DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 18 Aibreán 2018

Wednesday, 18 April 2018

Tháinig an Comhchoiste le chéile ag 9 a.m.

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Stephen Donnelly,	Colm Burke.
Bernard J. Durkan,	
Alan Kelly,	
Margaret Murphy O'Mahony,	
Kate O'Connell.	

I láthair / In attendance: Senator Rose Conway-Walsh.

Teachta / Deputy Louise O'Reilly sa Chathaoir / in the Chair.

Business of Joint Committee

Vice Chairman: Good morning. As we have a quorum, I call the meeting to order. We will first go into private session.

The joint committee went into private session at 9.07 a.m. and resumed in public session at 9.35 a.m.

Health Service Capacity Review: PA Consulting

Vice Chairman: We are in public session. We are meeting with PA Consulting, authors of the Health Service Capacity Review report for 2018. On behalf of the committee, I welcome Mr. Stephen Smyth, Mr. Tim Daly, Mr. Chris Nightingale and Mr. George MacGinnis of PA Consulting.

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 so do, 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, persons or entity by name or in such a way as to make him, her or it identifiable.

I advise witnesses that any 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.

The witnesses are welcome. I invite Mr. George MacGinnis to make his opening statement. I remind everyone present, including members of the committee, to switch off their phones or switch them to airplane mode since they cause havoc with the PA system.

Mr. George MacGinnis: I thank the Chair and members for the opportunity to present our review of the Health Service Capacity Review. Systematic analysis of capacity requirements should be a normal component of any healthcare system's planning cycle. The last review for Ireland was undertaken in 2007 and focused only on hospital bed capacity. This review was asked to provide a more wide-ranging assessment to include the capacity needs in both primary care and social care services for older people as well as in acute hospitals. The review quantifies the demand and future capacity implications across these three domains, which are those most affected by an ageing population and rising prevalence of long-term conditions. This also aligns with the Sláintecare report finding that the best health outcomes and value for money can be achieved by reorienting the model of care towards primary and community care.

The report sets out our assessment of current capacity, future demand and the impact of future reforms to provide two ends of a spectrum of potential future capacity needs. We will say more on each of these. We have established an agreed view of the current capacity across

the public and private sectors. This was determined using two methods. One was by looking at available resource data from 2016 and the second was by cross-checking with available activity data for 2016, which gives an added level of confidence in the baseline position for 2016 and allows us to reconcile any anomalies. In addition, we looked at the most recently available international benchmarking from the Organisation for Economic Co-operation and Development, OECD, and EUROSTAT to compare capacity in Ireland to six countries, Australia, New Zealand, Denmark, Norway, Sweden and Finland.

We looked at the drivers of future demand and estimated them to produce our view of the impact on future capacity requirements to 2031, creating the baseline for the assessment. Those drivers have been categorised in three ways. First is demographic, which relates to the growth and changing age structure of the population, notably the rise in the older population in Ireland being particularly dramatic. This aligns with what the committee has already heard from the Economic and Social Research Institute, ESRI. Second are non-demographic drivers, relating to other influences such as changes in medical practice, for instance the trends towards minimally invasive and day case surgery, and the increased prevalence of chronic disease. Third is addressing unmet demand. Waiting lists have been used to estimate unmet demand and the report incorporates the additional capacity needed to reduce waiting lists to an acceptable norm over a four-year period. We then set out an analysis of how key changes to the model of care could impact on future demand and capacity across the system. The review developed three main reform scenarios drawing on a review of current policies, published evidence and international comparators. These were tested through engagement with a wide range of stakeholders including the Department's international peer review group.

The reform scenarios align with current national policies and the recommendations in the Sláintecare report. In particular, they are based around the need to shift care away from an acute-led model, and they assume more integrated care, particularly for management of chronic conditions and care of older people. They have been defined and modelled in a way that enables us to add them together to come up with an overall assessment of the capacity implications. The three reform scenarios cover, first, the impact of the healthy Ireland strategy on demand that would be attributable to a broad range of initiatives including actions on tobacco, alcohol and obesity; second, an improved model of care centred around comprehensive community-based services; and third, hospital productivity improvements. We have taken account of how care needs to be delivered as locally as is clinically appropriate and only centralised where necessary. Productivity improvements come through improved patient flows through hospitals as well as improvements associated with elective-only sites. We also noted that much of the evidence for centralising more specialised services relates to improved clinical outcomes more than reducing bed demand.

In addition, the report also sets out the capacity implications of reducing the average bed occupancy from the current high levels.

Our headline findings are that the baseline scenario - and I remind members that this involves scaling the current model of care - would require significant increases in capacity across all aspects of the health service up to 2031, including an increase of 7,150 hospital beds on top of the current 13,310. This factors in the improved occupancy levels and is more than a 50% increase. It equates to opening a new 550-bed hospital like Tallaght every year from 2018 onwards. This is still accompanied by significant increases elsewhere across the system: a 30% increase in primary care workforce, a 40% increase in residential care beds and a 70% increase in home care over the period to 2031.

Moving towards the other end of the spectrum one will find that full implementation of all three reforms would alter the capacity needed across all sectors by 2031 to 2,590 extra hospital beds including around 2,100 inpatient, 300 day case, and 190 adult critical care beds. This a reduction of 4,560 on the baseline scenario and brings the new capacity down to opening a new 550-bed hospital every third year.

To achieve this there is an even larger increase in the capacity needed elsewhere in the system, including a further 11.5% points increase in the primary care workforce, making a the total increase of 48%; an additional 1,100 residential care beds, bringing the total extra needed to 13,000; and a further 50% increase in home care (home help hours and home care packages), making the total increase 120%. In undertaking the review, we have drawn on a wide range of sources, and we have also encountered the well documented limitations of the data available within the system. In this respect, the analysis of hospital bed capacity is considered robust and provides a sound basis for planning. There was insufficient data available within the timescales of the review to forecast beyond beds to include specific hospital facilities such as operating theatres and computed tomography, CT scanners. These would need to be picked up at the next stage as more detailed planning and designs for new facilities are developed. Our analysis has been sensitive to the specific context in Ireland, for instance in respect of the mix of public and private healthcare, the role of GPs and the nature of the social care services available. The core of the analysis draws on activity trends as seen in Hospital Inpatient Enquiry, HIPE, and other data sources. In developing the reform scenarios, we have not just used international comparators, we have drawn on a range of other sources including peer-reviewed studies, comparisons of performance across different parts of the system in Ireland, and the views of the many stakeholders engaged through workshops and consultation, as well as the advice from the international peer review group. The review was asked to inform the development of a national development plan for the next decade and in particular on the scale of the capital infrastructure that will be needed. Our findings have been accepted by Government and provision for them included in the recently published national development plan. The Department of Health also have our model and are using it to do more evidence-based planning.

In conclusion, the analysis has established two extremes that define the order of magnitude and range of potential capacity needs and associated the level of changes to the model of care. The scope of the review did not extend to a comprehensive workforce capacity assessment and one will be needed to assess the rate at which capacity in various parts of the system could be brought into service. The report sets out the landscape. Continuing with the current model of care, which is the baseline scenario, will see demand exceed capacity by over 7,000 hospital beds by 2031. The combined reform scenarios are ambitious. Noting the complexity involved in bringing a new hospital into service, we believe the combined reform scenarios are likely to be the more feasible option and this is the right basis to move planning to the next level of detail as set out in our recommendations for next steps. Lastly, may we please place on record our sincere thanks for the significant contributions made by the many people and organisations who were engaged in the review process through meetings, workshops and in contributing to the Department's consultation? The full report has been circulated to the committee and is publicly available on the Department's website. Thank you.

Vice Chairman: Thank you very much Mr. MacGinnis. I will invite committee members to ask questions and we will take them in groups of three. I ask members to bank the questions. I call Senator Burke, Deputy Donnelly and Deputy Durkan in that order.

Senator Colm Burke: I thank the witnesses for the very comprehensive overview and the

report itself.

One of the problems I find with the healthcare sector, and I have been following it for ten to 12 years, is the time it takes to get change. On the one hand we have had change in the Irish health system in the past three years with an additional 11,400 people now working in the healthcare sector compared to December 2014. I am not satisfied additional services are being delivered. I am concerned about how we can increase the workforce on one level but at the same time not be able to deliver the service to the people who need it on the other side. I am wondering from the work the consultants have undertaken how they see the process improving in terms of delivering these additional services. The best example of all is the children's hospital which has taken us nearly 25 years. The presentation this morning referred to the provision of a new 550 bed unit, literally, every year and then to a delivery every three years. To deliver it even every three years will be a huge demand. How does one fast track something like that? From Mr. MacGinnis's experience, what needs to be done? There is the whole process of identifying a suitable site, going through the planning process, going through the appeal process, getting the work done, and then the other issue on staffing.

On the staffing of our hospitals OECD reports indicate that we have a ratio of nurses per head of population that is one of the best in the world. If that is the position, how does one deal with the increase in the number of hospital beds if one already has a high ratio of nurses per head of population; how then is the service delivered? Do we grow the number of nursing positions again or does one start looking to where the work that nurses are doing now could be done by care assistants? We need to protect the nursing jobs but we also need to make sure that they have backup support. How could that be dealt with?

The third issue concerns a totally different matter. When we introduced the fair deal scheme in Ireland, which is for nursing homes, it was a new type of delivery of service. It was introduced and put in place over a short enough timeframe and has delivered. The problem now is that there are approximately 23,500 people in private nursing homes, plus a further 6,000 in community hospital facilities. There are approximately 637,000 elderly people in the State. By 2030, that figure will be 1 million. A proportionate increase in nursing home bed numbers would see us needing in or around 40,000 beds. To avoid it, home care provision would have to be increased. The delegates referred to a 70% increase in that regard. My concern is whether we will have an adequate number of people to provide that service. How do the delegates suggest we deal with recruiting them? On what do we need to focus if we are to get more people involved in providing what is a superb service for those who require it? Have the delegates only examined this question to the point of saying provision needs to be increased or have they actually analysed how we should increase it? We must increase it at a fast pace every year from now on, but I am concerned that we will not have enough people to provide the service. These are just some questions that immediately pop up from what the delegates have said.

As to structures in hospitals, a question arises as to whether we should change the role of nursing. The majority of nurses now have academic qualifications, but, to a large extent, we have not increased the role they play with patients. Many nurses are more than adequately qualified to deal with a lot of the issues junior doctors are handling. Should we examine workplace practices and the delegation of duties within hospitals? For instance, there is a significant reliance on junior doctors that is not seen in other countries where there are more structured systems under which permanent and nursing staff deliver services effectively.

Deputy Stephen S. Donnelly: As I have a number of questions, will I just ask one or two now and contribute again later? How does the Vice Chairman want me to go about this?

Should I lay all of them out now?

Vice Chairman: Will they take a while to answer?

Deputy Stephen S. Donnelly: They will.

Vice Chairman: Then it might be wiser to ask one or two, after which the Deputy will have an opportunity to speak again. Is that okay?

Deputy Stephen S. Donnelly: Yes.

Vice Chairman: I also have a few questions to ask, as do Deputies Bernard J. Durkan and Alan Kelly.

Deputy Stephen S. Donnelly: The delegates are welcome and I thank them for their work.

My first question is about the numbers. The main table shows the numbers of GPs, acute beds, ICU beds, physios and everything else, but it is not a full systems review. It is only a review of acute services and excludes mental health and palliative care services. My understanding is that within primary community care services the review focuses on the elderly. I will ask my first question and leave it at that for now. How incomplete is the picture the table provides? I do not mean that as a criticism of the work done. For example, if the capacity review shows that, in the reform scenario, we need 2,590 additional acute beds, would the total number of acute beds be likely to increase by much were the Department to commission the PA Consulting Group to undertake a full system review? Similarly, there is a significant number of additional GPs, physiotherapists, allied health professionals and practice nurses, but my concern is that, while the acute review might be reasonably comprehensive, the primary care services review is limited because it is focused on elderly persons. Will the delegates give us a sense of how much of the picture we are seeing? Based on their experience of this sort of analysis abroad, is it likely that the total projected numbers of GPs, practice nurses and so on would be significantly higher than what we are seeing if their group was to carry out a full system review of community, primary and social care services?

Deputy Bernard J. Durkan: I welcome our guests. I get a little confused from time to time, as the Vice Chairman knows. What confuses me are the confused responses we receive to our questions. For instance, I have heard expert opinion to the effect that we have too many hospital beds. Needless to say, I did not agree with it at the time. On the other hand, it has been stated we have significantly undersupplied hospital registrars. I am agreeable enough with that opinion.

To what degree did the PA Consulting Group examine the issue of bed shortages? How intensive was the research? For instance, did the delegates find out why and for how long a patient was waiting for a bed, how many patients were waiting to get into hospital for appointments and how many children were waiting? It is disgraceful and ludicrous that we must time and again deal with the same issue and ask ourselves why it is happening. Why is it happening? Has the research the delegates have undertaken adequately addressed the underlying issues? Concern has been expressed previously about the ageing population. I have been guilty of doing this from time to time, but I will also point out that the young population is also increasing, much more so than in any other European country. That fact is pushed to one side and never forms part of our considerations when planning for the future.

Have the delegates taken into account that, if there are extra beds, there will also have to

be extra nurses, which is what representatives of the Irish Nurses and Midwives Organisation, INMO, said when they appeared before us a number of weeks ago? Obviously, more doctors, consultants and so on are also needed. It is a large package and the Sláintecare report has dealt with it.

Have the delegates identified the problem insofar as bed requirements are concerned, knowing that we have a population that will continue to grow for some considerable time?

Vice Chairman: If the delegates take those questions, Deputies Alan Kelly and Stephen S. Donnelly and I will have an opportunity to ask further questions later.

Mr. Tim Daly: I will begin with Senator Colm Burke's question about what it will take and how to drive it forward. Mr. Nightingale might address the staffing numbers and skill mix, while Mr. MacGinnis might address the fair deal scheme questions, after which we can address Deputies Stephen S. Donnelly's and Bernard J. Durkan's questions.

I will highlight four aspects that we believe are important if progress is to be made in the reform and provision of capacity, the first of which is securing and maintaining clinical leadership in order that there is ownership of the reforms by the clinical body.

The second aspect is how one supports hospital groups in operating effectively as a network, including legal regulatory elements to ensure there are incentives for people to work and deliver care in a more integrated way. In particular and linked with the Senator's question about some of the problems in having the children's hospital established, there is the question of how to win hearts and minds among the clinicians and the public for service reconfiguration. With specialist services in particular, there is a good case for specialising when necessary and localising where one can, but there is also a hearts and minds element because in these situations care is often moving to a different location.

The third aspect we wish to highlight is aligning the hospital groups with the CHOs in order that Ireland can start moving towards population health planning.

The final aspect is detailed control, management and planning of any provision of extra capacity. Unless one monitors the position closely, one can easily provide extra capacity without getting the reform that is supposed to go with it. Behind it comes a load of more detailed work that one would need to do, particularly on the workforce. Mr. Nightingale will discuss the units of workforce that we used. The detailed work can be more nuanced in terms of the skill mix that lies behind some of the job titles that we have used in our modelling.

Mr. Chris Nightingale: Mr. MacGinnis will answer the question asked about nursing, while I will answer the scope question about workforce capacity.

Mr. George MacGinnis: I will give an introduction to the nursing problem. We talk in the report about the immediate injection of the capacity needed to get occupancy levels down to an acceptable norm. We make the point that, although we have quantified it in bed terms, in practical terms the measures that need to be used are very similar to those with which members will be familiar from the winter pressure planning process. A combination of things are needed to improve patient flow. In other industries that would be called productivity. There is a need to look at blockages in the system. That is why it was particularly important to look at capacity outside, as well as inside, hospitals. I know from my experience of working in the system here that this is a key driver of extended lengths of stay, particularly among older people. There are also internal measures that can be taken. When we worked with the national clinical

programmes in Tallaght, we could see that there was significant potential for improvements in patient flow within the main wards in the hospital, even in the emergency department and the acute medical units on the acute floor. Patients were being admitted who would not necessarily have needed to be admitted if the right tests and the right things had been done on time. It is possible for people to be given morning-after appointments in order that they do not have to wait overnight in the emergency department in circumstances in which they are not going to be seen. Comprehensive geriatric assessments can be made in order that patients who need to be admitted can be moved on quickly and effectively from the acute medical assessment unit. There are many productivity improvements that could be made.

Questions were asked about the staffing of hospitals and workforce reforms. We did not make a comprehensive workforce assessment. The review has significant workforce implications for capacity within hospitals and other areas. As Mr. Daly has alluded to, workforce reform should be on the cards when the scale of things is examined, but it is not something we have looked at specifically. It is really a matter for the professions to get together and agree what the suitable roles are. I have mentioned the work we are doing with the national clinical programmes in Tallaght. One of the simple measures on which we worked with them involved doctors being able to delegate to nurses the authority to discharge patients at the weekend. We worked with them on a paper form to authorise nurses to get on with discharging patients whose test results had come back with certain acceptable results without having to wait for the next ward round. The presence of advanced nurse practitioners is another example of the measures being introduced. Such personnel can engage in all sorts of duty, including prescribing. Consideration could also be given to workforce reform for care assistants in other areas. The scale we have set out means that there is no silver bullet. The comprehensive package of reforms we are discussing is akin to some of the reforms that were on the cards previously, as clearly outlined in the Oireachtas Sláintecare report last year. We expect it to come through.

I want to make sure I have answered the question about the changing role of nurses. I think I wrapped it up in my response to the two other questions. In summary, this is a big reform package. It is not just about providing capacity anywhere. As Mr. Daly said, if capacity is the only thing that is introduced, it will be used in the same old way - it will block up in same old way and we will get the same old results.

Mr. Chris Nightingale: I will answer Deputy Stephen S. Donnelly's questions about the scope of the review. Some good questions were asked. The exclusion of mental health and disability services from the scope of the review was agreed at the start when the terms were set out by the Department. The main reason for the exclusion was the potential lack of availability of good and timely data in the areas of mental health and disability services. Given that ongoing work was being carried out in these areas and in light of the timescale for the project, it was felt it was better to focus on acute primary care and social care services.

The Deputy's second point was related to the resources included in the primary care part of the study. As he pointed out, we picked up on GPs, nurses and some of the allied health professionals in the study because of the availability of relatively good data for the numbers of resources in these areas and the activities undertaken by these professionals. The data in question were broken down on a granular level in terms of the patients they were seeing. This meant that we could do our demand forecasting on the same basis as the other parts of the modelling. I would not expect the addition of additional resources to have an impact on the results achieved on the basis of the resources included in the report. The inclusion of other resources in the outputs would give a further richness to the report. By including other primary care resources

in the modelling, we would see the impact on them. It would not have a significant impact on the resources already included in the review. We are relatively confident that the resources at which we have looked would be taken into account in the modelling.

The Deputy asked a particular question about the over 65s. The second scenario we set out focused on the elderly cohort of patients and particularly the chronic conditions suffered by such patients. Essentially, we analysed whether we had missed the impact on those under the age of 65 years. As a baseline, we looked at primary care services across all three sectors and patients of all ages. This ensured the total population was included. Our analysis was not limited to those over the age of 65 years. As has been pointed out, the particular scenario we considered looked at changes in the model of care for patients over the age of 65 years. There were two reasons for this. First, given that the main impact of this scenario would be on the over-65 years population, we felt that by considering them we would cover the main impacts on chronic conditions of changes in primary care services. Second, we wanted to enable the scenarios to be added together. When we were looking at improvements in hospitals in the third scenario - the efficiency scenarios in hospitals and hospital systems - we mainly looked at people under the age of 65 years. This meant that when we were adding the scenarios at the end of the report and looking at their combined effect on the baseline, we could be confident that we were not double-counting impacts from overlapping scenarios. By ensuring the combination of the three scenarios could be additive and, therefore, their combined impact could be seen, we could deliver a simpler story and message at the end of the report.

Deputy Stephen S. Donnelly: I will repeat my main question for the purposes of clarity. How close do Mr. Nightingale and his colleagues believe the figures they have presented - they have referred to 2,600 acute beds and 1,500 new GPs - are to the full system requirement?

Mr. Chris Nightingale: We believe they are close. We do not think the addition of other resources would change the numbers. Additional resources such as mental health beds, mental health capacity or mental health nurses would be additive to the requirements of the system. The addition of mental health beds would not necessarily have a big impact on the resources at which we have already looked. The resources at which we have looked have been in their totality and the round. We would not expect those numbers to vary hugely if we were to look at other areas of the system.

Deputy Stephen S. Donnelly: Could I follow up on that response quickly by asking a technical question?

Vice Chairman: Yes. I will then move on because Deputies Bernard J. Durkan and Alan Kelly have questions to ask.

Deputy Stephen S. Donnelly: My question is specific to this area. It relates to one of the assumptions made. New evidence available shows that the introduction of free GP access for those aged six years and under has increased the number of visits by over 60%. It looks like that figure is going to trend downwards. We can assume that a figure of approximately 50% will apply. Behavioural economics provides us with compelling evidence that we use and, in most cases, over-use things that are completely free. I am concerned that if we make everything completely free at the point of use, we will see a very substantial increase beyond what would optimal use would be. What assumptions are made in the two future scenarios? Is it assumed in either scenario, as per the Sláintecare report, that acute primary care essentially will become free at the point of use for everybody? If so, what additional uptake is assumed? Econometrics show that a step change is created when there is a move from a marginal charge to a free service.

It is a non-linear relationship. What uptake is assumed in this modelling?

Mr. Chris Nightingale: On fees for primary care, we did not explicitly look at the potential change associated with paying or not paying for primary care. We assumed additional pressure on primary care services of 1% above and beyond the demographic pressures as a result of changes to the model of care or in the use of primary care services. We have seen in other health systems increasing pressure out of hospital. Either systems move from hospital or there is an increase in the use of primary care. In the report itself we did not consider the potential changes in funding.

Deputy Stephen S. Donnelly: On the basis that we are probably seeing a 60% increase in GP visits due entirely to making the service free, should the element have been included?

Mr. Chris Nightingale: I presume that would show additional pressures. We spoke with the Department about whether to include it as an additional scenario and the steering group recommended that we should not explicitly include it in the report as it was uncertain as to whether it would be applied. It was something we discussed within the project that did not go into the final report.

Vice Chairman: Deputy Durkan had some questions and we will get to those answers.

Senator Colm Burke: There is an issue about the training of people to provide home care as there has been mention of the huge increase in the provision of that care. Have the witnesses considered how to get the numbers to provide that home care?

Vice Chairman: There are a number of questions - I have some as well - relating specifically to staffing and the future-proofing element of recruitment. The elephant in the room is the retention of staff. Is it possible for the witnesses to briefly run through this? All of the assumptions made in the report are based on-----

Deputy Alan Kelly: The Vice Chairman is right. It is a catch-all.

Vice Chairman: We are all asking questions in the same kind of area. Will the witnesses explain if they assumed the recruitment would happen or if they have a strategy for it? Was it factored into the plans as to how many beds were going to be needed etc.? I am conscious that Deputy Durkan's questions may not have been reached but we are all asking the same kind of questions. Deputy Kelly has other questions and I will get to him as well.

Mr. Tim Daly: On a summary level, looking at the workforce practicalities and the delivery plan to get those was not something we were asked to do in the review. We were looking at the other demands in the system and its capacity before establishing the appropriate or most practical unit of demand or capacity, depending on the setting.

Deputy Alan Kelly: Is it possible to have a comprehensive review without doing that? That is a real question. It is a fundamental and basic question I cannot get past.

Mr. George MacGinnis: There is a starting point in a process. I fully understand the questions and their thrust. As we work from where we are to getting a comprehensive solution, we need to put a few building blocks in place to develop a more sophisticated analysis. Doing an overview of capacity needs based on an assessment of the demand and the trends of the demand is the right first step. As I indicated in the opening statement, that sets out a landscape around which we go. It is not that we have then not done a workforce assessment. Why do we think it

is the right landscape to go for? We know we have not modelled all the workforce in detail and we have set out very clearly a recommendation that a comprehensive workforce assessment is needed. As we worked up the scenarios, we pulled together workshops with a number of very senior people from across the system. These were not just system leaders but representatives from patient bodies and the like. We worked through with them the scenario in reality and what it means for Ireland. We looked at what is a reasonable quantification for the scenario. The way we constructed those takes account of people's views of what they think was deliverable, knowing that what we are giving is a broad order assessment of what is needed.

Both ends of the spectrum are pretty horrendous in terms of implications. Members have already pointed out the business of how long it takes to build a hospital. One asked a question specifically about expert opinion on there being too many beds. That was a view put forward by one of the members of the OECD panel and the view was that other countries are not building beds. When we considered it with the other members of the international peer review group, we saw that those countries that are beginning to get away with fewer beds than recommended have already done significant reform in their primary and community care and are already supporting patients in different ways. Given where Ireland is, it is a reasonable capacity assessment. Given the time and difficulty in bringing in capital infrastructure, one that looks to the minimum one can get away with is the best.

This leaves us with profound questions about how to get capacity and how to address the fair deal question, for example. It is about how to build that capacity in Ireland and the mechanisms for doing that. We have not looked at that in detail. As I stated, we have had some expert opinions from people across the system who have helped to shape those scenarios. The next stage is to look at that in detail. If we contrast the 2007 review with this one, in financial terms this iteration poses many more revenue and expenditure questions than were ever posed in the 2007 review. It puts on the table a much more comprehensive financial view of the scale likely to be needed. As I said, there are two extremes and perhaps the achievable goal will be somewhere in between. We think it will be closer to the reforms scenario option than the building option as we go on. Does that help to answer those questions?

Vice Chairman: To be frank, it does not answer the matter of workforce planning. Much of what has been said is predicated on the need for staff. We would not have a health service without its staff. Much of the difficulty experienced in the health service revolve's around the matter of recruitment and retention. It seems that maybe the report sidestepped that somewhat.

Mr. Chris Nightingale: Within the scope of the report the workforce was explicitly ruled out by the Department. We were explicitly told not to do a workforce review because one was already ongoing with the HSE.

Vice Chairman: We will take the next round of questions if that is okay. They will come from Deputies Kelly and Donnelly, and I have some questions as well.

Deputy Bernard J. Durkan: I am still waiting for a reply to my questions.

Vice Chairman: I apologise.

Deputy Bernard J. Durkan: It concerns the forensic nature of the examination and how sound is the basis.

Vice Chairman: Will the witnesses respond to Deputy Durkan?

Deputy Bernard J. Durkan: I am a very quiet fellow but not that quiet.

Vice Chairman: I apologise again. The witnesses might respond to Deputy Durkan before we give Deputy Kelly his opportunity. He will get an award for being very patient this morning.

Mr. Chris Nightingale: One question concerned the data we looked at and whether we took into account current pressures on the system in terms of waiting lists. Those were explicitly considered in the way we constructed the model and methodology. For unmet demand we looked at where we had available waiting list data from the National Treatment Purchase Fund with respect to current pressure on services and how the lists could be run down with short-term capacity. It was explicitly considered.

The Deputy's second point was around the growing young population. The Central Statistics Office forecasts do not show a growing young population but rather that it will stay relatively stable. Really it is the elderly population that will grow, with those over 65 going up by 60% over the next 15 years, and those over 85 going up by nearly 100%. Other western economies are not seeing such extreme growth in the elderly populations but they see similar pressures from that elderly population. People are living longer because of better treatment but also living with chronic conditions that still cost the health system money.

Deputy Bernard J. Durkan: Has the use of home care packages and their impact been factored in? Did the witnesses consider, for example, the potential growth in the home care system, with relays of carers treating patients in the home? It is part of the long and short-term strategy of the Department of Health.

Mr. George MacGinnis: In the development of the scenarios, we had a good debate, which is reflected in the scenarios relating to moving people out of hospitals and how many should go to residential care beds, how much the system is being reformed and the use of home care packages, telecare and other forms of care as an alternative to residential care. The way that we factor that in is reflected in the assessment of the figures we gave earlier.

Deputy Bernard J. Durkan: Has Mr. MacGinnis identified the precise impact in terms of numbers of the development of the home care package system?

Mr. George MacGinnis: The question would be the definition of "precise" in this case. We have identified the quantification at a level that we believe is appropriate for this level of planning. Further work will be required to flesh that out to ascertain whether 1,300 residential care beds is the right number or whether more or less could be done with home care. There will be more detailed work at the implementation stage but the numbers give the committee the order of magnitude and the general shape of the resource requirements for the fair deal scheme, home care packages and residential care beds.

Deputy Alan Kelly: The report is a contribution, which is helpful but is hamstrung. By not considering the issue of workforce planning, the report is similar to a jigsaw with a massive piece missing from it. It cannot be displayed because the piece is so significant. That is not the fault of the PA Consulting Group representatives because they were told not to do it but that is a glaring and obvious mistake. As these reports are a snapshot in time, workforce planning is not something that can be added on. It should have been part of the process. We can take the report as what it is but as regards it being a contribution to the overall process, having sat for 11 months to produce the Sláintecare report, it will not have a significant impact because it is corrupted. Our issues in this regard revolve around having the people to do the work in the first

place that dictate decision making, strategies and pathways and that is not part of this review.

With regard to reform options, are there any silver bullets? Do any issues jump out to help deliver the capacity needed?

I refer to the issue of the community healthcare organisation, CHOs. and hospital groups. We spent a great deal of time on this for Sláintecare. This issue is bonkers. How much would the representatives dial up that issue? What solutions can be provided quickly?

On the alignment of the report with Sláintecare, do significant issues jump out that are contradictory?

There are demographic challenges in the context of future capacity but are there other infrastructural challenges that are not obvious? In particular, are there geographical issues that jump off the page but which perhaps do not appear to those who are close to delivering health services? Are there external factors that could have an impact on the capacity that could be delivered by the health service, particularly in dispersed geographical areas?

Deputy Stephen S. Donnelly: I have a question about the comparative analysis and benchmarking. It is something that puzzles me about the healthcare system. The capacity review says that even to get to an 85% occupancy rate, 1,300 new beds are needed, which is a huge number. The international benchmarking chapter on page 16 of the main report, which is useful, shows that we have a younger population and, therefore, currently, we should need less of everything in healthcare *per capita*, except perhaps maternity care. According to the resourcing figures, which have been benchmarked against good healthcare systems such as Australia, Norway, Sweden and New Zealand - these are best in class and not OECD averages - we have approximately the same number of GPs, nurses and hospital beds *per capita* but we have a younger population and, therefore, we should need fewer. At the same time, we are experiencing poor healthcare outcomes comparatively and the capacity review says that even today, a huge number of new beds are needed. Those two outcomes do not intuitively tie together. Will the witnesses explain why, if we need less *per capita* and technically we have more GPs, nurses and beds than we should need relative to some of the best healthcare systems in the world, the capacity review has found that we have much less than we need? What is going on with that?

Vice Chairman: The submission refers to the available resource data from 2016 and the activity data, which I assume is the hospital in-patient enquiry, HIPE, data, from 2016. We ask the HSE many questions and while I would dearly love to say we get many answers, sometimes we do not. We have had trouble getting information on activities, for example, the number of operations performed in theatres, or basic information such as whether the theatre is open. Where did the witnesses obtain the data? To whom did they speak? Where do the resource data come from and to what do they refer?

The 2007 capacity review was undertaken by the witnesses' company. According to that, there were 11,660 beds. By 2016, this number had reduced to 10,500, which is a reduction of 1,160. Where did all the beds go? Are they in the system? Are they on wards that are closed? We did not experience significant hospital closures. Where are those beds? What hospitals are they in? What type of beds are they? When I saw that figure, it threw me.

It is lost on me why workforce planning would not have been included in this review because all the beds in the world could be opened but if the staff members are not available to provide care, they are not much use. I am worried that workforce planning was explicitly ex-

cluded because in 2007 it was part of the review. At the time, I was part of the working time directive compliance implementation group and we had an expert group on skills mix which recommended an 80:20 ratio for nurses and healthcare assistants. I wonder if that has been factored in to some of the witnesses' thinking. It exists already and a lot of work has already been done on skills mix and ratios.

How was the figure of 13,000 residential care beds arrived at? Depending on how one looks at it, different numbers can come up. It strikes me as odd that this will not be included and it is very worrying that workforce, skills mix and future planning are not part of it. We do not just have an issue with recruitment and retention in our acute hospitals but have them across the board. We also have an ageing GP population, which will further complicate matters. I am aware that health service staff have been reformed to death so I hesitate to use the word "reform" but without the workforce the reforms will not happen and we will not enhance bed capacity without an adequate skills mix. How can the increases of which the witnesses spoke be achieved?

Mr. Tim Daly: I agree with the Vice Chairman that, to get a complete picture, this needs to be done. Page 55 of our summary report talks about next steps and the feasibility of the workforce impact of this.

Vice Chairman: This is the same company which did the review in 2007. At any stage did it make its views known to the Department? It would make sense as the Department presumably commissioned the company. Did the company advise that it would make sense to do a workforce plan alongside a capacity review? The Department would have sought the company's advice and seems to have discounted some of it.

Mr. Chris Nightingale: There was a discussion on determining the scope of the reviews and we raised it at that point. We asked whether we would look at the workforce as we were doing it, particularly given that we were looking at the workforce in the primary care sector. The decision was not to do it because other workforce planning reviews were ongoing and we felt it was covered, though we said it could be included. A workforce capacity review is slightly different from workforce planning and there is a level of detail into which we would not expect to go, such as the working plans for doctors' health and job plans. The number of beds gives a proxy for the workforce and there is a view on the primary care workforce. There is a range between 7,000 to 2,000 beds and this can be converted into a number for nurses, though we have not done that in the report. Everybody can see that there is a big impact on workforce requirements, which is what everybody is driving at. However, we did not go into how one recruits, trains and retains those as that is for more detailed workforce planning.

Vice Chairman: Which ratio of nurses to beds does the company use?

Mr. Chris Nightingale: One could look at different systems and say the range of the nursing workforce in Ireland is X-----

Vice Chairman: That is like asking how long a piece of string is. A pilot has just been completed, which will mean we have to substantially increase the number of nurses in the workforce. The pilot achieved really good results but the difficulty is that we are on a merry-go-round and we keep coming back to the issues of recruitment and retention.

Mr. Chris Nightingale: Yes.

Vice Chairman: Members of the committee are very frustrated that the issue was not part

of the company's work. What stage are the other workforce planning reviews at? I do not believe the pilot started before the bed capacity review was completed. Perhaps the details were not given.

Mr. Chris Nightingale: We were probably told the name of the review but I cannot remember it off hand. We asked whether we should link in with our results and cross-check issues such as demand but we were not required to follow through on it.

Vice Chairman: That is very interesting, and a bit disappointing.

Mr. George MacGinnis: Deputy Kelly asked about reform options, community health organisations and hospital groups. We have modelled capacity to say what is required at CHO level and at hospital group level. When one does a strategic capacity assessment, some of the specifics are going to get in the way and current performance is related to specifics to some extent. The international direction of travel is towards population health management, which requires accountable care in the US, for example, and generally requires that, in planning delivery of services, one has a comprehensive view of the hospital, community and social care services that the population will receive so that one can make outcome-based decisions to put resources into different places, so that one gets the effect one wants. A misalignment of populations has been clear in England recently. Most of the rest of the UK has population health boundaries but England went away from this and, in the past two years, it has been struggling to realign the governance of the system so that hospitals, primary care and mental health organisations start talking about common populations. We believe the same challenge will emerge in Ireland.

When we worked with the national clinical programmes in Tallaght, one of the issues we saw was the number of different organisations involved in discharges from the hospital, the number of different procedures for discharging and the number of discharge co-ordinators with whom the hospital had to work. The more fragmented and complex the picture is, the more difficult it is for the system to achieve the level of patient care and the patient experience to which we aspire. We have modelled capacity needs and there are implications, particularly in the third scenario, for how hospital groups work together and with their catchment areas, community health organisations etc.

We are not specifically modelling a scenario to reshape the CHOs so that they are all lined up as there are complex issues in doing that. However, in getting systems to work together, there is a legal structure. We need to ask if people are able to work together and can flex budgets. Hearts and minds will be a factor and we need to ask if people will accept it if things go in different directions. Certain specialties are delivered in some places and not in others and we have to ask if people will accept such changes in authority in the groups involved. We agree with the Sláintecare report that an alignment is, in principle, a good thing and other systems are, indeed, heading back in that direction.

We were asked about challenges we may not have foreseen in the area of future capacity. We have to model what is sensible to model. We have looked at challenges in what we call "non-demographic growth", which is a technical phrase for things that happen that do not involve people getting bigger and older. For example, we looked at the trend in day cases and we found that it was a trend that would probably stop, rather than carry on. There were factors associated with bed blocking, among other issues, which meant that hospitals were performing day cases as an alternative to some of the other surgeries they would probably have preferred to be doing at that time. We have changed some of those trends. We can pick up some of the non-demographic growth. One would anticipate that, over time, medical technology will change,

but I do not believe that it will change in a completely transformational way in the next ten to 15 years time. There will be more personalised medicine on a relatively small scale which might have some implications for capacity at a very detailed level. There may be a number of gene and cell therapy clean rooms, some wards, and things like that. However, at this stage I do not believe, in terms of the level of detail we have provided and the parameters we have provided, that it is sensible to add in any other factor to do that. That is a sensible basis for planning.

Mr. Tim Daly: I would sound a note of caution on how we make those international comparisons. We use them, in the main, in two ways. We look at the different counting rules and definitions that different health systems will use for hospital beds or a GP, etc. Behind these headline indicators there is a raft of other factors within the system that are driving this. It is not the case that every country has exactly the same health system and that therefore it is possible to make like-for-like comparisons. The Deputy is right when he speaks about where the comparators are versus what is a younger population. Given that the population is going to be ageing more quickly in comparison to other health systems, it is even more worrying than it might otherwise be.

Why was a caution not provided with these metrics? The results seem counter-intuitive. The degree of integration within the health system is an issue. In a previous answer Mr. MacGinnis spoke about some of the factors that lead to the better use of resources, which mean that less capacity is required to deal with demand.

The policy and incentives surrounding the system that allows patients to flow through is another issue. The third issue - the figures for which are contained in chapter three - is public health and drivers such as size and age of the population as well as its relative health. These things are driving that slightly counter-intuitive view.

The Chair asked about bed capacity.

Deputy Stephen S. Donnelly: I would like to respond on that question.

Vice Chairman: The Deputy will have another opportunity.

Deputy Stephen S. Donnelly: It is on the same topic.

Vice Chairman: The Deputy should be very brief.

Deputy Stephen S. Donnelly: We should have fewer GPs. It would appear that we have more than enough, on the face of it, and more than enough acute beds. The reasons given are the lack of integration, misaligned incentives and public health. The witness may well be correct on the lack of integration. However, when taking a systems view, it probably does not matter that much. What does a lack of integration mean? It means that people are going into acute settings who might have been seen in the community, or people are going in for referrals to specialists who perhaps could have been seen by a physiotherapist. We actually appear to have more clinical assets in the primary care settings and more clinical assets in the acute setting, so a lack of integration may suggest that we have people who are going into hospital who perhaps should be staying in the community. However, if we have more assets in the community and more assets in the hospital, once adjustments are made for a younger population, then I am not entirely sure that I buy lack of integration as a reason.

Vice Chairman: Can the Deputy ask a question?

Deputy Stephen S. Donnelly: I have not finished the question.

Vice Chairman: I asked the Deputy to be brief. I am conscious that there are a number of other people who are indicating.

Deputy Stephen S. Donnelly: I am being brief. Could the witness talk more about the misalignment of incentives? What exactly is that? On public health, the figures shown again do not suggest that we are less healthy. Life expectancy is very high. Obesity is one factor, but on the other factors we seem to be doing okay. Can the witness go into a little bit more depth? I did not get much insight from the answer he has given so far.

Mr. George MacGinnis: I will expand. Some of what I say is based on my wider experience of working in the Irish health system. On the international comparators, I would draw the Deputy's attention to the comparator on activity on page 21 of the report, specifically the average length of stay rates for inpatient acute care. In Ireland the performance in this area has been declining. One of the points made about integration is that patient flow is blocked and people get stuck in hospitals, which means that the productivity of the workforce, in OECD terms, declines, so patients do not get as much health care as they might otherwise with that same workforce.

The Deputy mentioned GPs, which was one of the things that came up in the review. We very deliberately described a primary care workforce in the review. The advice from New Zealand was that the mix is currently very GP heavy. We have not looked specifically at that, but in other areas where we have looked at this question GPs operating alone tended to have different productivity outcomes to GPs working in larger teams where there is a degree of specialisation, for example women's services, diabetes and things like that within the GP community. In particular, the nurse GP ratio could be looked at. In New Zealand many general practice tasks are carried out by nurses, with issues escalated to doctors when appropriate. Nurses are able to carry out many of these tasks. My understanding is that the Department has put in place a programme for building primary care centres, but is having difficulty attracting GPs to relocate and work from those centres. We believe that productivity within the system is hampered by some of these workforce factors. It is also hampered by the lack of integration. On a practical level, how many different forms have to be filled out and how many different people have to be contacted to move someone on? That is affected by the fragmentation within the system at present.

Ireland still has a long journey to take in terms of resourcing healthcare. The way that budgets work does not encourage an output, let alone an outcome, review of what is being achieved. It is very much an input-based strategy, and things will not change until that approach is altered. I do not mean changes at a managerial level. There is a very real sense among clinicians that they understand and own patient outcomes. They know that the decisions they make every day not to discharge someone from an acute ward condemns someone to an extra stay on a trolley in an emergency department. Those are risk-based decisions, and they are difficult, but that is the kind of real cultural change that is required across the system.

Mr. Tim Daly: On the public health indicators, yes, Irish people have a long life expectancy, but if one looks at the figures we have on smoking and alcohol consumption it is a different picture. It shows a particular lifestyle exists. This also applies to the issue of obesity. That is the point I was making on public health. Those drivers will effectively create a proportionately greater demand for size and age of population.

Vice Chairman: I asked some specific questions on beds.

Mr. Chris Nightingale: Your question, Vice Chairman, was around where we got the data from the HSE. I concur that it is challenging to get data from the HSE, having spent-----

Vice Chairman: That is one way of putting it.

Mr. Chris Nightingale: We undertook a 16 week project with a four-week timescale for collecting data. We were still looking for stuff in week 12. That was something we encountered. However, we did get good information from the hospital inpatient enquiry data system. That was the main data source we used for in-hospital activity. In the opening statement we mentioned that initially the plan was to include theatres and diagnostics as key resources in the acute sector. It was not possible to get the associated data in the time available. We explicitly asked for it on several occasions. One reason was that we would have had to go to individual hospitals to get the data as there was no centralised dataset that we were given access to, despite requesting it. I concur with the statement on the data.

Vice Chairman: Does PA Consulting Group have any comment on disappearing beds?

Mr. George MacGinnis: We did not specifically look at the disappearing beds. I know that-----

Vice Chairman: I asked for your view on where they might be in terms of hospitals distribution. In 2007, PA Consulting Group recommended a form of integration. Clearly, that did not happen. In the intervening time there appears to have been a drop-off in the number of beds counted. Is that explained by a change in the methodology of counting? Are the beds still where they were and covered in dust with no one available to make them function?

Mr. George MacGinnis: I was not surprised that there were fewer beds in the audit. That is partly because of the measures the health service has been subjected to, including the year-on-year financial reductions following the financial crisis. I was not surprised that the number we were starting with was different or that wards have been assigned for a different purpose and so on. We have not looked at-----

Deputy Bernard J. Durkan: There were bed reductions during the boom as well.

Vice Chairman: That is not the point.

Deputy Bernard J. Durkan: I know.

Vice Chairman: The point I am making is that in 2007, an assessment of the number of beds was carried out and a projection was made on how many would be needed if the health service was to be integrated. I recall "integration" was the buzzword. There was no integration but there was a consequential reduction in the number of beds. I am not going back to the time before that-----

Deputy Bernard J. Durkan: It is same point.

Vice Chairman: Let us go back to the report in 2007. It is fairly clear that the beds recorded are no longer available for the people who need them.

Mr. George MacGinnis: I think there will be a broader question for the committee to direct queries to the Department about the fitness for purpose of the current stock. I note the committee report makes reference to infection control and single patient rooms and so on. There is a wider question but I do not think there is great value in going back and asking where they are.

It could be that those responsible have reduced the size or wards and so on.

Vice Chairman: I disagree with you on that point, Mr. MacGinnis. If we do not go back to see where they went, then we could lose some in future, and that would be most unfortunate.

I am conscious that several people are waiting to come in. My questions have been answered. Senator Burke, Deputy O'Connell and Senator Conway-Walsh have indicated.

Senator Colm Burke: Let us consider the integration issue. I find a major disengagement between the hospitals and general practitioners and between GPs and public health nurses. The consultants have looked at other systems, including systems in New Zealand. In looking at systems outside Ireland did they find far greater co-ordination between the hospitals, GPs and public health nurses?

I was shocked after speaking to someone last night who has had a serious operation. The person has been discharged from hospital and is living alone. All the person gets from the public health nurse is a telephone call and there is no follow-up checking. The person is six weeks out of hospital and is in what I would consider to be a serious enough medical condition, but there is no co-ordination. No one has written to the public health nurse saying the nurse should call to this person once every week.

The consultants have looked at other systems. This is not an area where we need to invest money. It is simply about setting up new structural co-ordination. Did the consultants look at that in the context of delivering far more effective services by the co-ordination of services?

I have looked at the set-up in Canada, where GPs go into and work in hospitals. Some might work two days per week or two half-days per week there. That is the level of contact. In Ireland, a patient is in a hospital one day and the next day he is talking to the GP, who has little communication from the hospital. Has PA Consulting Group looked at that issue?

Deputy Kate O'Connell: I am sorry for coming in and out. I hope I will not repeat some of the questions asked before. If I do, let me know. Productivity of the workforce was mentioned, as was primary care service being GP-heavy. The consultants referred to single GPs operating on their own. When it comes to the geographical situation in Ireland, this is an issue because we have remote parts with low population. There is need for single GPs to service these communities. Although I am all for the primary care centre, it simply will not work in certain parts of Ireland. The consultants spoke to their experience rather than the report. Has that been considered?

Attracting GPs to primary care centres seems to be an issue in Ireland. We appear to have some good centres set up but getting GPs to come and work in what is a semi-corporate set-up is difficult. It was always the case that it was integral to a GP's work that she was in charge of her practice and was almost a doctor and a business person in the same way as a pharmacist. I am a pharmacist by profession. Is that where PA Consulting Group believes the barrier is? Is it a question of losing that autonomy? Do the consultants have any views on that?

The consultants spoke about how in other countries nurses are upskilled to do certain jobs and GPs become more specialist. Do the consultants have any view on the barriers to GPs letting go of certain bread-and-butter practices, for want of a better phrase, that are crucial to keeping a certain baseline revenue coming in to a practice? I have in mind things like repeat prescriptions for contraceptives. I firmly believe these can be done in the community pharmacy setting through the Oregon algorithm to make it safe to deal with contraceptive needs of women

and men.

The consultants spoke about the current stock value. Will they elaborate a little on the beds we have? They spoke about isolation rooms. Will they elaborate on that? Is it the case that the stock we have is not primary stock? We may have large numbers of eight-bed wards. I take it from what the consultants have said that such a set-up might be counter-intuitive because if there is an eight-bed ward and disease is spreading, then it will compound the issue and we will have more admissions.

Senator Burke referred to the New Zealand model whereby the GPs go into the hospital. I was at a hospital in Kilkenny looking at the system in operation there. To my mind, the system operating there is the way forward. It is not the solution but it is a partial solution. It seems bizarre that a GP, who is the anchor to a patient's healthcare, would refer a patient to a hospital and then the patient goes into the same room as another who has broken his leg on the football pitch, even though the first patient has essentially already been triaged by the GP.

I imagine the consultants know that in Carlow and Kilkenny a community pharmacist is involved in the discharge process. The service is more seamless and there are fewer errors. Have the PA Consulting Group considered that? In reply to a member, I think it was Deputy Donnelly, it was stated that a consultant leaving somebody in an acute bed for a day longer has repercussions for those on a trolley somewhere. Perhaps I took up that point incorrectly.

Mr. George MacGinnis: Does the Deputy wish me to come back on that point straight away?

Deputy Kate O'Connell: In a minute. Many of us present sat on that committee and put a great deal of time into ways to try to deal with as many services in the primary care setting as possible, which is the whole point of Sláintecare. Is the report by PA Consulting assuming that everything will stay static, apart from demographics, or are the consultants taking into account that slowly but surely clients requiring minor treatments will be moved and have that service provided in a primary care setting and that hospitals will be for those who are very ill?

Vice Chairman: I thank Deputy O'Connell. I call Senator Conway-Walsh. I think all members may wish to contribute on the issue raised by Deputy O'Connell at some stage.

Senator Rose Conway-Walsh: I thank the witnesses for their presentations. I was listening to them in the office, although I was not physically present. One of the issues that concerns me about the health service is the cost-benefit analysis that is done on the decisions that are made. It is not obvious to me that the cost-benefit analysis on some of the decisions is correct. This includes some of the decisions to close district hospital beds and so on and the impact that has in the short, medium and long term. Is it possible for the HSE to supply to the committee secretariat or to members exactly what elements are used in the cost-benefit analysis? That would help us to understand the decisions. I do not have confidence in the cost-benefit analysis models that are being used, either to make decisions on the closure of beds or for centralisation of services. I take the point made about the centralisation of services and the improved outcomes and I would certainly agree with that, but we need to see the sacrifices that are made for that in terms of access to health care services in rural areas and the importance of putting in place services at a local level where it is safe to do so. We have not done that and have failed dismally to do that.

I take it from the accents of the witnesses that they would be very familiar with the NHS in

the United Kingdom. I know that Mr. Stevens was looking at the model of moving away from the centralisation and privatisation model and bringing it back to communities. We have continued to talk about that for 20 years but we have not put actions behind the words.

I cite the most recent decision in respect of the withdrawal of the Versatis plasters from those who have a medical card. I am not at all satisfied that there was a proper cost-benefit analysis done in reaching that decision, which affected 25,000 people, in terms of the extra hospitalisation, medicines and anti-depressants that were required. Leaving aside the humanity of the decision, if we are looking at the impact of the decision economically, I do not believe the decision was correct.

I would like the witnesses to expand on the question of modelling and how we can have more transparency and accountability around the modelling and adoption of new drugs such as Translarna and the impact that would have. How can Britain provide free GP care for 60 million people and we cannot do it for 5 million people? As a person who lived in Britain for a long time and accessed that service, I cannot understand why we cannot do the same. Will the witnesses give us three primary reasons why they think that we are failing to do the same here?

The document provided to us is good, but has the scenario of an all-island approach to the delivery of health care been considered? In the timeframe 2000 to 2031, there is a growing realisation that we are working towards a united Ireland and an all island approach to services such as health care, education and so on. It is imperative that those models are being worked out properly in the Department and the HSE, in particular that they would look at the impact of Brexit. There is much more I could say about primary care in the health service, but I know other members wish to put questions, so I would appreciate a response on those key issues.

Vice Chairman: I thank Senator Conway-Walsh. On the point made by Deputy O'Connell on whether a staff member in the health service is aware that if he or she does not discharge a patient, this may cause another individual in the accident and emergency department to stay an additional night on a trolley, I used to represent staff in the health service and they are acutely aware of that, but they are dealing with a finite resource and very often the decisions they make are resource dependent. I do not believe that remark was intended in that way, but the remark could be construed by health service workers as being somewhat dismissive because clearly they are doing their best. To clarify that remark, will the witnesses outline for us who from the health service workforce, outside of the people whom one would call the management, did they meet? Did they talk to those on the front line of delivering the services about the challenges they are facing day in, day out, week in and week out, which are all resource dependent? If hard work resulted in us having a marvellous health service, we would have the greatest health service in the world. Unfortunately, all of their hard work comes up constantly against resource challenges, to put it kindly.

Mr. George MacGinnis: My comment was an illustration of the use of the capacity that the health services in Ireland have. If a bed is used for one reason, and that is an extra day's stay in bed because somebody is not able to do a ward round, that bed is therefore not available to somebody else. I agree wholeheartedly with members that the people I have met and talked to across the system want to deliver the best care possible. Under pressure, they feel the bounds of their world are often much more limited than the whole hospital, so they hold on to beds so that their patients can get into those beds. They are under pressure for other reasons so they are unable to do the ward rounds that would allow them to get people discharged faster. There are all sorts of reasons at a human and a practical level. When capacity is used in a way that looks like it is overused, and the trend of rising average length of stay in Ireland would suggest

that, as a whole, the system is behaving in that way, that has an implication. That is what I was saying. I would say that. I would also preface my comments that none of us is a clinician. A number of the questions we have been asked are actually about clinical decisions, but we are able to look at the impact of clinical decisions system wide and comment on what the sum of those decisions means to the system and, in this context, specifically for capacity. That is the context in which we were doing that.

Deputy Kate O'Connell: The comment by Mr. MacGinnis is unhelpful, but it was useful for him to point out that he is not a clinician. I have an issue, however, which I imagine is shared by members. The suggestion is that a consultant, who has a duty of care to a patient in an acute bed, should be worried about what is happening downstairs. To my mind that is not their job. The duty of care is to the patient in the bed. Will Mr. MacGinnis elaborate further on his comment about consultants holding on to beds to service their patients? If there is truth in this we, as a committee, need to investigate. I do not know what Mr. MacGinnis is getting at. I do not want to misquote him, but is he suggesting that, for example, an orthopaedic surgeon might keep a lad in a bed a day longer because he knows he has a patient coming in? What is he suggesting here? It is unhelpful to make comments like this and to have to clarify and preface and so on. The witnesses are here as witnesses to a committee of the Oireachtas. Making comments that are not necessarily backed up by anything other than opinion is unhelpful. Will Mr. MacGinnis elaborate further on the idea of holding on to beds?

Mr. George MacGinnis: All we are saying is that the average length of stay in hospitals appears to be higher in Ireland than we would have seen in some other systems for similar procedures. That means that the number of beds used for the same sorts of issues is higher than in other systems. I was trying to understand why that is. It is not because people in Ireland are physiologically different from people in other countries. It is to do with the way the system works. I will answer Deputy O'Connell's question while addressing Senator Colm Burke's and give some examples. Some of this is about the integration of the system and the issues of engagement between hospitals and GPs and between GPs and practice nurses and so on. We have looked at other systems. I have worked in other systems, and not just the system of the country from which my accent comes.

In terms of returning people to the community out of hospital, in the US there was a behaviour at a system level to reduce the average length of stay continually, which resulted in people getting out of hospital too quickly. Penalty tariffs were introduced. In effect, the insurers would no longer pay for a readmission that happened after 30 days. This had a significant impact in the US. In England a similar tariff was introduced. It has not had the same dramatic effect as it had in the US for other reasons, but there was a behavioural driver linked to resource which indicated that if work was given to be done in the community, resources were needed to do that work. It is not a question of whether people are discharged early. In the example the Senator gave of someone needing a call, that is extra work for someone's workload. What is that person's caseload? Can he or she do that? Is the resource following the patient? This is what we mean when we talk about population health. We mean that when rational decisions are made which say that care is better delivered in community settings, it is not just a matter of getting everyone out of hospital. The community providers have to be resourced. We have to recognise that. Another really good example from the UK was discharge summaries. The community teams there were unable to do their job because they were not being informed by the hospitals in time. Again, a system was introduced to get people out. I think similar initiatives are being worked on in Ireland which will enable hospitals to get discharge summaries out to GPs as effectively.

This sort of integrated care involves quite difficult clinical governance issues. I did some work in Scotland where the system has quite a different structure from that of England. I was working in a surprisingly remote area. I will not name it, but it had the equivalent of a model 3 hospital and several model 2 equivalent hospitals. GPs had admitting rights to the model 2 hospitals. It was found that people from remote rural communities were being sent to the model 3 hospital, often for diagnostic tests, and were being admitted to older wards and being held on to. Why was this happening? It was because the consultants in the hospitals did not think that the GPs would have the time or the facilities to look after the patients at risk properly. They started to work on a different model of clinical governance whereby people could be stepped down into the model 2 equivalent hospitals while still under the consultant and in which there was an information system that allowed the consultant to keep an eye on the patient. It was particularly used for cases of sepsis. The sepsis teams were still able to give that service to the model 2 hospitals and the model 2 hospitals were a safe and effective place for patients to be. Evidence was coming out that people who were returned to that type of model 2 hospital, which had community rooms and so on, actually returned home faster than if they had been recuperating in a ward in the model 3 fully acute hospital. The hospitals worked on that model. That is an example of how it is not just about providing the capacity or giving some good policy. There is a lot of clinical governance and detailed work involved and the way that resources move around the system needs to work for this to work effectively in Ireland.

Mr. Tim Daly: On the cost-benefit analysis side, I cannot speak for what the HSE has used, but I can offer a view on the common factors we generally see health systems considering when they are involved in service change. Such changes can range from very centralised surgery services down to more localised services such as the ones we have been involved in which have included the use of telecare or telehealth locally to help shift out care and different ways in which paramedics and ambulances can contribute to the system. I would highlight six factors which generally come up. The first is about quality. Underneath that there are the clinical outcomes, the patient experience and patient safety. What impact will a given change, be it a service change or a policy, procedural or regulatory change, have? The second factor is access. In the questions the committee has raised, we have spoken about what a change means for remote communities. Some services need to be very local, others need clinical volumes to get good outcomes. Another factor is the workforce. We have discussed that. Part of that workforce factor is the education and training requirements. The junior doctors, trainee nurses and allied health professionals need to see the right amount of patients in order to train. The productivity of a training establishment will be different and a system needs to reflect that.

The fifth factor relates to the financial side and the net present value. However, that is, as the committee can see, one of six factors. The final factor is deliverability. We have spoken about the next steps and feasibility. Whether it is a massive building programme or a big requirement to train up and create a workforce, how it will be delivered must be considered. That is just at a national level but it is equally applicable at a local level if a GP-led health centre or a more local hospital is being set up. It must be considered whether it can be practically delivered in terms of infrastructure, IT, estate, timing and such things. Those are the six factors that repeatedly come up. Then there will always be, depending on the level at which it is being done, particular local issues. There may be a particular issue around health inequalities in a particular area that needs to be addressed. This would mean that provision in that area would be designed slightly differently. That would be our general view of the cost-benefit analysis but, as I have said, we cannot speak to exactly what the HSE would use.

Senator Rose Conway-Walsh: What is difficult to understand is how a cost-benefit analy-

sis, CBA, in the North, which is just a few miles up the road, can deliver something like Versatis or Translarna while a CBA here can say that it is not viable. Even looking at those factors, I cannot see how the variables would be so different across a small island as to result in a different outcome.

Mr. George MacGinnis: I am going to duck the issue slightly. The Senator's comment goes to the heart of the eligibility assessments which HIQA and other organisations would carry out as against the sort of things which the National Institute for Health and Care Excellence, NICE, would look at. Even in Scotland some of those decisions have varied. Based on local populations, different decisions have been arrived at from those in England. That is really a question on eligibility for the authorities here. Looking at demand and capacity - which we are here to talk about - having clear thresholds is an important part of keeping a handle on demand and ensuring that the activity is correctly directed at those clinically most justified. Other people will be held to account for those decisions. Similarly, the issue of medical cards is outside the scope of anything we can comment on here. A question was asked on medical cards. That is a detail. It would be for people to make a clear, clinical, economic and welfare judgment on the cases presented. The two systems North and South are clearly very different. However, they are both under huge pressures. At a detailed level, perhaps they will be making different financial decisions, based on some of the choices in front of them. In that regard, some variation is not unexpected between different systems and different parts of systems.

Deputy Kate O'Connell: Senator Conway-Walsh referred to the National Health Service, NHS, and the provision of free GP care. The witnesses, with their experience, might outline the current waiting times to see a GP in the UK. I worked in the NHS about 15 years ago. The system has changed completely, to my mind. I was there at the time of A Vision for Change. I am led to believe that people can be waiting up to three weeks for a standard GP appointment. A private healthcare system is also emerging in the UK that was never there before. NHS consultants are doing what consultants do here to some extent, namely, working in the NHS and then channelling some patients into their private facilities.

Although many people seem to hail the NHS as the great bastion of primary integrated healthcare, it is not all as shiny and rosy as people like to make it out. I will comment on the cost-benefit analysis. Perhaps the witnesses, who seem to know a lot about the cost of things, can respond. The cost of Versatis patches for one year here was going to be €36 million. That was the same cost projected for the whole UK population for the same time. If the witnesses have a calculator, they might perhaps tell us how many things we could have bought for that €36 million. How many beds could we have provided? Economic decisions have to be made in health. I absolutely recognise the value many patients found with those patches, but it was not just the GMS that was stopped, private patients were stopped as well. It is being brought up here, week in, week out by Senator Conway-Walsh.

Vice Chairman: I fully appreciate that-----

Deputy Kate O'Connell: It is unacceptable as far as I am concerned that it is being thrown out there-----

Vice Chairman: Deputy O'Connell, please.

Deputy Kate O'Connell: -----constantly every week.

Vice Chairman: Will Deputy O'Connell please stick to the topic? We are here to consider

the bed capacity review. The questions were asked in respect of the bed capacity review report. I ask for a response to those.

Deputy Kate O'Connell: With respect-----

Vice Chairman: I want to add something. Perhaps a comment might be forthcoming. I was leafing through some stuff here and some notes I had. According to the *Irish Medical Times*, the average length of stay in this State had fallen from 7.8 days to 5.5 days. How would there be a difference? Much of what was said in the last session was predicated on us being an outlier in respect of the average length of stay. However, it seems to me that we are not. If that forms a part of the report, or if some of what has been recommended hinges on that, perhaps the witnesses can explain because the figures I have to hand indicate that we have reduced our length of stay.

Senator Colm Burke: In fairness to the witnesses, medical practices have changed as well. In other countries also, the time people spend in hospitals has come down quite a bit more than here. All the clinical evidence shows that.

Vice Chairman: Perhaps the witnesses will comment on that.

Mr. Tim Daly: I will comment on the GP practice. I agree there is much more work to be done on integration in the NHS. On Deputy O'Connell's earlier points, there is something about the definition of primary care that in itself is not always helpful. There is stuff that needs to be done at home by home care packages and by clinicians. There is also stuff that needs to be done out of hospital. There is a question as to whether that is done in a GP practice or whether that practice is part of a health centre or whether it is done by practice nurses, pharmacists or a whole range of professionals. The NHS is looking at how one might disaggregate and define that care which is between what one historically would have thought of as default GP care and the referral to a consultant in a hospital. That is a real broad band of work. I agree many health systems are grappling with that same problem.

Mr. Chris Nightingale: In the baseline scenario of length of stay, it was examined at a regional level and by patient cohort as well. I refer to specialty and age group. The baseline was held as was. In scenario three - which looked at central hospital efficiencies - one of the outcomes of central hospital efficiencies, and integrated care, was reduction in length of stay. It was considered in scenario two as well. The Department was keen not to benchmark that against international comparators. Rather, it was keen to look within the Irish system at the length of stay. It was benchmarked against best performance internally. We looked at the median across all of the hospitals within age category and speciality. We asked what would happen if everybody got to the median level? For those at median, what would happen if we got to a 25th percentile? The answer was there would be some improvement over five years. That was felt by the steering group to be a reasonable improvement in length of stay. It was not a case of saying let us get to the position in Finland or Australia. It was to get to the best practice currently in Ireland. It was likewise with levels of allied health professionals, AHPs, and CHOs. It was all internally benchmarked against the best practice in the Irish system at the moment. That was felt to be a reasonable benchmark in respect of what should be pushed for, that is, scenarios that could be achieved rather than pie-in-the-sky scenarios.

Vice Chairman: I thank the witnesses. Are there any further questions?

Senator Colm Burke: On what Mr. MacGinnis said, I had a case in a Dublin hospital

where a person occupied a bed from February 2016 to November 2016. In May 2016, it was agreed that he needed to be moved to a step-down facility. However, there was a row between the HSE and the hospital as to where he should go and so a person occupied a bed from May 2016 to November 2016 while people were having a good stand-up row about how to manage it. That is an example of a hospital bed being occupied unnecessarily. It follows on from what the witness said earlier. That is one extreme example that I have come across. That was not in Cork but occurred in a Dublin hospital.

Vice Chairman: I think we could all list those type of cases. I call Senator Conway-Walsh to make one brief point. Then we will wrap up.

Senator Rose Conway-Walsh: It is on what Deputy O'Connell said. We cannot treat this in isolation. Within the cost-benefit analysis, I was trying to get at the fact that there are negative externalities that must be considered. One of those is not how many beds could we provide for €36 million but how many beds do we need to provide because of this decision that has been made. I will leave it at that.

Vice Chairman: I thank the Senator. I also thank our witnesses, Mr. Stephen Smyth, Mr. Tim Daly, Mr. Chris Nightingale and Mr. George MacGinnis, for their attendance and for the information and answers they have given in response to all our questions. We thank them for their time. As there is no other business, this meeting of the joint committee is adjourned. Is that agreed? Agreed.

The joint committee adjourned at 11.30 a.m. until 9 a.m. on Wednesday, 25 April 2018.