tuesdays, so there is a surge from both sides on beds. We are therefore always going to have difficulties on Mondays and Tuesdays. Should we have elective theatre lists on Saturdays and Sundays, and all weekdays? There is a lot of medical literature to say that evening out elective surgery across the seven-day week would improve one's ability to deal with surges through the emergency system.

As a society, we close down for six or seven days over Christmas. We all want to do that, yet people still get sick. How can we expect the system to cope? This year there was a Saturday and Sunday, and the bank holiday, so the system re-opened for three days before it shut down again for four days. Are we surprised therefore that things back up? When I say "shut down" I do not just mean the acute hospital sector. I also mean that it is very hard to get someone out into the community on Christmas Day or St. Stephen's Day. It is hard to arrange for a public health nurse to visit a patient on Christmas Day. Society makes these decisions. We all want Christmas Day off to be with our families. If we want people to work on these highly valued days in the year, we need to staff them enough and incentivise people to work then.

Weekend discharges are not as good as we want. It has definitely improved in some hospitals, particularly on Saturdays, although it is still not great on Sundays. That is not just because consultants are not doing ward rounds, it is because access to community follow up is difficult at weekends.

This committee is not about emergency medicine. I would love to sit here and tell members of the committee all the good things about emergency medicine, but I am not allowed to do so because this is about overcrowding. So do not confuse both - emergency medicine is not simply overcrowding.

The transitional space or annexe for patients is not safe. We used to have models where we shoved all the admitted patients out into a room and they could not be seen. They were having cardiac arrests out there and no one could get to them. Patients need to have nursing and medical care, even while they are waiting on trolleys. They are easiest to nurse when they are visible and they are visible on the corridors. Not all departments nurse on the corridors. We do not nurse on the corridors in my department, but that means that I do not have cubicles to bring patients in the waiting room into. Therefore, nursing staff have to balance where the biggest

risk is going to be. If we do not have enough nurses to nurse patients the best thing we can do is to put them into a visible space where we can see them. That is why they are on the corridors. I am sorry if it is undignified, but clinically it is the safest place for them to be if we have no beds for them. If we have money to build annexes for them, we have money to build beds, so I would not support building annexes.

Deputy Billy Kelleher: There would still be emergency medicine staff in the annexe. One would not put them into an annexe, close the door and say: "We'll come back in a couple of hours." In recent times, we have had cases of patients dying on trolleys in corridors because of an inability to provide proper care in the corridor setting.

Dr. Emily O'Conor: Yes.

Deputy Billy Kelleher: Surely a room with nurses and emergency medicine consultants is better than corridors, is it not?

Dr. Emily O'Conor: But we do not have the nurses. We do not have extra nurses.

Deputy Billy Kelleher: That is the point I am making.

Dr. Emily O'Conor: We do not have those nurses. At the moment, the current cohort of emergency department nurses that are there to staff emergency department patients are also looking after these admitted in-patients. Therefore, instead of having five patients to look after, a nurse might have ten to look after. The safest place for nurses to nurse them is where they can see them. There is a clinical risk to putting patients away if one cannot staff them. As I said earlier, if we can build annexes we can build proper beds and staff them.

Why do we have 80 emergency department consultants in emergency medicine? That is all we have ever agreed on. The national programme for emergency medicine has much higher numbers. We need over 200 consultants in emergency medicine, but there is no money for it. We have jobs filled on a *locum* basis and there are unfilled jobs because of working conditions and remuneration. Both need to be sorted. I have addressed 8 p.m. to 8 a.m. working, but I can speak more about that if the committee so wishes.

Can we improve with what we have? I think we can, yes. We can continue to improve the way we work. Working from 8 a.m. to 8 p.m. and improving how the system works out-of-hours is part of that. By God, however, we have worked on process change so much over the last few years, and we have made progress. We have managed to keep trolley waits static in Dublin emergency departments despite the increase in numbers of attendances, so there have been improvements, but give us room to breathe and hopefully we can improve processes more. Yes, the elderly in nursing homes come to emergency departments out of hours. More advance planning led by consultant geriatricians and palliative care teams in nursing homes might prevent some of that. Nursing homes need to know there will not be adverse reporting and family expectations because the loved one has not been transported and has subsequently died. We as a society need to be mature about this. I see very debilitated patients transferred to emergency departments for a blocked catheter etc. at night. We could do better. In addition, we need to be able to die in nursing homes.

As for nurse prescribing, we have lots of nurse prescribers for emergency medicine and ionising radiation. We are one of the best practices for crossover of clinical skills between nursing groups and consultant groups. We have clinical nurse specialists and advanced nurse practitioners. We have really good practice on crossing skills and the boundaries are not as

demarcated in emergency medicine as they are perhaps in other specialties. We can lead out on that if the committee wishes.

I have already addressed Deputy Durkan's questions. Societal expectations have changed, which is the main reason, and population has increased. In the United Kingdom, the Royal College of Emergency Medicine is fighting back again because there is still talk there of reducing bed numbers. That could happen if we got processes so perfect that most patients could be seen in ambulatory manner. Yes, in an ideal world we might have fewer beds but not in the short or medium term with our current processes or those in the UK. Yes, it would be less expensive to maintain patients in car parks. The Deputy is right that it is less expensive to maintain patients on trolleys in emergency departments than to open wards and bring in nurses to do that work.

Deputy Bernard J. Durkan: What about the concept of a larger ward where skeleton staff, for want of a better word-----

Dr. Emily O'Conor: A Nightingale ward.

Deputy Bernard J. Durkan: I remember being in Jervis Street Hospital in 1972 when the fire broke out in Noyek's and patients were brought in to the emergency department. The wards were very big at the time with perhaps 50 patients. I do not suggest that as a resolution but it would be better than having patients in a corridor or anywhere else. At the same time such patients would be under observation because one nurse can observe several patients in a larger arena as well as or better than they can in a corridor.

Dr. Emily O'Conor: I will refer that question to Mr. Doran because I do not know the nursing reasons for moving from Nightingale wards to smaller wards.

On recruitment of consultants, pay is greater in Australia but there is a more significant point. In my department we see approximately 35,000 new patients a year. There were two of us for the past ten years and we have worked very hard and we hope to have five consultants soon. In a department of the same size in Australia - I know this because my trainees go to work in them - there would be 22 consultants, working 33 hours a week on shifts. While it is a question of money, it is also a question of working conditions. The starting salary in the UK is lower but there are significant increments as they go through their career. Being honest, the starting salary for new consultants is not enough. They suffered the special 30% financial emergency measures in the public interest, FEMPI, imposition. I have a young colleague working with me and with that 30% drop, it simply is not enough. The only people taking that contract at the moment are those with domestic responsibilities who feel they have to. That needs to be changed.

I am not an expert on the fair deal. I will pass over those questions.

In response to Deputy Murphy O'Mahony, yes, all emergency departments employ triage 24 hours a day, seven days a week. It is called the Manchester triage symptom and is delivered by trained nurses. Most places have a computerised system for that but some do not. The system is standardised and reproducible. We did not have a triage scale suitable for children but the emergency medicine programme has recently introduced the Irish children's triage scale, which is going national now.

In response to the question about the number of trainees compared with consultants, we have always run a pyramidal system where the top of the pyramid is very thin and the base is very broad. That is the tradition in this country and that is how I trained. We want desperately to overturn the pyramid so that most of the care is delivered by consultants with a few trainees

coming through for experience and training. Consultants are expensive to train and employ and that will take investment but medically that is the way we need to go.

Deputy Alan Kelly: I apologise for my absence earlier on but multiple things were going on.

Several of the members present also serve on the Committee on the Future of Healthcare, which is a separate committee setting up a strategy for ten years. We had a submission from the chief executive officer of the Mid-west hospitals group, Ms Colette Cowan, who is dealing with one of the biggest emergency problems in the country, in Limerick. I represent Tipperary. On one side there is Limerick and on the other there is Clonmel, two of the worst emergency department situations in Ireland. They are chaotic. People in Tipperary are afraid to attend emergency departments. In her submission, Ms Cowan made clear that the solution is to take a large portion of her budget from her and put it into the community to prevent people ending up in the emergency department. It was an amazing submission. I presume the priority for the Committee on the Future of Healthcare will be the investment needed in the community side of health care, and how quickly we can get that out there. My colleagues can correct me if I am wrong.

I found it immoral to hear news reports on RTE or Today FM or Newstalk of the trolley watch figures during the emergency followed by advertisements from private hospitals for patients to come to their accident and emergency departments. What is Dr. O'Conor's opinion of this? Personally, given my political philosophy I believe in public services but for a period there is capacity in these private accident and emergency departments. I know they cannot do everything but they can deal with normal knocks and bits and pieces. They should be seconded during crises such as the recent one because their capacity is not being used to the full.

There has to be a statistical analysis or a heat map of why in some locations some general practitioners, GPs, have a higher rate of referral than others, even in the same town. Why are the ambulance personnel in the mid-west telling me they cannot work because of the volume of referrals from some GPs while others make very few referrals yet their case loads are more or less the same? What are we going to do about it? All these things are intertwined.

I accept that we need to change the way consultants and clinicians are paid. We also need to change their work practices. The idea that we work five days per week and are closed for eight days over Christmas is insane. There must be a seven-day roster. We must have clinicians, consultants and so forth coming in, discharging people and doing their job seven days a week. That must be part of the contract. In addition, we must ensure GPs have a contract that deals with unsocial hours in a realistic way, so we do not have a situation such as the one in the Chairman's county where Shannondoc went from 58 hours down to eight when it went from 12 doctors down to ten, which is scandalous.

Part of an issue here, aside from staffing and beds, is that the IT infrastructure is crazy. I have been through the emergency department in Limerick a number of times. What is happening there is crazy. It is not the fault of anybody there but it is crazy. It takes up so much time.

On the minor injury units and the pathways through which patients are put into emergency theatres, I am not convinced it is working as well as it should. People are ending up in accident and emergency departments when they should be in the minor injury unit. That area must be re-examined. When one arrives in Ennis or Nenagh hospitals there is a massive sign in front which says, effectively, that one must go to Limerick if there is basically anything wrong. The

management of that pathway is not working to the maximum and more people are ending up in accident and emergency departments. I keep referring to Limerick hospital because it is the model one hospital in my area. That should change.

On the issue of opening transitional beds, and I accept there are issues across the board in terms of staffing, beds and so forth, there is capacity to open transitional beds in many areas of the country without too much funding. There is a former hospital in Cashel on which X amount has been spent, which I will be reviewing in the Committee of Public Accounts. It does not have a single patient, which is incredible. If that cannot be used for transitional care, when the hospital a few minutes down the road has one of the worst emergency department crises in Ireland, I do not know what can.

I have a final few comments or questions. I am very much taken by the issue of modular building. I support it. It appears to be taking a long time from procurement. I do not know what it will be but, personally, I believe it will be extensions in all but name albeit perhaps modular in nature. Obviously, it will not be full build. From a capital point of view, I am not convinced that this happening as quickly as we need it. I take on board the views on nursing homes. People should have end-of-life facilities in those homes because obviously that will take away pressure. It is all about diverting pressure away from accident and emergency departments through multiple decisions.

My final comment is on transport. I am deeply frustrated with the way in which ambulance personnel are left waiting. To see the queue of ambulances left outside University Hospital Limerick over the Christmas period was frightening. There is also the knock-on impact of what happens if there is an emergency in the locality. That process must be dealt with in a more efficient way. Second, and this refers to what I said earlier, I realise funding was provided in respect of other transport facilities to bring critical patients. Most of them do not operate outside normal working hours. They need to be expanded and, in particular, they need to be used to bring patients to a step-down facility after being in a model one hospital and for GP referrals for non-critical patients. A situation where ambulances are being used for all of this is causing even greater problems and risks when it comes to accident and emergency departments.

Chairman: Before we take our final summing up, because the HSE representatives are waiting, perhaps when Mr. Doran is finished responding to the other questions he will comment on accountability and transparency in how our services are managed. Is there a difficulty in finding out who is responsible for making decisions which have knock-on effects on other parts of the service, to their detriment?

Mr. Liam Doran: I will try to be brief. There were a number of questions and some repetition. There are a number of reasons that the figures have improved in Dublin, as in not improved but stood still, as opposed to the country, where they have got really bad. The infrastructure in Dublin in terms of access to continuing care beds and so forth is better than in other parts of the country. There are improved process issues as well. There are a number of advanced nurse practitioners, ANPs, in a number of the Dublin hospitals, which also speeds patient flow. The group I spoke of that recommended the 107 staff for admitted patients also recommended that we should have 150 ANPs. We currently have 78 across the country. There is no funding for that. It is proven that ANPs greatly help in terms of minor injuries, patient flow and so forth. St. James's Hospital has six ANPs and has the lowest number of trolleys. It has high patient satisfaction rates. Advanced nurse practitioners work, but again there is no rush or stated intention to deliver them on the ground to meet and deal with the patients, which is all that matters in this situation. I do not wish to suggest that Dublin is good. It is just that the situation outside

of Dublin has gone south so badly so quickly that it is truly alarming.

I must be very blunt. We reap the harvest of fundamentally flawed decisions taken within the last decade. Reconfiguration of acute hospital services was an unmitigated disaster. I will go toe to toe with anybody about that. When one talks about reconfiguration the two areas that come to mind are the north east and the mid-west. In the north east in 2007, appalling as it was, there were 2,800 people on trolleys. In the Lourdes hospital last year there were 5,600, and it was 7,000 in the year before that. That is when Navan, Louth and Monaghan were taken out. I am not saying they are perfect but one must give the alternatives that are there. Deputy Kelly spoke about minor injuries units and so forth. They must work on a 24-7 basis and be properly staffed. If those units and services are closed down and then only one door is provided, should anybody be surprised that the one door gets overcrowded?

If one wishes to see the total and utter madness of policy decisions taken ten years ago, look at the mid-west. In 2007, Limerick had 1,367 people on trolleys. Last year, it had 8,090. That is not the fault of the clinicians on the front line or the nursing staff. It is the fault of whoever made the decision to shut down services in Nenagh and Ennis without building up Limerick. On top of that, HIQA decided that the accident and emergency department in Limerick is unfit for purpose. Did that not dawn on somebody before they made the decision to put everybody into Limerick? It is the same in Galway. It is unfit for purpose. I accept that alternatives are being built, but it is building alternatives ten years after the fact. That is why one wonders at policy decisions. I am including political policy decisions as well. They have to be owned by people when we reap the harvest in terms of what has been done in various areas outside of Dublin.

There was a question about the impact of private hospitals. I have to concur. We do not measure so we do not know. However, at 5 p.m. or 6 p.m. anybody who needs care is transferred back to the nearest public hospital, because the staff are going home. No harm to them, but that is the position. I understand the rationale for pointing to their capacity but it would be an expensive alternative to be forced on the public health system. Everybody must remember we have the fundamental problem that we have a two-tier health system which offers perverse incentives to certain key players in the system as to how they work and offers speedier access to care for those who can afford to pay for it. In fairness to emergency departments, they do not do that. In emergency departments, everybody is treated absolutely the same. They are triaged and the system responds. Our emergency department service is world class at consultant, nurse and support staff level, when one gets in there. They will not lose anybody who could be saved. However, they are just overrun. They are not inpatient wards. That is what is compromising care, particularly the care of admitted patients.

A question was asked about what was good or bad about the winter initiative. One always has to try to be balanced. This year's winter initiative was primarily aimed at transitional care, reducing delayed discharges and improving home help supports and home care packages. To a very significant extent, it achieved those targets and it did well with dedicated funding in those areas. As somebody said, the original provision was 55 acute beds with 17 opened. They then had the meltdown on the first Tuesday in the year. It was a crash course, and they said they had to do it better again. They came up with 63 beds. Some of it was regurgitating the 55 beds that had not opened in the first instance. They opened 25 beds in Galway. The only way they opened them was by cancelling the leave of the nursing staff. They cannot keep doing that. It is a Band-Aid over the problem. I remain unconvinced they will open those additional acute beds. There were aspects of the winter initiative that worked, and if they had not been there, the 612

people on trolleys would have been 800, in terms of delayed discharges and blocking up beds. I am using the wrong phrase, but the members know what I am saying.

Can we foresee the flu epidemic? We can never deal with anything like that, given that we have 95% to 100% occupancy in our acute hospitals week in, week out. We cannot deal with any extreme demand. The only way we deal with it is by cancelling elective procedures. That is all we do. We cancel planned operations. As Dr. O'Conor said, the bed managers have the job of ringing people once, twice or, on occasion, three times. On behalf of ICTU, I make the following point. Can anyone explain the policy that we admit every year that we cannot do elective work, and so we give money, through the NTPF, to private hospitals to do the operations the public system does not have the capacity to do, but we never tackle the capacity issue?

Deputy Alan Kelly: We are chasing our tail.

Mr. Liam Doran: Correct. And it will get longer and longer as people's expectations and demand rises for interventionist care, preventative procedures and so on. This is right, fair and reasonable. However, I am not convinced it does the taxpayer any good to use that arm to spend €20 million.

We could not cope with a massive disaster. However, I never underestimate the ability of health service staff, whom I admire and represent, to move mountains in an exceptional situation. The chances are that mountains would be moved. However, they are moving mountains every day, not on exceptional days, and that is the problem.

Issues were raised about the correct care at the correct time, choice issue, acute beds and the nine to five issue. At the risk of irking people, acute hospitals still primarily function at an optimum level Monday to Friday, nine to five. It has not changed. The emergency department task force is good at measuring everything. The latest dashboard figure we saw was 12% discharge at weekends. That was the same 18 months ago as it was in November. In the emergency department task force there is a commitment to empower and enable delegated discharge in accordance with national agreements and cross-team discharge, having regard for the consultants' ongoing responsibility for their patients. There is another commitment to ensure an appropriate level of senior clinical decision-making in emergency departments. There is a requirement to ensure there is a senior decision-making presence in emergency departments during peak hours with consultant availability on an 8 a.m. to 8 p.m. basis, subject to resource. That is the get out of jail clause. We lack the human capital to do it in many areas and the managerial capacity to do it on some occasions.

It is very difficult. We need to change everyone's *modus operandi*. We need consultants and senior registrars in emergency departments over a longer span of hours to make the key decisions. If, because of other pressures, consultant surgeons are unable to use theatre time, which is not good, could they be better utilised in the emergency departments, given that they have the experience? Somebody asked what we could do in the short term. These are the kind of things we could do in the short term. We could make use of the senior clinical decision-makers and ask them to attend on a rostered basis out of hours in order that they can make key decisions, get and interpret the diagnostics, map out the patient's journey and discharge where they can. Non-consultant hospital doctors, NCHDs, will practise defensively. We all know that. It was that way when I was a nurse. I am sure it is still that way in practice, and I would do the same myself. If I get it wrong and send someone away, there will be a follow-on. Therefore, they hold patients and get the registrars to examine the patients. Therefore we need to spread the clinical decision-makers.

I gave a wrong figure for public health nurses, PHNs. We are two fewer at the end of last year than we were in the previous year. This is not due to retirements but because we just do not have them. Any qualified PHN has a permanent post upon qualification. We do not have enough to meet retirements and we have none for locum cover. PHNs spend three or four months of each year covering annual leave in two areas. Patients are prioritised and, after a while, a person becomes so unwell, they end up in the emergency department. Everything we do is connected to everything else.

I agree with Dr. O'Conor on patient need and who decides. When it comes to acute interventions and decision-making, the clinicians, correctly, reign supreme and the system responds. Patient need is relegated. Directors of nursing who seek additional agency nurses to look after patients to the level required by the patient are frequently having their requests turned down due to resource implications. They are told to make do. The reduced number of nurses has to cover the acutely ill patients. To Deputy Bernard Durkan, I make the point that international research well proves that a ratio of one nurse to eight or more patients does harm and results in poor patient outcomes. Nurses are frequently left in acutely ill patient environments responsible for 12 to 16 patients. This compromises care.

I am not being, so to speak, industrial relations about this. It is too big an issue. It is not just about industrial relations. We have staffing agreements based on international research about what is required, and every day we have hospitals which admit they cannot reach them. We have emergency departments working four or five nurses short. I am not even getting into the admitted patients and the additional staff required for them.

Somebody asked me to identify three actions that could be taken. The first is staffing. If we cannot build the beds, we can incentivise the staff in order that patients who are there get better care. We need more nurses and senior clinical decision-makers in the system. It is a labour market out there. These professionals have choices and they are not choosing to work in Ireland, especially in our public health service. Providing additional beds is the second action. The third is to provide home help and home care services over seven days. The idea that they stop on a Friday and do not restart until the Monday, or the Tuesday on a bank holiday, is barmy. A person's deterioration may not be spotted. They need the supports every morning. Just half an hour in the morning and half an hour in the evening can keep a person at home and give them the spur or the rung on the ladder they need. It is taken away for two or three days every week, and the Government says it provides community-based support services. I am not getting into the bigger issue of more bed capacity, which we all know we need. Those are the three immediate things we need.

Dr. O'Conor spoke about the first Tuesday of each year and each week. It is predictable. We asked for a roster for senior clinical decision makers to be *in situ* in the community and in acute settings through the Christmas and new year period, but, as a staff rep, I am still waiting to see it. It is not just the acute system, but also the community system that has to stay awake and operate on a seven-over-seven basis.

Deputy Alan Kelly: To clarify, Mr. Doran asked for that.

Mr. Liam Doran: Yes. We were told that it existed.

Deputy Alan Kelly: Does it exist?

Mr. Liam Doran: It does somewhere, I am sure. I do not doubt the people who told me.

Deputy Alan Kelly: Mr. Doran has never seen it.

Mr. Liam Doran: No.

Deputy Alan Kelly: Has anyone seen it?

Deputy Louise O'Reilly: It is certainly not in operation, even if it exists on paper.

Mr. Liam Doran: I have not seen it. People say it exists, but I have not seen the roster.

Deputy Alan Kelly: Perhaps the HSE can ask for a copy of it. It would be a good exercise. Can that be recorded in the minutes please?

Mr. Liam Doran: The point about the predictability of Tuesday is correct. The Tuesday spike is a factor of the lack of discharges at weekends that should have happened had people come in to make those decisions, the recommencement of clinics on Mondays that might lead to referrals and the recommencement of elective work in some houses totally detached in some cases from recognition of the fact that emergency departments have been under pressure all weekend. The spike is predictable.

Dr. O'Conor answered the question on warehousing. If we can build modular units to house the admitted patients, we can build wards to look after them properly. To be blunt, that is not done because it is cheaper to leave patients in the emergency department where the same number of nursing staff must do two jobs, namely, their normal emergency department jobs and looking after these admitted patients, trying to prepare them, awaiting their transfers upstairs, etc.

Warehousing has a clinical risk. Patients are taken out of sight and sent down dark corridors. Limerick's emergency department is an appalling disgrace. It is a walk-in wardrobe that is the major trauma unit for the mid-western health region. Its staff at all levels are heroes and its patients are victims. That has to be said long and loud. Leaving patients in sight is safer than the alternative, but it is not right or good.

Chairman: We must finish. While I am sorry to interrupt Mr. Doran, could he devote some time to the questions of accountability and transparency? Are there deficiencies in how we view the decisions that are made and see whether they are being made responsibly and are clinically or managerially correct?

Mr. Liam Doran: I will make two points first, but I promise that I will answer then. I wish to address elderly care in nursing and community homes. We are in a race to the bottom in terms of the quality of care given to our elderly. The cost of care is the fixation that governs under the fair deal scheme and in public nursing homes. We are constantly told that the cost of care is cheaper in private nursing homes than it is in public hospitals and that we must drive the weekly cost per patient in the latter down to the level of the former. That is fundamentally wrong and unfair and is a race to the bottom. It forgets the increased complexity of the public hospital patient and so on. It also negates the likelihood that we will develop services in the nursing home environment. Dr. O'Conor spoke about this. We must keep residents in nursing homes or continuing care facilities where we can manage their acute episodic development, be that via intravenous, IV, antibiotics, managing transfusions and fluid balances, phlebotomies, blood tests, etc. Patients do not need to go as often as they do, but that requires a different skill mix in the nursing home arena. It is a richer skill mix, to use an old-fashioned word, and it costs money. That has an impact on the fair deal scheme, funding and so on. Everything is

connected to everything else. If we want to make the nursing home sector do more, it will need more staff of a qualified level, which will have a cost. The same applies in the public sector, but we need to do it.

Regarding accountability and transparency, the only people who are accountable in the public health service are those on the front line who have a register that allows them to continue to work. Consultant, registrar, NCHD and nursing staff have paid the price - patients have paid the greatest price - of flawed decision making by management and the political system with no accountability whatsoever. Accountability rests fully with those who are out there trying to do a job. If they make an error, they are subject to a complaint or whatever. That is the price that they pay, but the general management structure - I do not deny for one second that it works hard and has difficult choices to make - is not around when the situation goes wrong. The consultant, registrar and nurse are, yet all evidence and research shows that they are not empowered to make resource-related decisions. This follows through to clinical-related decisions because we still have a system in which senior management at group and hospital levels oversee what is happening but little accountability attaches to them. When something goes wrong, the consultant, registrar or nurse is before the regulator, which is happening with increasing incidence.

Chairman: I thank Mr. Doran. I might give a final word to Ms Doherty of Patient Focus.

Ms Brigid Doherty: We agree with most of what has been said, especially on opening wards and larger wards. Patients who are admitted to emergency departments when no beds are available are sick and need those beds. They need medical care. Those wards, units or corridors must be staffed appropriately. Otherwise, patients will die. The number of complaints that we received regarding emergency departments increased last year. In the previous year, there were very few complaints. The number of GP complaints is increasing because people feel that they are not getting the service that they should - for example, they are being sent to emergency departments instead of being seen. We ask that everyone work together somehow or other.

Regarding emergencies and disasters, I was in London during the bombings. Front-line staff pulled out all the stops and people were cared for. That is what front-line staff do, which needs to be acknowledged.

Chairman: I thank Ms Doherty. I will leave the final word to Dr. O'Conor.

Dr. Emily O'Conor: I cannot answer all of Deputy Kelly's queries, but he used the word "chaotic". I do not want that to go out to the general public excessively. I will be the consultant on the shop floor tomorrow in my department from 8 a.m. to 8 p.m. I will be on call. It might look chaotic but, between me and my senior nurse shift lead, we will know what is happening on the floor and we will have a handle on things. Even if I disappear to "resus" for a while before coming back, the shift lead will know where everyone is.

Deputy Alan Kelly: I have no doubt about that.

Dr. Emily O'Conor: It appears chaotic and sometimes it gets away from us, but we generally know what is going on.

Deputy Alan Kelly: I accept that.

Dr. Emily O'Conor: Deputy O'Connell asked about my third thing. At some stage, we need to move on from overcrowding and celebrate how fantastic our emergency care service is from pre-hospital through the acute-care setting. Morale is at an all-time low because all that

staff hear about is the terrible overcrowding and the complaints. That is not us. We would love to attend some forum and discuss the good elements of emergency medicine instead of always discussing overcrowding.

Chairman: I thank the witnesses for attending. We have kept them beyond their allotted time. We have also kept the HSE beyond its allotted time. I thank Dr. O'Conor, Ms King and Mr. Doran from the ICTU and Ms O'Connor and Ms Doherty from Patient Focus for their evidence. We will suspend proceedings for a few moments in order to facilitate the witnesses.

Sitting suspended at 4.59 p.m. and resumed at 5 p.m.

Chairman: This is session two of our meeting this afternoon. We are meeting representatives of the Health Service Executive, HSE, in regard to overcrowding in emergency departments. On behalf of the committee, I welcome from the HSE Mr. Liam Woods, national director of the acute hospitals division, Mr. Damien McCallion, HSE national director of the National Ambulance Service and emergency management, who is responsible for co-ordinating the HSE's winter plan, Dr. Colm Henry, clinical adviser of the acute hospital division, and Ms Angela Fitzgerald, deputy national director of acute hospitals.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to 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 asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. I advise that any submission or opening statement made to the committee may be published on its website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

I ask Mr. Liam Woods to make his opening statement.

Mr. Liam Woods: I thank the Chairman and members for the invitation to attend. We welcome the opportunity to appear before the committee and engage with members.

Our urgent and emergency care service operates across the health and social care system. It comprises a wide range of services, including the National Ambulance Service, emergency departments, injury units, GP out-of-hours services, primary care, acute mental health services and community intervention teams, to name but a few of the emergency and urgent care services that make up this system. Throughout 2016, our urgent and emergency care system saw a substantial rise in activity, including 310,000 emergency ambulance calls, representing a 4% increase over the previous year, 1.155 million emergency department attendances, representing a rise of 4.9% over 2015, and 286,000 emergency department admissions, representing a 5.3% increase over 2015.

I will now set out some of the key causes of the current pressures on our urgent and emergency care system and the actions being taken by the HSE in light of these pressures. During the first week of 2017, an unacceptable level of overcrowding was evident in emergency departments. Emergency department overcrowding and long patient waiting times for emergency

care are of critical concern within the health service in terms of providing patients with timely access to necessary care.

In December 2016 and January 2017, there were a number of factors that led to increased pressure on the numbers of patients delayed for admission. These include increased demand for emergency care, a 6% increase in attendances in December 2016 over 2015, a 7.2% increase in admissions in December 2016 over 2015, a 7% increase in respect of GP out-of-hours services in December 2016 over 2015, and an 18% increase in ambulance calls in December 2016 over December 2015.

With regard to bed capacity, as of 24 January 2017 there have been 150 acute beds and 190 community beds closed within our public health system due to essential refurbishment, infection prevention and control, and staffing deficits. There has been an increase in influenza and respiratory-related illness. This commenced in mid-December, earlier than last year, with influenza virus strain H3N2. This primarily affects those aged 65 and older. In the period in question, we recorded the highest ever number of respiratory admissions in our hospitals. It is well recognised that the causes and effects of emergency department overcrowding are multifaceted, complex and health service-wide. The causes span a range of complex issues across the health service, including: increased demand for acute hospital care; underdevelopment of alternative avenues of access to health services in primary and social care; limited acute bed capacity; and challenges in meeting the increasing demands of our ageing population for social care services to facilitate timely discharge of patients from acute hospital settings. As a result, the response to emergency department overcrowding cannot be limited to focusing on emergency departments alone but must be health system-wide. Improving processes and achieving efficiencies in hospitals in order to alleviate emergency department overcrowding continue to be priorities. Additionally, to address the causes and challenges of emergency department overcrowding and sustain the solution a more strategic approach is needed, from both policy and operational perspectives, in the medium and longer term.

Our population is ageing and it is expected that the number of people aged over 65 years will increase by nearly 110,000 in the next five years. The number aged 65 years and over increased by 30.2% between 2006 and 2015. This trend will continue, with projections from the Central Statistics Office showing a 37% increase in the 65 years and over age group between 2015 and 2026. This is great news and is due in no small way to significant improvements in treatment and care provided by the health services.

A large proportion of this age group is living with two or more chronic conditions which make many of our older citizens more vulnerable and frail. Emergency departments have seen evidence of this over the holiday period with people aged over 75 years constituting 14% of total emergency department attendances for December 2016. In turn, December 2016 saw a corresponding 12% increase in the number of people aged over 75 years being admitted to hospital through our emergency departments when compared to December 2015.

The aim of the winter initiative plan 2016-17 is to provide a focus on specific measures required to help minimise the surge in activity experienced at this time of year across hospital and community services. One of the key objectives is to reduce the numbers of people waiting to be discharged from hospitals and require specific supports and pathways to do so. Targeted reduction of delayed discharges freed up the equivalent of an additional 200 beds for the acute system. This was achieved through increased provision of fair deal and home care capacity.

The plan contains a number of key measures in terms of hospital avoidance, timely ac-

cess and discharge. It is being implemented through a specific and detailed planning process required in all hospitals and community health care organisations. The detailed actions in the plan are set out in appendix 1. Most of these actions are already implemented, bringing tangible benefits to the system and patients. Under the plan, €40 million was invested to alleviate winter pressures.

While considerable planning was undertaken through the winter initiative, the system's ability to expand to meet spikes in demand is limited by a number of factors that vary from hospital to hospital. These include: not having enough beds in the system to deal with a surge; difficulties in recruiting nursing staff, which, in turn, pose a challenge in opening some of our surge capacity beds; and a shortage of certain services in some parts of the community such as diagnostics or access to home care. The early onset of influenza, coupled with a significant rise in respiratory illnesses during the holiday period, put further pressure on an already stretched system, particularly in the context of people aged over 75 years.

In light of ongoing pressures on emergency departments, on 5 January 2017, the Health Service Executive announced a series of additional measures as part of the existing winter initiative plan. These measures focused on augmenting the supports for primary and community care, targeting a small growth in acute capacity and further strengthening existing actions, such as our information campaigns on influenza vaccines. These additional actions are also set out in appendix 1.

The HSE has a steering group in place, comprising all the key operational divisions, which reviews performance of the winter initiative to ensure an integrated approach across our hospitals and community services. The HSE's special delivery unit oversees progress across all our services on a daily basis. This is in addition to the normal line management of our hospitals and community health care organisations delivered through the HSE's accountability framework. In addition, an oversight group has been put in place by the Department of Health to oversee progress with the winter initiative plan and agree any revised actions as challenges arise.

A dedicated focus will be needed to progress the development of the acute model of care; structured demand and capacity planning; effective information systems enabling analysis of emergency care demand and utilisation and facilitating appropriate performance oversight; staffing capacity; bed capacity; and continued process improvement in hospitals. The recently announced acute bed review will be one important piece of the long-term solution. In addition, to address the causes of emergency department overcrowding in the longer term, the enhancement of primary and social care services, the development of integrated patient centred care for the management of chronic conditions, investment in hospital infrastructure and models for the delivery of acute services all need to form part of a strategic health policy initiative.

Within a more responsive health system, many more people could and should be treated within the community, for example, through an enhanced primary care service. Additional investment in the community would mean that many scans and tests could be done without people having to attend acute hospitals, more home supports could allow people to move out of hospital sooner and community intervention teams could treat people in their own homes rather than in a hospital environment. However, this would involve a decisive shift away from the most expensive form of treating and caring for people, namely, the acute hospital system.

The scenes of overcrowding we witnessed at the start of January were distressing for both patients and staff, and for this we apologise. However, unless we shift our model of health care from its current hospital-centric focus and towards the community, with the associated invest-

ment required, we will continue to be challenged in delivering the service we would wish for our patients. The appendices set out the specific actions in the winter plan and feature a number of graphs on trends. In particular, the final page features a graph depicting the trend of delayed discharges. The substantial reduction in delayed discharges shown has been one of the successes of the plan. This has had a significant beneficial effect in the east of the country where the number of delayed discharges tends to be high. It is less so elsewhere where access to home care on an accelerated basis is more important. My colleagues and I will endeavour to answer any questions members may have.

Senator Colm Burke: I thank Mr. Woods for his presentation and apologise to him for the lengthy delay in commencing our discussion. On accident and emergency department overcrowding and hospital overcrowding in general, Nursing Homes Ireland today issued a statement in which it indicated it had understood since July 2016 that the Health Service Executive would engage with the organisation on planning for the winter initiative. This understanding was based on the view that demand for hospital care would increase significantly, leading to significant efforts to discharge patients from hospital at an early stage. The statement notes, however, that no such engagement took place. I ask Mr. Woods to explain the reason for this.

I understand there were 742 vacant nursing home beds nationally at the end of December 2016. In the first two weeks of January 2017, hospitals experienced severe overcrowding. Despite this, the level of engagement with Nursing Homes Ireland has been extremely poor. Why did the HSE not engage with Nursing Homes Ireland before the end of November to plan for a problem that everyone knew was coming down the tracks?

At any one time, between 500 and 600 people are occupying hospital beds as a result of delayed discharges. These are patients who are ready to go home or move to nursing home care. People who transfer from a hospital to a nursing home do not need to stay in nursing home care for 12 months or two years because we also have step-down facilities. However, these facilities do not seem to have been developed as part of the HSE model and there appears to be considerable reluctance to develop them. Surely, plans could be made every year long before winter arrives to use step-down facilities in a much more imaginative way than is currently the case. It does not make sense to have 742 vacant beds in nursing homes when our hospitals are clogged up. It should also be noted that a hospital stay costs between €6,000 and €7,000 per week, whereas the weekly cost of a private nursing home bed is less than €1,200. I do not understand the reason this matter was not addressed before the problem arose.

On the recruitment of nurses, I will cite one case that highlights a problem with flexibility in the recruitment process. I am aware of a woman with a young family who wished to return to nursing and made clear in her interview that she would be available to work on certain days and unavailable on other days due to family commitments because she has young children. She was told: "We can't take you on, but the best thing you can do is go and apply to an agency and we'll have to take you on in accordance with the hours you're able to work then under the agency." That does not make sense. I am talking about someone who wanted to work in the HSE. I accept she was not able to work from 8 a.m. to 5 p.m. or 9 a.m. to 5 p.m. five days a week, but she was available to come on board in the HSE. However, she was advised to become employed by an agency, which would enable her to get the flexible hours she wanted. That is a huge cost to the HSE. There are serious questions at managerial level on not working to try to facilitate people in order to get them into the system and to ensure we have continuity of care for patients and all that.

I need clarification from the HSE on those two points.

Deputy Margaret Murphy O'Mahony: I thank Mr. Woods for his presentation and thank all the witnesses for their attendance. I apologise for keeping them waiting. I have some questions on emergency departments in general. Is there a communication system between emergency departments and GPs and community services to pass on recommendations relating to people leaving emergency departments?

Is the European directive requiring that junior doctors work no more than 48 hours a week and no more than 24 hours together being adhered to? The practice of employing GPs in emergency departments is a new concept to me. How is that going? Could it be expanded? As far as I know there are no actual contracts with the GPs at the moment. Would having a contract available enhance that service?

Deputy Bernard J. Durkan: I am sorry for being absent because I manage bilocation - hopefully effectively. I welcome our guests. This has been a long day on this subject and other subjects.

On the ongoing administration of health services, we have two bodies, the HSE and the Department of Health, and to my mind the twain shall never meet. In my opinion it does not work that way and it will remain my opinion. I believe it should be regionalised similar to but not the same as the previous health boards. I think it would be more effective, accountable and representative in terms of having all constituent bodies represented on a board somewhere in a region directly relating to the region for which it dispensed the services. At another meeting we have already discussed the realignment of the hospitals in line with something like that.

To what extent has the HSE looked at the requirements in the health services in terms of elective surgery, acute bed accommodation and accident and emergency department accommodation? If the HSE has quantified it, how has it quantified it? What is the HSE's proposed resolution to what is clearly a problem? I asked this question previously. I did not get the answer but I think it came by accident. Presumably we need more beds and more staff at accident and emergency departments to clear the problems that arise every year at an acute time. In the event of building up the services to the extent that this can be dealt with without major controversies and overcrowding with consequent dangers to patients, staff and everybody else, how does the HSE then deploy the service that is capable of meeting that surge the rest of the time? I think I know the answer, but I will not say it until I hear it again.

We have spoken about hiring and retaining staff, which seems to be a huge difficulty - more so than anything else. We have had comparisons with various jurisdictions over recent years, including with the one across the water next door, which also seems to be having serious problems at its accident and emergency departments, despite having been seen as the Rolls Royce of services up to some time ago. We also know about the Dutch, French and Canadian health services, all of which have been much vaunted and are still not perfect because they seem to have the same problems.

I did not mention this previously but it is appalling to have someone awaiting elective surgery, such as a hip operation for example, where they are suffering acute pain over a long period. They may have to wait for two years. I have dealt with many people, as I am sure has the Chairman, who have waited for two years and more in severe pain, which is no help to them whatsoever. There have been many discussions, meetings and protests over emergencies and various things that have gone wrong in recent years, some significant and some that should not have gone wrong. Have we learned from all those things? Can we put in place within a reasonable time a resolution to them without having to wait four or five years of suffering the same

anxiety as we have at the moment?

Chairman: Mr. Woods might like to answer some of those questions.

Mr. Liam Woods: Senator Colm Burke spoke about Nursing Homes Ireland, NHI, and I am surprised at that statement. I know that officials from our social care division meet representatives of the NHI. In the eastern part of the country we are running a bed bureau where we receive lists on an ongoing basis of beds that are available. Through that bed bureau we constantly look to connect hospitals and community services with potential nursing home or indeed transitional care spaces for patients. I would need to look at the statement and discuss it with my colleagues on the social care side. It would surprise me that there would not be such dialogue. If the NHI is saying that-----

Senator Colm Burke: They raised this with me in early January. I did not mention it to the Minister. My understanding was that engagement was to take place, but that it has not taken place. At a time of overcrowding in the hospitals, there are 742 vacant beds.

Mr. Liam Woods: At any time we would be aware of the number of beds they have available for us and we constantly try to place patients in those beds. I would need to get a comment from my social care colleagues on the specific point, but I hear the point the Senator is making.

Regarding the 500 to 600 people who are clinically fit for discharge, one of the successes of the winter plan has been that the number has dropped to the mid-400s. We would still like to see that come down further, but that is as low as it has been for some years. The Senator made a point about transition care availability. Under the winter initiative we have specifically sought to accelerate access to transition care to facilitate quicker movement from hospitals to care settings which may result in people moving to nursing home environments or home with support depending on the particular individual's needs. We have invested in additional spaces, but the Senator is right to highlight that for the future, access to that kind of space and indeed rehabilitation space will be very important.

The point the Senator made about recruitment of nurses and flexibility is absolutely right. The hospital system has approximately 8,000 nurses who work shorter hours. We need to support flexibility or else, as he rightly has said, we end up paying a premium for agency staff. It is always better for us to have staff who are on our own books, permanent and working in the facilities on an ongoing basis. To the extent that this is happening even in individual cases, it would concern me. It is certainly something I would like to follow up on. We have specific targets to reduce agency nursing where we can and employ nurses directly. We have a project team, co-operatively including the INMO, working on trying to achieve a target of 1,000 nurses in this current year in that way.

Deputy Murphy O'Mahony asked if there is communication between GPs and hospitals. There are discharge letters. That would be very much a part of the norm in terms of patients being discharged. Clearly, there can be communication inward to the hospital from GPs, in terms of outpatient referrals or specific comments in a letter. Half of all those who come to an emergency department have letters from their GP stating something about their particular conditions.

On the European Working Time Directive, EWTD, and compliance for junior doctors, we monitor and report on this monthly. Indeed, we occasionally report to Brussels in terms of our requirements under the directive. Our compliance has greatly improved and is 98% regarding the 24-hour requirement while 81% is the last figure I saw regarding the 48-hour requirement.

We are looking to increase that, but the figure has come from well below that level. There are challenges in some specialties. There are small numbers of doctors in our national specialties and we are still pursuing that aspect.

It can happen on occasion that GPs work in emergency departments. Where it happens, the reports I have received are that it works well. Contractual issues in that context have not arisen. It could be part of a wider dialogue with GPs in terms of a GP contract for the future but it has not been presented to me as an obstacle at any point. Not all GPs favour working in emergency departments but where they do, as it is reported, it works well.

In response to Deputy Durkan's point, the structural comments are really a matter for policy. I heard the Deputy articulate them at the Committee on the Future of Healthcare also and they are noted. On the question of whether we have studied capacity-----

Deputy Bernard J. Durkan: Why only at the Committee on the Future of Healthcare? Accident and emergency is an urgent issue now, and could be tomorrow again. The purpose of the question was to try to elicit what might be done as a matter of urgency to deal with the problems that existed last year and the year before and will exist next year unless something is done about them this year.

Mr. Liam Woods: To answer the second part of Deputy Durkan's question, on the notion of studying capacity and providing capacity to meet service demand for the future, which I was just coming to, in my experience structures will not resolve the service and process issues. We have looked at capacity, however, and we see clearly that there is demand in our emergency departments and, as the Deputy mentioned, regarding our inpatient and day-case waiting lists which is in excess of our capacity to supply. If we look at the demographics over a period of perhaps the next 30 years and look at our current model, without changing the model of care the total requirement for bed days within our hospital environment will double. Clearly, the response to that - some of the committee's earlier discussions are relevant to this aspect - lies in identifying what kind of solutions are necessary, for example, investment in community-provided services, in primary care and in social care. Older person services, particularly in the community, will be key to addressing that growth in demand.

In terms of the here and now, the winter initiative has been focused and of the €40 million provided, €34 million has gone to providing services in the community. That recognises that we need to provide space in our hospitals for work to be done. We recognise the need to grow that space, but we also see that access to community services, both primary care and social care, is a vital component in that regard.

Deputy Durkan asked a specific question about surge capacity and how we handle it. As the committee will be aware, hospitals are running at 100% in any event at present. An earlier contributor pointed out that most of the major hospitals are in that position. I said that 85% would be a more desirable norm in terms of hospitals internationally, and allowing for proper scheduling of work.

Deputy Bernard J. Durkan: How can we achieve that?

Mr. Liam Woods: From our point of view, there are two dimensions. The first is about capacity and ensuring that we are planning and making available sufficient capacity. In the current winter plan, we are growing capacity in the community and there is a small growth in the hospital environment capacity. This year, we were initially putting in 55 beds, but it has

increased to 98 beds on the hospital side. Last year, the number was 300. I understand the underlying demographic would require us to put in 300 to 400 beds on an annual basis. There is a challenge in that regard for us.

On the capacity required in the community, the fair deal scheme is running well at present in the sense that it is able to provide space, as required, to hospitals. It is doing that within its current funding limit and it is working well for us right now. The home care community intervention team capacity that has gone in as part of the winter initiative, some of which was there already, is also vital because it enables people to stay at home or return home and be treated there. Some of the committee's earlier conversations about the work of community intervention teams and the outpatient antibiotic programme are relevant in that regard.

On the idea of a surge in capacity, the critical point is that hospitals are full all the time. At this time of the year, they are more full with work related to admissions from emergency departments. The price of that is that there is less capacity to do elective work and the staffing requirements relating to running the hospital are reasonably consistent.

There is a need to grow staff numbers, as Deputy Durkan referenced. We see that in terms both of the wider demographic but also in providing additional targeted capacity right now. In the acute system, the service plan this year provides for approximately 100 more nursing staff. Our staff numbers have been rising. If one looks back, between 2008 and now, there was a clear reduction through austerity and the number has been rising again over the past two to three years. This year, overall nursing numbers are up by over 200 and doctor numbers are also up, but we recognise that is coming from a low base. The impact of austerity on the global recruitment and maintenance of staff in the health system is still being washed through. If one looks at the demographic over that period, clearly we have a lot to do. We take the point about staff.

The hiring and retaining of staff is a significant issue. The rate varies to some extent across the country but the capacity to hire and retain staff in what is an internationally competitive market for medical and nursing skills is a challenge for us. We have to adopt as best we can strategies that are both friendly to staff work requirements and which invest in facilities that give rise to good working conditions. Clearly, the stresses and pressures of operating in emergency departments as they are at present are a significant challenge for staff.

On elective surgery and waiting times for elective surgery, we put in resources last year to address wait times beyond 18 months. We fully accept that is only the tail and that there is an underlying growth in demand. Hospitals in the past year have grown their service provision by approximately 33,000 cases. What is happening within the hospital environment is that throughput is growing but the demand is growing quicker, and we have to address that through providing extra capacity and also looking in some instances at the model through which care is delivered. There are opportunities within hospitals. For example, since 2009 the surgical programme is effectively using less bed space and is doing more work more efficiently with more patients being seen. That kind of opportunity exists within the hospital system. I agree with Deputy Durkan that our elective targets are not where we would want them to be. I fully accept there is a capacity requirement around delivering those targets. There is a requirement for both staff and beds.

Deputy Bernard J. Durkan: I am sorry to interrupt again, but how much of that can the HSE deliver in a year? The public and many members here and elsewhere are anxious to ascertain how long it will take. We hear every year that we are getting a step further but all we are doing is chasing after the wagon. Is it possible to identify precisely what is needed at least to

hold the problem without all of these emergencies, patients on trolleys all over the place, and patients on long waiting lists? What can the HSE do in one year?

Mr. Liam Woods: On the timing of delivery, the key requirements for the HSE, apart from funding approval to act within the resources provided by the Oireachtas, is recruitment. For us, the timescale around recruitment is between six months and one year, realistically, depending on the type of staff. Consultant staff can take up to a year to recruit and that is the sort of timescale we work to actioning additional services provided through consultants. We can recruit other staff grades more quickly. A challenge we face is that if we run a competition to recruit any grade, be it a nurse, paramedic or other staff, half the applications will come from within our organisation. Therefore, we often have to go through two processes to get staff. There are issues associated with staffing.

The current physical hospital infrastructure is close to capacity. We have examined what we could do additionally. The beds we are opening this year are in spaces we can readily make available by doing relatively minor capital works. The timing for capital works is more significant. One of the reasons we emphasise community services for this time period is that, while they are required, we can contract and put them in place more quickly or employ staff to put them in place more quickly.

The capacity study at a wider level that is to be undertaken by the Department of Health, into which we will certainly have an input, will identify both the current and future requirements for bed capacity in the system. The Deputy's question was on the volume of service we need to stay with the demographic and catch up with the current demand for service, which will remain as we are pushed by the demographic. I expect that will be considered output of the capacity study itself. We have considered that in terms of our own view of the capacity we have and what we need.

Timescales to implement significant new hospital infrastructural projects are typically between three and five years. If one is considering structures such as ward blocks or substantial hospital expansion, those timescales typically apply. We have examined other options that may be available to us in order to move more quickly but, typically for a substantial hospital build, it takes three to five years to go through design, planning, construction, completion and the handover.

Chairman: With regard to hospital emergency department overcrowding, it is a given that every witness who has appeared at this meeting and the meetings on the future of health care accepts there is a bed capacity issue. That cannot be addressed in the immediate term. The bed capacity review will undoubtedly outline that there is a shortage of beds. The number of beds needed may be debatable but there is certainly a shortage in the system. Given that, the only option left is to try to make the system we have more efficient. That is what we are trying to do. There are many components to trying to make the system more efficient. To put it simply, the hospital system cannot cope with the number of people coming in. Are there strategies we can devise that reduce the number of people who require acute hospital care, be it through increased resources or bolstering staff in the community to look after patients? There is capacity in that regard to reduce demand. We have to balance that with the demographics. The population is getting older and people have multiple chronic morbidities. Certainly, they should be looked after within the community. There needs to be an examination of how we can prevent people ending up in casualty departments. How can we stop that?

The other aspect is the question of how we can get people who have completed their acute

care back out into the community. Senator Colm Burke has mentioned that the nursing homes association has identified it has capacity to take people out of hospitals once they have completed their acute care. That is another aspect of efficiency.

The third aspect of efficiency concerns the fact that, within the hospital system itself, there are inefficiencies in regard to patient flow and the way in which patients are managed within hospitals. I refer also to access to diagnostics, staffing and the recruitment necessary if people are to be looked after in hospital. All these aspects of care can be managed within the constraints of our bed capacity. The delegation is saying that we will not have a substantial increase in capacity for three to five years so all the other factors need to be addressed to make the system more efficient.

With regard to recruitment and retention of staff, how can we make our system more attractive? Obviously, it is not attractive. That is why people are not taking up the posts and why our nurses and doctors are emigrating. The system is so inefficient that there is no job satisfaction and a very high stress level. Bearing in mind the efficiencies I have outlined, is there capacity to improve the service?

Mr. Liam Woods: I take the Chairman's point about capacity. The points made about the opportunities to improve efficiency and flow within hospitals are well made. There has been a lot of progress in that area. That is reflected in the underlying data on the volumes of care being provided in the hospital space but there is no doubt that there is more to do. Work specifically focusing on that is under way at some sites.

Recruitment and retention are clearly key to expanding the service. The Chairman is correct to state our response capacities involve our doing everything we can within the capacity we have. We must grow it where we can but we must also invest in primary and social care. Work in this regard commenced last year. The integrated care programmes, particularly relating to certain chronic conditions, and the programme for the care of the frail elderly are designed to provide models of care that will support citizens outside the hospital environment, at home, in a primary care environment. That work is commencing. It is very important work because this is an area of significant current demand and one that will be subject to growth in demand. The Chairman is right to conclude that the hospital system could not deal with all that demand in volume terms. It would be inappropriate for it to fully consider doing that. The Chairman's points are well made.

From my experience of driving the country and visiting sites, I know there are many areas of care and hospitals where excellent service is being provided, and staff are very motivated in this regard. I fully agree that they are sometimes delivering care in conditions that are far less than ideal for delivering care. Sometimes they are delivering care in very modern facilities. The story varies as one goes around the country.

The capacity to recruit and retain staff is key for us. The investment we need in primary social care and in expanding hospital care where we can in the coming 12 months and the 12 months thereafter will be very much dependent on the response to providing an environment that is attractive to work in, has adequate remuneration and is competitive internationally. There is no question about that. Those are the kinds of drivers we need to examine.

Creating a vision that sets out a journey for the future health system is necessary. The report the Oireachtas will produce will be an important component. Achieving a coherent, singular view on the direction of travel and providing that for staff around the country is important at a

higher level in the here and now. We are in competition internationally for staff who are actually difficult to get and we will have to continue to advertise and seek to provide flexibility in the manner referred to by Senator Burke if we are to attract them.

Deputy Billy Kelleher: I apologise because I had to leave between the contribution of the previous witness and Mr. Woods' presentation. I have read his presentation, however.

I wish to raise just a few issues. We are primarily inviting witnesses here to discuss the issue of overcrowding in our emergency departments. This is basically what Mr. Woods referred to in his presentation. He mentioned the winter initiative and all that flows from that.

The Minister for Health, Deputy Leo Varadkar, convened a task force in December 2014 and outlined that its objectives were to establish a communication platform, to inform, drive and support the HSE acute hospital division's implementation plan, to identify collaborative working arrangements, to anticipate potential problems or issues and to ensure appropriate structures, processes and controls.

I said to the witnesses in the earlier session that, as an Opposition Deputy, I could have drafted the press release on overcrowding on the first Tuesday of 2017 as far back as October. That is the reality of the matter. Every week, on Tuesday mornings, we will have the highest number of people on trolleys in our emergency departments. That is also a given. These are the known knowns. In that context, accepting that there are considerable capacity issues across the hospital system affecting acute beds, care unit beds, step-down facilities and transitional beds, how much closer are we to making our hospitals work over a greater number of hours? Reference is made to senior clinical decision makers being available between 8 p.m. and 8 a.m. That is the case in emergency departments but not in other areas. How far have we gone towards providing access to senior clinical decision makers and diagnostics on an eight-to-eight basis, or seven days per week? What are the obstacles to that? Is IR issues one of them? Are there contractual issues or capacity problems in recruiting additional staff to oversee expanded diagnostics and extended hours?

Emergency medicine consultants have been before us today and other people have appeared before the Committee on the Future of Healthcare, chaired by Deputy Róisín Shortall. It seems that we have made very little progress in the area of elderly people presenting in our emergency departments across the country. I refer particularly to the transfer of elderly patients from nursing homes or community settings to emergency departments, primarily for intravenous antibiotics, catheters and things that could and should be done in the community setting. Given the major challenge facing us in terms of demographics and our life expectancy and ageing profile, our geriatric services and supports to the communities are not what they should be. Should we not deal with this issue with some urgency? If we do not we will end up, year after year, with the same problems with overcrowding and the almost inhumane treatment of transferring people in ambulances from their home care setting, such as a nursing home or a high-dependency home care package, to an acute hospital system which is anything but ideal. Capacity in the shape of geriatric services, consultant geriatricians, nurse specialists and public health nurses does not seem to be expanding by much. Are we making progress in that area?

We have 80 emergency medical consultants and 29 who provide acute and emergency cover at hospitals. What are the obstacles to recruiting emergency medical consultants? The recommendations are that the number should be at least doubled. Is it a matter of the remuneration packages or that we have not been recruiting? Are the staff just not there? Why can we not expand the service, knowing that it would address the issues?

In a presentation to the Committee on the Future of Healthcare, Mr. O'Brien said that if we stay as we are in terms of capacity, within a short number of years there will be no capacity in the public health system to deal with elective care, such as surgery and both inpatient and outpatient treatments. We would effectively be an acute public health system dealing with elective surgeries when they become acute. That will have profound implications for our ability to deal with patients in a timely manner. How much of this is at play in the pressures in our acute hospitals and emergency departments on a daily basis? On Monday morning people come in for elective surgeries but they take up the space required for those admitted through the emergency department. Is there any way to look at a seven-day week, or putting on elective surgeries over the weekend to deal with the weekly overcrowding crisis we see on Mondays and Tuesdays?

Deputy Louise O'Reilly: I apologise for missing the first bit of the meeting. I had a matter to attend to but I read the submission. Representatives from ICTU were before us earlier and they referred to a report commissioned and published in August 2016 which recommended that 107 nurses be employed to nurse patients already admitted and on trolleys. They advised us that, as of last Friday, there was no provision in the HSE service plan for the employment of these nurses. Can the witnesses comment on that? The provision of advanced nurse practitioners has reached 78 but surely we could do an awful lot better. As Mr. Liam Doran said, St. James's Hospital has six advanced nurse practitioners and consistently has the lowest level of trolleys across the country, albeit the figure is not zero. We can very easily make the link between the availability of ANPs and the reduction in trolleys, which we all agree needs to be tackled, so can we not do something quickly in this regard?

My head spins with the figures relating to the winter initiative, not because I do not understand them but because sometimes it seems the same bed is counted twice. How many additional hospital beds are currently open, staffed and operational? How many transitional care beds are there as of today? Where are the 300 additional acute beds referred to in the submission? Are they open? Are they on top of the 55 that were quoted? Are they brand new?

There was an emphasis in the submission on the need to transition to primary care and everybody says this. A fantastic, brand new, beautiful, shiny primary care centre is about to open in Balbriggan. Unfortunately, according to a answer given by the HSE to a parliamentary question, no new staff are going into it. There are no new staff for the north county but the north county is already stretched to capacity. I do not want to dwell on a local issue but this illustrates that there is a lot of talk but not much to back it up. While everybody may say we need to go down the road of primary care, nobody does anything about it. Maybe the witnesses can talk about the siloed nature of the health service and how the acute sector will not give up its budget to fund primary care. Maybe it cannot do this but I would appreciate it if the witnesses would comment on the point.

The representatives from ICTU said that when the ratio of nurses to patients is worse than 1:8, care can become compromised. Would the witnesses agree with this figure? Everybody is a little bit tired of the HSE scrapping with the INMO about figures so I would hope the HSE would agree on this one. Can the witnesses comment on what ICTU said afterwards, namely, that most emergency departments are routinely short-staffed by four or five nurses or more, leaving a ratio of one to 16, which would clearly not be acceptable.

Dr. O'Conor from the Irish Association for Emergency Medicine was asked how we were fixed to cope with a disaster. Staff will probably say they cope with disasters every day of the week but I am talking about an actual disaster. While there is a critical incident protocol, I am reading between the lines. To be fair, the people who were in did not go as far as I would. I

say we are not set up at all to cope with a disaster involving a massive influx. We already rely very heavily on the goodwill of the people who work in our emergency departments, from the man or woman delivering food to nurses and consultants. Sometimes, goodwill is all that gets us through a serious critical incident. In the estimation of Mr. Woods, how well set up are we for a critical incident? In a previous life I sat on the group that looked at critical incident management and I put it to him that we are not very well set up at all. If there were a critical incident, how would we be fixed given that we have 612 people waiting on trolleys? We have now reached that stage. It rarely drops below 500. Would we be lucky if the critical incident happened in one area rather than another?

Senator Kieran O'Donnell: I thank the Chairman for allowing me to participate in the committee's meeting. I have one or two questions to direct to Mr. Woods. Specifically, this is about University Hospital Limerick's accident and emergency department and, more particularly, proceeding to build a 96-bed acute unit on the grounds of the hospital. In 2009, reconfiguration took place. There is context around the need to provide these beds. The report was predicated on 138 co-location beds being built on the University Hospital Limerick site but the co-location project never proceeded. At the same time, Ennis, Nenagh and St. John's closed their full-time accident and emergency departments and 50 beds left those hospitals at that time. We have a bed capacity crisis with significant numbers on trolleys. It is a continual problem. If this 96-bed acute unit were built, it would take a lot of the pressure off when coupled with the new state-of-the-art accident and emergency department going ahead this year and opening by May.

I thank Mr. Woods for giving the go-ahead. I have had discussions with him on the matter over recent weeks and he gave the go-ahead yesterday to allow the design phase for the 96-bed acute unit to proceed. That has been communicated to estates at University Hospital Limerick and to myself as of yesterday. I would like to see this project in Limerick progressed under the capital review. It is included in the HSE's own capital plan. Mr. Woods might just give me the process as he sees it. For me, it is about not losing any more time. That is why I have campaigned so hard to get lift-off, as it were, on the 96-bed acute unit. What I want to know now is when shovels will be on site to start to build the unit. It will be four storeys over the existing dialysis unit which is alongside the new accident and emergency department with approximately 24 beds per floor. Where does Mr. Woods see the process from design to build? What do we need to deal with to ensure it gets built and what is the timeframe?

Mr. Liam Woods: I will take Deputy Kelleher's questions first and I may ask colleagues to take one or two. He made an observation on senior decision-makers and asked where we are with having them available between 8 p.m. and 8 a.m. An 8 p.m. to 8 a.m. service for diagnostics is substantively in place. It came into place as part of the negotiations on the Lansdowne Road agreement. In terms of senior clinical decision-makers, there are a couple of issues. The Deputy asked what the driving factors were. The availability and total number of senior decision-makers are challenges for us, as I am sure the Deputy is aware, when one reviews the OECD data. That varies by site. I was in Cork University Hospital not so far back and I saw the senior decision-makers come down at about 10.30 p.m. from theatre to support the emergency department. We have a strong commitment from our clinical groupings and directors within hospital groups and on hospital sites. They are constantly working to ensure that clinical decision-making is available to provide for effective flow. Clearly, that is our significant concern. We have challenges in that which are primarily about capacity. Some facilities may have one to two emergency department physicians and that does not provide for round-the-clock service. I have not personally experienced anything in contractual terms around that. The Deputy refer-

enced contract. The main challenge we face is that there are many and competing demands on the delivery of services with a fixed number of clinicians on site.

The Deputy is absolutely right to say the support of older persons in the community is key. It is the kind of work that has gone on in Gurranabraher, St. Mary's and in the St. Francis unit reaching into communities to support more people at home and expanding the already in place outpatient antibiotic treatment process to ensure people from nursing homes do not need to come into an acute environment, which is critical. We do some of that but could do more. I ask Dr. Henry to make one or two comments on that as a geriatrician himself.

Dr. Colm Henry: It is a very apt comment about older people. Previous speakers have alluded not just to demographic change but to the fact that in the past ten years people are surviving to a greater extent from interventions on heart disease, stroke and cancer than we could have imagined even a short time ago in medical terms. This winter we saw that the rate at which those over 75 were presenting was up December on December by 13%, which is much more than could be explained by demographics. It is a reflection of people surviving with chronic disease. By the time they come to an emergency department, the chances are they will have to be admitted. Our focus cannot just be on building hospital capacity to deal with older people who need hospital care but on shifting care into the community.

There are a number of initiatives and Dr. O'Conor alluded to this in terms of Connolly Hospital and the Mater where geriatricians appointed both to the hospitals and the community succeeded in reducing the number of patients referred from nursing homes to emergency departments at a time when the nursing home population expanded in the catchment. We are expanding this to seven other sites nationally. It means dehospitalising the care of older people where one can and an earlier alert system for those who are sick in order that they can be seen in another environment such as a day hospital. It also means interventions which can be targeted long before people get so sick that they have to come to an emergency department. As I said, by the time an old person with a chronic disease comes to an emergency department, it is likely he or she will need to be admitted regardless of whether a senior decision-maker is there.

Mr. Liam Woods: The Deputy referenced emergency department consultants, where the number is 80, the need to grow that and where we are with that. There were six additional approvals in 2015 and we are still recruiting four, such is the timescale to attract senior clinicians. We acknowledge fully that we need more emergency department consultants. The constraints on that are related to recruitment and, when we look forward, it is probably about the capacity programme and targeted investment in specific sites to grow capacity there. Does Ms Fitzgerald want to add anything?

Ms Angela Fitzgerald: It is fair to say we do not have enough emergency department physicians. The point was made around 24-7 cover. We have 12 sites with fewer than two wholetime equivalent staff members and, as such, their capacity to provide out-of-hours cover is very compromised. In 2015, we put in five additional consultants. It was a very small number. We had hoped to do more of that this year but we are not in a position to do it. Alongside that, we have been trying to build capability around the acute medical assessment units in order that they can support emergency physicians. By any objective comparison, we do not have the numbers to provide 24-7 cover across the current number of emergency departments we have. Dr. Henry is involved in looking at the trauma review which will allow us to think about emergency networks. I am sure Dr. Emily O'Conor spoke a bit about that.

The way forward in organising and configuring services is probably hub centres supported

by emergency centres providing some but not all of the services. In the short term the impact of austerity has hit us most significantly in consultant numbers. Mr. Woods mentioned the OECD's Health at a Glance report. We do quite well in comparisons on nursing numbers. Liam Doran would not be very happy with me for saying that. We do very badly in the comparisons on consultant numbers. There is work to be done. The establishment of the groups allows for more logical thinking on how to prioritise emergency physicians and this is the work we must do in 2017.

I will answer Deputy O'Reilly's question on nursing. There were several strands to her question but as part of the emergency department agreement we had with the INMO, there was recognition that at the time there were 144 vacant posts. We have a commitment and funding to put these in place. At our most recent review with the INMO, it emerged that between 80% and 90% of the posts were in place. As the Deputy quite rightly stated, the challenge is attracting people into an unattractive environment. There is a bit of chicken-and-egg situation. If we get the staff in, we will make it more attractive. The second piece is with regard to the norms we use.

Deputy Louise O'Reilly: I ask Ms Fitzgerald to return to the numbers. To be fair to the representatives from the ICTU, they were very clear that last Friday they were told with regard to nurses specifically designated under the report issued in August for bedside nursing-----

Ms Angela Fitzgerald: That is the second point.

Deputy Louise O'Reilly: -----that there are no resources for them.

Ms Angela Fitzgerald: There are two aspects. One is the normal nursing requirements for somebody being treated in an emergency department, and the vacancy factor is 144. Deputy O'Reilly is quite right that over and above this a review was done by the Department. This stated if we accept in the short term that we have boarded patients, which are patients who are not yet able to get to a bed but who need to be nursed, the number is 107. I did the calculation and I know this is the number. It is based on an agreed methodology in the review, looking back at the average number of trolleys. As was said at a meeting last week, the challenge for us is we were not given the resources to put this in place. With regard to accepting the number, 107 has been accepted as the agreed number. It is our number. The agreed number for the normal running of the emergency department is 144 vacant posts. These have been supported.

Other measures under the emergency department agreement have been taken on senior decision-making in nursing. As committee members know, 26 patient flow emergency department nurses were agreed at assistant director of nursing level and they are being recruited. Grade 1 clinical nurse managers were agreed for every emergency department and grade 2 clinical nurse managers were agreed for a specific number of departments. All of these are either recruited or in process. The total number between these initiatives is approximately 216 posts. There is no disagreement between us and the INMO on the requirement to have adequate nursing. We have agreed a process on the 144. A specific measure on boarded patients identified through the agreement was recognised as requiring additional funding. At this time we do not have the resources to put this in place.

Deputy Louise O'Reilly: The need has been recognised. As a result, the HSE, the clinicians, their representatives and all of the people in charge of recognising where there is a need have identified the need for 107 nurses to deal with what we all do not want, but which we now must accept as a fact - I would say because of Government policy but others would probably

have other ideas - but it is what it is. Ms Fitzgerald is saying that the resources for these 107 nurses have not been provided.

Ms Angela Fitzgerald: Not this time.

Deputy Louise O'Reilly: I presume the blockage, such as it is, relates to the Department of Health. Am I barking up the wrong tree? Is there somewhere else from where the money should be coming? All of these issues are interlinked, which is exactly what I was driving at when I said I get confused about the figures. If all of the people in charge of this have agreed that 107 nurses are needed for the boarded patients, or whatever phrase we want to use, the poor unfortunates on trolleys is what most people call them, but there is no funding for this. I presume this should come from the Department of Health.

Ms Angela Fitzgerald: Everybody here knows from where the funds come. Certainly in the interim the challenge is the patients are typically nursed and this creates displacement elsewhere. It is important the committee understands nursing is provided to manage the patients but it means staffing elsewhere in the hospital is challenged. Something else we are trying to do in the very short term is to reduce this. The basis for this is not being able to place patients up the house. We have already made progress, working with the INMO through weekly engagement, on ensuring that we make improvements on this on a day to day basis. The HSE would not want to see boarded patients accepted on an ongoing basis and that there is a plan to fail. We and the INMO recognise that staff found should be placed up the house if the situation improves. This is the situation at present.

The Deputy specifically asked about the beds. Initially, 55 acute beds were announced, with 18 step-down beds in Mercy University Hospital. Due to staffing challenges, some of the named sites for the 55 beds were not able to proceed in time for winter. We redirected the resource. As of today 28 beds are open in Galway and there are ten in Beaumont, with an additional five beds outside of the 55, 18 beds in Mercy-----

Deputy Louise O'Reilly: Are they additional to the 55 or are they part of the 55?

Ms Angela Fitzgerald: The 55 originally included provision of ten in Naas, 12 in Tullamore and 15 in Waterford. Regrettably, due to the ongoing challenges of attracting in Naas and Waterford because of bed closures funding was redirected and in simple terms it was given to open beds in Galway. The latter has now opened 28 beds instead of the beds that were to open in Naas and Waterford. The beds in Beaumont included in the original 55 have been opened. The 18 beds in Mercy University Hospital, which were not in the 55 because they are step-down beds, have also been opened. Seven of the original 55 beds have been opened in Mullingar and 15 beds have opened in the Mater hospital. Originally our intention was to do a collaboration with the Mater Private Hospital. We had to accept that in the short term the Mater Private Hospital could not meet the needs required on a continuous basis and funding was redirected to provide for 15 beds in the Mater hospital. This gives a total of 78 beds. The intention is to open 12 beds in Tullamore in February. They will open between mid February and the end of that month. I would be happy to give the Deputy a written report on this if she wishes.

Deputy Louise O'Reilly: I do, and I thank Ms Fitzgerald.

Chairman: Will Ms Fitzgerald sent it to the committee?

Ms Angela Fitzgerald: Absolutely.

Mr. Liam Woods: I will pick up on the questions on elective care asked by Deputy Kelleher. The Tuesday figure referred to and the pattern of admissions of electives and urgent electives does, of course, have an effect on trolleys, and hospitals are constantly balancing demands from emergency departments and demands for elective work. With regard to weekend work, on occasion and during the course of last year we funded specific activity over weekends where it was feasible to do so. We have the capacity in clinical and nursing terms to do so. Primarily this was done through the waiting list initiative. The constraints on this are the availability of people and restrictions on total supply. We can give the Deputy the list of the 300 beds from 2015 to 2016. They all opened, but we can give a list of their current status if it is helpful.

A question was asked about Balbriggan primary care centre. I will ask Mr. McCallion to address primary care centres generally - Balbriggan is a case in point - along with the questions on emergency planning observations.

Mr. Damien McCallion: With regard to older people from nursing homes presenting in emergency departments, they represent approximately 2% to 3% of all admissions. We have 15 community intervention teams in the country. Four came through the winter initiative and they are still in the formation stage. These are the teams that typically go into nursing homes. The Deputy's question is fair. There is still further scope for this. Some of the teams work very well and some are trying to expand the geographical areas they cover for patients. There is also work to be done on general practice with regard to medical oversight. There is further scope there. There is one very good example, which has published research, in the Mater where, as referred to by Dr. Colm Henry, the geriatrician has gone out to provide some of that clinical oversight and worked with the community intervention team to try to keep a larger number of people in what is their home - a nursing home - versus their having to be brought into hospital. Where it has worked it has been successful and there is definitely further scope in the area.

Deputy Louise O'Reilly: Are the community intervention teams made up of a combination of directly employed and outsourced staff?

Mr. Damien McCallion: It is a mixture.

Deputy Louise O'Reilly: Does Mr. McCallion have an idea of the breakdown?

Mr. Damien McCallion: I do not have the breakdown with me but we can get it for the committee.

Deputy Louise O'Reilly: I suspect there are many more outsourced staff than there are in-house staff, but I could be wrong. Mr. McCallion might provide the information to the committee.

Mr. Damien McCallion: I will. Some of it will be down to historical reasons in terms of capacity to recruit and so on, but we can give the breakdown to the committee.

In terms of the points made by the Chairman on primary care and what we can do in the intervening years, in general terms there is significant further scope. We all accept that to build hospital beds and other capacity in the community will take time. I have mentioned the community intervention teams and there are good examples of this but there are other areas where we have further work to do to enhance primary care. One example is what is happening in Mallow where consultants come out from Cork University Hospital. Diagnostic facilities are available there as well.

On specific resourcing of certain centres, be they in Balbriggan or elsewhere, initially the primary care centres are developed around the existing resources but we are trying to identify where we can put in new resources. For example, this year under the chronic disease programme people will be going in to work with primary care teams on diabetes. To get full geographical coverage will take time but there has been investment in recent years in diabetic nurse specialists to go out to work with practices.

The GP contract is also key. Some diagnostic facilities have been rolled out in primary care and one of our additional measures in January was to try to extend that roll-out for a time but that is still very much at the formative stage.

Therefore, there is definitely more scope in terms of the point about the specific centre. On the broader point the Chairman made about what primary care can contribute given the length of time it will take and the challenge we will inevitably face over the next number of winters, there is a need for significant investment in the resource to make those function in a much more powerful way in trying to avoid presentation to emergency departments.

Deputy Louise O'Reilly: Mr. McCallion states that there is a need for significant investment, but is there a plan? I appreciate I am being a little parochial but Mr. McCallion stated that the centre in Balbriggan would be developed around existing resources. Mr. McCallion knows already that the existing resources are not adequate to meet demand, so to say it is being developed around existing resources effectively means that we will have general practitioners moving into beautiful buildings, with the ground floor probably leased out to pharmacists, coffee shop proprietors and the devil knows what, but there will be no actual additional services. It does not sound to me like there is any plan to shift over to primary care. There is a plan to talk a lot about shifting over to primary care but there is no plan to actually do it. That is where we find not just mine, but a collective frustration. We all know there is a need to move to primary care but, with respect, the HSE is in the driving seat. However, it either does not have a map or the will to move on it. I do not know what it is happening but there seems to be a blockage. There is no need to state repeatedly at the committee meetings and elsewhere that there is a need to move to primary care. We agree. The question is how it will happen and what is being done. Mr. McCallion stated that it will be developed within existing resources but we have established that existing resources are not sufficient. As Deputy Kelleher alluded to earlier, we might as well write the press release now for the first Tuesday in January 2018 because nothing is going to change.

Mr. Damien McCallion: To deal with the point about existing resources, I was referring to moving from old buildings to new buildings which in itself is not what brings the resources. Clinical programmes are being run nationally that are setting out alternatives in terms of how primary care can develop, so there is a roadmap but it will require resourcing. To give some examples, community intervention teams are one part of it. Other areas include the development of injury units and trying to promote and encourage people to utilise those rather than emergency departments. In terms of general practice and primary care, this is also about chronic disease management. That is one of the national programmes, which is looking at putting resources in around chronic obstructive pulmonary disease, COPD, diabetes and so on. For example, for the first time there is now a full register of those with diabetes. We are trying to develop and sustain it so that services can be planned around it.

There is a fairly clear roadmap. Some of it is developing and some of it is still in the early stages, but there are resources following it. In terms of the sort of things we are talking about today, the pressures the system is under, the growth in the population and the points Dr. Colm

Henry referred to earlier, the level of investment will have to be enhanced significantly to make those centres work better. A key issue will be the GP contract. GPs are one of the key resources in primary care. It is clear that all of those things will have to come together.

To clarify, a number of projects are running. As I stated, we have four more community intervention teams so they now total 15. In terms of chronic disease management, resources are being deployed around diabetes and in other chronic diseases as well. Another area that is being examined and which has been mentioned a couple of times is an integrated care pathway, that is, we are examining how the system works for patients both going into hospital and coming out of hospital, and the process side. There are clinical programmes set up around all of those and they are also starting to identify the resources that are required. Some of them take time to come to fruition in the sense of providing the evidence that they function.

The other one I will mention is the frail elderly programme which is working in six areas in the country at the moment. One of those is in Sligo. It is in the hospital and is examining how frail and elderly patients are managed within the system when they require admission. The programme would cite that as being one of the key factors in their ability to manage the trolleys down to a lower level this year given all the things we spoke about earlier. Some of those take time to come through but they are looking at all aspects, both resources and process in-hospital and out-of-hospital.

Chairman: To take up the point about trying to take the pressure from our hospital system, the GP contract is absolutely essential. If hospital centred care is to be transferred to community centred care, it will most likely be a GP-led primary care service. There is significant potential for the management of chronic illness in primary care if the potential is released, but we have a huge manpower problem in general practice. Some 33% of the GP population is aged more than 55 years of age. There will be a huge manpower gap, if care and services are transferred to primary care, because the GPs are not on the ground. However, there is huge potential for taking pressure from the hospital system. The added potential is to integrate primary care with secondary care because there is a major gap between primary and secondary care. Deputy Margaret Murphy O'Mahony spoke about communication. That there is little communication between primary care and secondary care in terms of discussing patients and developing services is a significant problem. All that has to be taken into account when talking about changing the service and taking pressure from our hospital services.

Mr. Damien McCallion: I agree. Deputy Louise O'Reilly raised one other point that I have not addressed, which relates to critical incident management and emergency management. One of my areas of responsibility is emergency management. She was probably referring to two levels: one is the day-to-day basis in the hospital and the management systems around risk that are in place. There are systems, escalation protocols and so on to manage that daily in terms of making decisions when hospitals come under pressure.

On the wider perspective, there is an emergency management framework. The HSE works in the same way as the Garda and those in other inter-agency areas. We are constantly running tests in that regard. We just had a discussion at our own leadership team yesterday in terms of running people through it. There is constantly simulation. We were taken through one yesterday in relation to a major road traffic accident in the north west that was simulated live on the road. All of the emergency services were involved that would have an impact on the hospital. The process and framework is constantly tested. Being trained for these events is one thing but to test it and simulate it is another. There is strong evidence that unless we are doing that regularly we will not address it. Therefore, on major emergencies, there is a well-established

framework. We have strengthened the resources in that area to work with the hospitals and our community partners as well in terms of community health organisations to do that.

Deputy Louise O'Reilly: What does strengthened the resources mean?

Mr. Damien McCallion: We have put in extra people-----

Deputy Louise O'Reilly: How many?

Mr. Damien McCallion: -----into the team.

Deputy Louise O'Reilly: Is this the team that will be developing it or the team dealing with it when the critical incident happens?

Mr. Damien McCallion: It is the team of people that would work, support and train the people in the hospitals in the community who are reliant on people coming in with the expertise to help them. They are stretched as it is just doing their day jobs. These experts come in and run through the exercise and the training and ensure that the structures etc. are in place so that if something does happen hospitals and communities are organised to do it.

Deputy Louise O'Reilly: How many and at what grade? If the information is not to hand, that is fine. We are happy for it to be sent to the committee following the meeting.

Mr. Damien McCallion: I can send the Deputy the details.

Deputy Louise O'Reilly: I asked two questions that were not answered.

Mr. Liam Woods: There were a couple of other questions to which I need to come back.

Chairman: I am sorry, as I interrupted.

Mr. Liam Woods: If I do not respond to all of them, Deputy Louise O'Reilly can let me know. One of them was whether the acute hospital sector would surrender budgets. I am the director of acute hospital services in the HSE and from my perspective, as part of the answer to the question, we will face a challenge in needing a resource to transition to a primary care-driven service. The notion of a safe transition from one model to another and resourcing it arises and I am sure it will be flagged by the Oireachtas through the work of the committee. Having said that, where work is being transferred and staff are moving too, of course, it is possible. However, I would be very alert to the pressures on the acute system to do work that truly needs to be done in the acute environment. There is upward pressure in high intensity areas of service for that resource. The answer is a little mixed. It is hard for me as director of acute hospital services to consider that, of course, but if it is working as part of an overall plan for transition funding, it will be part of our journey but only part of it.

Deputy Louise O'Reilly asked whether we agreed with the one in eight figure for the nurse-to-patient ratio. The study conducted by the Department of nurse numbers nationally used generically a ration of one in eight and we would not argue with it. There are areas of care where the ratio may be more intensive, but, broadly, we would not argue with that figure.

Deputy Louise O'Reilly: Does Mr. Woods accept that the number of patients to nurses is far above that ratio across much of the acute sector?

Mr. Liam Woods: Yes, it has been studied and a report is available to us from the Department with which we have collaborated, as have colleagues in the INMO.

There was a specific question about University Hospital Limerick and building of the 96 bed unit on the grounds. The ICU building, the dialysis service investment and the new emergency department will I hope come onstream later this year. There is also the education block at the back of the site. They have all been significant developments, although there is an issue with the basic ward stock, on which I have corresponded with the hospital. I can assure Senator Kieran O'Donnell that we will issue from our estates department approval to commence the design phase. The Senator referred to the steps beyond that phase. There is a procurement process and there will be a design phase followed by planning, as I am sure he is aware. I could correspond with him or ask the estates department to set out the steps involved in the process. We are also involved in a mid-term capital review process. If I understand the question the Senator asked, it was about the availability of funding when the design phase was complete, when the building work would start and there would be JCBs on site. The natural flow of the project will probably take a year or a little more, from now until there is a design and subsequently a move towards planning. Our position, in terms of the global capital base of the HSE, will be known to us at that stage, pending completion of the mid-term review which will take place in the coming months.

Senator Kieran O'Donnell: Is that the national capital review?

Mr. Liam Woods: Yes; that is correct.

Deputy Louise O'Reilly: Could the correspondence also be circulated to the committee?

Mr. Liam Woods: Yes, absolutely. We can ask the estates department to send the information to the committee on the phasing of capital projects.

Deputy Louise O'Reilly: I asked a question about advanced nurse practitioners, ANPs. I wish to be very clear because we are short of time and possibly patience at this stage, although not in my case. There are 78 advanced nurse practitioners, but there should be 150. This time next year, if we are all lucky enough to be back, how many more ANPs will there be, taking into account the fact that some of them must be coming up to retirement age? I am thinking of one in particular whom I know and who, if she has not gone already, is probably due to leave fairly soon. How close to the 150 target will we be?

Mr. Liam Woods: I agree with the Deputy's underlying point that advanced nurse practitioners are a very valuable resource in the wider health environment, both in emergency departments and elsewhere, as has been demonstrated to be the case. We agreed with our partners that the figure would be 148, close to the 150 to which the Deputy referred. Our objective is to grow to that number as quickly as we can. We have approximately 80.

Ms Angela Fitzgerald: We had 80 last year. By the time the report was announced we had eight posts in planning and they were approved. There is no specific provision. There is also a lead-in time because, as the Deputy is aware, they have to be at clinical nurse specialist, CNS, level. A total of 107 were in a resource bucket, but the bucket is empty Our objective is to engage in the planning. The difference between a clinical nurse specialist and an advanced nurse practitioner is small, but to get people into training, we will start the process this year.

Deputy Louise O'Reilly: On my question about the number this time next year, will we be lucky to have 78, that is, if some do not retire?

Mr. Liam Woods: We will come back to the Deputy with the projected number based on the number in training because that is the limiter, as the Deputy will understand.

Deputy Louise O'Reilly: I have an idea what it is.

Mr. Liam Woods: Yes, I know. As I do not wish to give the Deputy a wrong number, I would prefer to come back to her with the correct information.

Deputy Louise O'Reilly: That is fair enough.

Senator Kieran O'Donnell: We want the emergency department in University Hospital Limerick to open in May. That is critical. I have corresponded with the Minister, Deputy Simon Harris, and spoken to the CEO of the HSE, Mr. Tony O'Brien. I have also spoken at length to Mr. Woods about the 96 bed acute unit, which is also critical. It is good news that the design phase is under way and that we have lost no more time. Mr. Woods expects the mid-term national capital plan review to take place in the next couple of months. The health section of the capital plan is extremely important. For example, in the education sector, if no new schools were built in recent years, there will be a problem due to the increase in the size of the population. There are few, if any, new emergency departments, while there has been no increased bed capacity in acute services. I, therefore, call on the Government to ensure the project will go ahead. I also urge the HSE to ensure it is part of its priorities. Will Mr. Woods comment briefly on the matter? The Minister has given a commitment that if the emergency department in University Hospital Limerick is ready, it will be opened in May. I have spoken to the CEO of the hospital and been told that staff are being recruited.

The HSE must prioritise the 96 bed acute unit in order that when the mid-term national capital plan review takes place, the project will go ahead. I am concerned that the headline projects in Dublin such as the national children's hospital and the national maternity hospital, both of which are very welcome, will take priority. It is extremely important that major projects outside Dublin go ahead. I refer to hospitals in which there is a lack of capacity, including University Hospital Limerick. It is vital that the 96 bed acute unit is built.

Will Mr. Woods deal with the opening of the emergency department in May and assure us that the 96 bed acute unit is a priority for the HSE? It is very good news that the design work is under way and that we have not lost more time, but I wish to hear that the HSE is committed to funding the project which will cost €25 million. If funding comes through following the mid-term review of the national capital development plan which I very much hope will be the case, how long will it be before JCBs are on site and the 96 bed acute unit is fully operational?

Mr. Liam Woods: I thank the Senator.

Chairman: I will allow Senator Colm Burke to contribute. That will complete the questions from members.

Senator Colm Burke: To come back to the Nursing Homes Ireland issue, may I have a written response? Can a response be sent to the committee because Nursing Homes Ireland stated in its statement issued today that the emergency department task force had never engaged with it? The position needs to be clarified in writing because the issue is important and it is in the public domain.

I accept that it is not within Mr. Woods's area, but I ask for a written response to be sent to the committee on another issue also. In the Cork north River Lee area there were 68 public health or community nurses. I am not clear on the distinction between the two. At any one time last year ten were out on sick leave or maternity leave and there were no replacements for them. That seems to be what is happening in the sector. If a nurse in a hospital was out on

leave, someone would be brought in to replace him or her. I do not expect to receive a response today, but I ask for a written reply to be given to the committee. In the future, if someone is out on sick leave or some other form of leave for an extended period, sufficient backup support should be provided.

Mr. Liam Woods: University Hospital Limerick in Dooradoyle is a priority. We understand that capacity at the hospital is very stretched, to put it mildly, and the acute medical programme has assessed that, so rest assured there is value, need and prioritisation-----

Senator Kieran O'Donnell: Is it a priority?

Mr. Liam Woods: Absolutely. From an internal HSE perspective, I would see it as a priority. In respect of the point the Senator makes about things being shovel ready, we can show him technically what will happen there and we will do so. The mid-term review is tied into the overall Government process. The Senator's observations around the number of schoolchildren, teachers, desks and schools are well made. The capacity study under way in the Department and work we will do to support that will look at articulating the requirement around the moving demographic in terms of the scale and, in particular, the ageing element of that and what it means to the balance-----

Senator Kieran O'Donnell: It involves University Hospital Limerick and the mid-west and the dire need for the 96-bed unit as part of the capital plan to be funded.

Mr. Liam Woods: That is understood. The Senator understands that we await the outcome of the mid-term review, which is a matter for Government more widely. In response to Senator Colm Burke, we will come back-----

Senator Kieran O'Donnell: What about the emergency department?

Mr. Liam Woods: As I understand it, the emergency department will be handed over around the end of May - some time approaching mid year. The HSE service plan shows that it would open in quarter 3.

Senator Kieran O'Donnell: We have since had discussions with the Minister about that and he has given a commitment that if it is ready to open in May, the HSE will look at it. We are at breaking point in Limerick. Whatever numbers we go on, we have the largest number of people on trolleys in any hospital in Ireland.

Mr. Liam Woods: The need is not disputed. The Senator is correct in saying that it needs to be available as soon as it is physically ready to be available. It would need more dialogue with the group and the group CEO to look at the likely phasing, but the Senator rightly referred to a requirement to recruit and scale up around what would be a significantly larger operation.

Senator Kieran O'Donnell: If it is ready by May with staff in place, will the new emergency department be opened?

Mr. Liam Woods: I would like to see it open. We do face a challenge, which is referenced at the back of our service plan, but-----

Senator Kieran O'Donnell: The project date was deferred from March to May. If the project is ready - I am holding the management of University Hospital Limerick to account on this - if staff are in place, if it has been handed over and if it is in place infrastructurally by May, which is what the people of Limerick were promised, will the HSE support the opening of the

new accident and emergency department?

Mr. Liam Woods: I understand.

Senator Kieran O'Donnell: Is the answer "Yes"?

Mr. Liam Woods: The answer is "Yes" within the constraints of the resources we have to do that.

Senator Kieran O'Donnell: Dare I say it, that is not quite the answer I was looking for. This is a more straightforward answer. The original date was March and was then moved to May. Recruitment of staff is under way. Mr. Woods has visited the accident and emergency department in University Hospital Limerick and knows how dire it is. It is too small and claustrophobic. The reconfiguration took place in 2009. The cart was put before the horse. The new accident and emergency department should have been built at that time and the new bed capacity should have been provided, but neither was done. I am passionate about this because I have been on the ground all that time. A commitment was given by everyone that this new accident and emergency department would be opened in May. I am told by the management of University Hospital Limerick that it is recruiting. If the staff are in place and it is ready to be opened in May, will the HSE support that?

Mr. Liam Woods: We will do everything we can to get it opened in May or early June.

I can confirm to Senator Colm Burke that we will respond to writing. To clear up a slight misunderstanding regarding what he initially said, I had thought the suggestion was that the social care division had not been in dialogue, which surprised me. I take the comment about the task force and we will correspond with the Senator on it. In respect of the points made about sick leave and maternity leave, there is capacity to replace those on sick leave or maternity leave because the budget is in place for those staff. We face challenges in community care and hospitals. We have a relatively young workforce that is strongly feminised.

Senator Colm Burke: I was advised that when it looked for replacement staff, they were not provided so ten out of 68 staff were out at any one time. In fairness, we are all out for very genuine reasons but it is a huge number out of a staff of 68 and I do not think it should be allowed to arise again.

Mr. Liam Woods: I will ask the division involved to respond directly to the Senator.

Chairman: I thank all the witnesses for attending the committee meeting and apologise for keeping them waiting for two hours and for keeping them here until 6.45 p.m. On behalf of the committee, I thank Ms Fitzgerald, Mr. McCallion, Mr. Woods and Dr. Henry for coming in and giving evidence.

The joint committee adjourned at 6.45 p.m. until 9 a.m. on Thursday, 2 February 2017.