The Joint Committee met at 9 a.m.

Comhaltai a bhí i láthair / Members present:

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<th>Stephen Donnelly,</th>
<th>Colm Burke,</th>
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<td>Bernard J. Durkan,</td>
<td>John Dolan.</td>
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<td>Margaret Murphy O’Mahony,</td>
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<td>Kate O’Connell,</td>
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<td>Louise O’Reilly.</td>
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I láthair / In attendance: Deputy John Brassil and Senator Rose Conway-Walsh.

Teachta / Deputy Michael Harty sa Chathaoir / in the Chair.
Quarterly Update on Health Issues: Discussion

Chairman: The purpose of this morning’s meeting is to engage with the Minister, his officials, the new director general of the HSE and his staff to update the committee on current issues relating to the health service. On behalf of the committee, I welcome the Minister, Deputy Harris. Ministers of State will be coming shortly. I welcome Mr. Jim Breslin, Secretary General of the Department of Health and Mr. Paul Reid, the new director general of the HSE. I congratulate him on his appointment. We look forward to working with him in many years to come. We welcome Ms Anne O’Connor, Mr. Liam Woods, Dr. Colm Henry and, from University Hospital Waterford, Ms Grace Rothwell.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(l) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I advise the witnesses that any opening statements they have made to the committee may be published on the committee’s website after this meeting.

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

I alert members of the committee that the Minister is under pressure for time and needs to leave by 12.30 p.m. I ask them to ask concise questions. We have a representative, Ms Rothwell, from University Hospital Waterford, so we will also address issues relating to that.

Deputy Louise O’Reilly: Will that be a separate section or will we take them all together?

Chairman: The meeting will probably take on a life of its own. If we can deal with it within the substance of the meeting, that is good. If there are unanswered questions, we can devote some time to it. I ask the Minister to make his opening statement.

Minister for Health (Deputy Simon Harris): I am delighted to be here this morning. I thank the committee for the invitation and the engagement that I know we will have. I welcome Mr. Paul Reid, the new director general of the HSE, and his colleagues in the HSE. I wish Paul well in his new role, as I am sure we all do. He is a very exciting and important appointment for our health service at a crucial time when we have record levels of investment but also an ambitious reform programme that we need to deliver on. I also take the opportunity to thank Ms Anne O’Connor, the deputy director general, for her tremendous commitment while serving as the interim director general of the HSE for the past months.
I am happy to be here to give an update on recent developments in the health sector and issues affecting the Department of Health and the HSE. I am particularly pleased to report on a number of positive developments. We have spoken at length in this committee about the need to transform how our health services are delivered. Our population is rapidly changing and brings with it changing healthcare needs. Like other countries, the Irish health service needs to change radically if it, too, is properly to meet the health needs of our population. We need to rethink how we deliver services, placing a greater emphasis on prevention and population health initiatives to support people to live independently in their communities for as long as possible. We need to deliver efficient, effective, sustainable health and social care services to meet the needs of all of our citizens. This will require a whole society approach with new ways of thinking and of working together.

The good news is that Sláintecare provides us with that roadmap and vision for the future of healthcare. We have talked a lot at this committee about where we are with Sláintecare. I am pleased to say that we are now making substantial progress. The focus of our implementation plan is on establishing the building blocks for a very significant shift in the way in which health and social care services are delivered in Ireland, through the provision of four overarching goals and ten high level strategic actions. These include changes and improvements to our health services and a range of new measures to strengthen structures, governance and accountability. This system-wide reform process commenced with the appointment of Laura Magahy as the executive director to lead the Sláintecare implementation office. I know Ms Magahy has engaged and will continue to engage with members of this committee because it is important that we retain that cross-party consensus and buy-in to the delivery of Sláintecare.

We have an action plan for 2019 in place. This sets out a detailed and programmatic approach to the delivery and clear structure of how we will deliver this ambitious reform programme. We have had many strategies in the past. There is now a very programmatic approach led by Ms Magahy saying exactly what we will do, when we will do it, and how we will track that delivery. The Sláintecare team published its report for the first quarter recently and that showed that 28 of the actions that were due for delivery were all on track. Every quarter, we will publish a progress report on how we are getting on in that regard. I will also report to Government every quarter, with a memorandum for the information of Government. There will be nowhere to hide for anybody who does not want to get on board with this reform agenda. There is great enthusiasm across the health service, including the HSE and the Department of Health, for the delivery of this programme.

The budget provided more than €200 million of additional funding to support a range of priorities proposed in the Sláintecare implementation strategy. This includes funding for a modernised general practitioner, GP, contract and ultimately for the expansion of free GP care; new therapy posts to address waiting lists for children with disabilities; new development funding aimed at further enhancing mental health teams; reduced user charges and out of pocket payments for prescription charges on the drug payment scheme; and increased investment for the National Treatment Purchase Fund, which will be used to treat 70,000 patients on waiting lists this year. The overall additional funding also includes the €20 million Sláintecare integration fund, launched in March. This is very exciting and a different way of doing business. The health service is putting a dedicated, ring-fenced fund in place and inviting people involved in the delivery of healthcare to pitch their ideas. It asks how people can make Sláintecare happen in their primary care centres and organisations. Organisations do not have to be a part of the HSE. They can be voluntary organisations which provide health services. The enthusiasm for this fund has been overwhelming. Many people have put forward very good ideas. The fund
will focus on proposals that support the development of existing and new best practice projects that deliver integrated care, which shift services to the community and which have the potential to be scaled nationally. We will be announcing the projects to be funded by this year’s integration fund in the next number of weeks.

I am delighted to say that the transformation process required to deliver Sláintecare is well under way. However, there is a lot of work left to do. I am sure that this committee, under the chairmanship of Deputy Harty, will lead in that regard.

I have been asked many times when talks on a new package for GPs would conclude. I have always said that they would be finished shortly, and now they are done. I am particularly happy that my Department has concluded a landmark agreement with the Irish Medical Organisation, IMO, on a major package of GP contractual reforms. As I said in Killarney at the annual conference of the IMO, this is not the end of our engagement with GPs. We are far from finished. Indeed, the new agreement commits to a strategic review of general practice. This is a landmark agreement which will help transform and reform the Irish health service. It will help to stabilise general practice after very significant cuts during the austerity years and restore levels of funding. In return, GPs will sign up to do things in a new and different way. It represents a €210 million investment in general practice over the next four years. This is a 40% increase on the funding currently available.

A sum of €80 million will be available for the management of chronic diseases, which is a crucial Sláintecare initiative. The idea is that people with certain chronic diseases such as certain heart diseases, diabetes and asthma can now be treated in the community under this deal, seeing their local GP rather than going to the hospital. A wide-ranging set of modernisation measures has also been agreed in the areas of e-health, medicines management and multidisciplinary working. That agreement has been published on my Department’s website, and I am sure it will be happy to continue to engage with the committee.

We are making good progress on our primary care centres. We now have 127 fully operational care centres, up from 70 at the end of 2012. In 2018, 18 primary care centres became operational, a further nine will open this year, and 11 more will open in 2020. We are beginning to fill in the gaps throughout the country in terms of the provision of primary care centres. These should not just be viewed as buildings but also as infrastructure that can help enable change. In addition, eight primary care centres are at the advanced planning stage.

We are expanding our community intervention teams, CITs, and have increased the number of paediatric home care packages, PHCPs, being provided. The HSE is also progressing the improvement of access to radiology services for patients in primary care. There is no point in just having these buildings. We also need diagnostic tools in the buildings where appropriate. I recently saw an example of this in the Athlone primary care centre, where X-rays and ultrasounds are being carried out, taking significant pressure off the Midland Regional Hospital in Mullingar.

I will comment briefly on the progress we have made on the industrial relations front. The Labour Court recommendation on nurses and midwives envisaged a range of tangible and specific nurse practice measures that the court viewed as the basis for a fundamental change in the role of the staff nurse grade. It spoke of the need for a new enhanced nurse practice role. I welcome that there was a positive ballot by the Irish Nurses and Midwives Organisation accepting this Labour Court recommendation. This will result in a new contract for a new enhanced practice nurse who will be working in different, more flexible ways, help us realise transformative
change in the nursing profession, and help us to better support many of our nurses financially as well. I had an opportunity to speak to the INMO at its annual conference in Trim on that issue.

We need more capacity in the health service. We can carry out many reforms in the primary care system, but it does not get us away from the fact that we still need additional capacity in terms of beds. I am now regularly publishing an open beds report. I have or am about to publish the latest report, showing that the number of open hospital beds in Ireland continues to increase. The graph is very clear. After dips during the recessionary years, and perhaps before that, the number of hospital beds in our system continues to grow.

I have received the report of the de Buitléir group to examine the removal of private practice from public hospitals. This was a key recommendation of the Sláintecare report. I have nailed my colours to the mast politically. I am in favour of it. Not everyone else has. I welcome people’s views on the matter. My Department is considering the report and its recommendations. We cannot have a situation where public patients are deprived access to healthcare in busy public hospitals when private practice continues, in some cases unabated, in those settings. This will not be done overnight but will involve significant work and consideration by the Government. We will consider the report and its recommendations, engage with other relevant Departments and ultimately go to the Government for its decision. Under Sláintecare I gave a commitment to carrying out this independent review, and I thank Mr. Donal de Buitléir and his colleagues on that group for their work. It is a very comprehensive examination of private activity in public hospitals and contains a small number of recommendations. It takes a practical approach to removing private practice from public hospitals and details the impacts this removal would have, the timeframe that should apply and how it should be phased out.

The committee will be aware that we intend to bring in a new independent board and governance structure for the HSE. This will be very important and will coincide with the arrival of our new director general, who will become the new CEO. I have engaged with the Opposition on this, Deputy Donnelly in particular, in terms of amending the composition of that board. I expect to return to the Seanad next week to finalise the amendments we agreed in the Dáil. I certainly hope the Seanad will consider it. I will then return to the Dáil finally to adopt the Bill with a view to that board taking up office in June. It is very important. This was also a key aspect of the Sláintecare report.

It would be remiss of me not to acknowledge the Cross judgment. I have discussed it in the Dáil with the Chairman and other colleagues present. I continue to consider the judgement with officials, the State Claims Agency and the Office of the Attorney General. As discussed, we received correspondence from the HSE which sets out potential implications for, in particular, screening services arising from the judgment. It is important that we be allowed some time to tease through these issues and that we collectively work to address them. I ask those in leadership positions in the medical profession to work with me during this time as we reflect on the judgment and form a fuller understanding of the potential implications and what other jurisdictions do in this regard. I want the clinical community to know that I, as Minister for Health, the Government and the Oireachtas understands its concerns. We are committed to working with it to address its concerns. I intend to meet the leadership of the medical profession as part of my response to the issues arising.

Mr. Paul Reid: I am joined by my colleagues, Ms Anne O’Connor, deputy director general, Mr. Liam Woods, national director of acute services, Dr. Colm Henry, chief clinical officer, and Ms Grace Rothwell, general manager of University Hospital Waterford. I commenced my role as the HSE director general last Tuesday, 14 May 2019. Prior to this I was chief executive of
Fingal County Council for the past five years. Before that I was the chief operations officer in the Department of Public Expenditure and Reform. Most of my previous career has been in the private sector, mainly as an executive director with Eir. During my time in Fingal County Council I worked closely with community healthcare organisations, primary care centres and, indeed, many community-based projects and Healthy Ireland initiatives. In 2017, I was invited by former Minister of State, Deputy McEntee, to be vice chair of the national task force on youth mental health. I was also a member of the advisory council on Sláintecare.

As a committed public servant, there is no greater role than to be working with a dedicated and valued workforce, striving to make people’s lives better. I have set out three immediate priorities for the organisation and, indeed, for the new chairman and board. These are the delivery of quality and safe services to the public, including patients and service users; transitioning to a new model of integrated care; and strengthening the confidence and trust in the organisation from many of our stakeholders, including the public and patients. I look forward to working with the chairman and members of the HSE board, together with health services staff throughout the country, to achieve these important priorities. I also look forward to working with the Chair and the members of this committee and commit to providing them with the information they need to carry out their important role.

The Sláintecare report for 2017 signalled a new direction for the delivery of health and social care services in Ireland. It sets out a new model of regional and integrated care to deliver quality and safe services to our patients and service users. As mentioned by the Minister, to support early implementation, in budget 2019, €20 million was provided for the establishment of a Sláintecare integration fund to test and determine how services could best be delivered. I have been really impressed by how the system has responded overwhelmingly to date, from the bottom up, with initiatives that will ensure the integration fund will support reform in front-line services where we can make the greatest impact.

On financial matters which are very challenging for the organisation overall, I issued a memo within the organisation on 14 May. I understand it has been made available to the committee. It highlights the need to break even financially, while prioritising the safety of services. In the next week or so the chief financial officer, CFO, of the organisation and I will be meeting senior management to review plans and assess how we might be able to achieve this outcome.

Notwithstanding the strengthened controls, it is a fact that the health service is dealing with increased demands. This process is intended, therefore, to ensure we will commit resources, where required, within the available resources. It is a very challenging process, but we must build a culture where we deliver within the budget allocated to us by the Oireachtas and the State. We will be in a stronger position in the future to invest in the new models of care.

On scheduled care, it is a fact that waiting times remain too long. Notwithstanding this, there has been considerable progress made in reducing the numbers waiting for access to surgery. The figures published for April show that the number of patients waiting for inpatient/day case procedures was 70,295. This represents a decrease of over 9,000, when compared to the figure for April in the previous year. The investment made by the Government is greatly welcomed and supported by collaboration between the HSE, the Department of Health and the National Treatment Purchase Fund, NTPF.

Outpatient waiting lists remain too high, with 551,965 waiting for an appointment. The numbers waiting were adversely impacted on in the early part of the year as a result of strike action. To ensure a consistent approach to the validation of waiting lists, the HSE and the NTPF
have worked closely to establish a central validation office which is supporting the adoption of a consistent approach to the validation of waiting lists across all of the acute hospitals.

On unscheduled care, the demand for emergency care continues to grow year on year. The figure for the first quarter of the showed a 7.6% increase, at over 23,700 patients, compared to the figure for the same period last year. I fully acknowledge that there is a need for a significant improvement in waiting times for patients. It is a key area on which we will focus.

We have initiated a review of the winter planning process in 2018 and 2019. With the agreement of the Minister, the HSE is extending the review to include the commissioning of an independent expert group to carry out a review of emergency department performance and activity over the winter period on nine individual hospital sites and in their associated community healthcare organisation, CHO, areas. The expert group will examine emergency department performance, but in so doing will have regard to capacity, bed utilisation, internal capability, including consultant manpower, medical, nursing and overall staffing levels. It will report its findings and recommendations as part of the winter review report for 2018 and 2019. It is expected that it will be completed within a three month period. We believe it can result in some good evaluations and learnings, not just from the winter planning process but also overall as to what is best practice across the various hospitals and groups.

On the subject of mortuaries, the mortuary at University Hospital Waterford, UHW, is the south-east regional centre for autopsies. I recognise that the current facilities are not compliant with contemporary requirements. On my second day in this role in the HSE I visited the hospital and the mortuary and spoke to local management, staff, consultants and a pathologist. Interim control measures are now in place and additional refrigeration capacity is also being made available. In acknowledging the issues raised and concerns expressed by staff at University Hospital Waterford, a review of mortuary services is planned. It will include a review of existing mortuary facilities. The terms of reference for the review are being finalised and it is hoped the final report will be available in September. Mortuary capital development is included in the HSE’s plan and has been approved since March, with approval to go to tender in May. The expectation is a new building will be in place within two years.

On HPV vaccination, provisional uptake of the girls’ programme is at 70% in respect of the first dose in 2018-19, which represents an increase of 60% on the figure for the school year 2017-18. Older girls are coming forward to receive the vaccine where they had previously refused. This has to be welcomed by everybody. The second dose is being delivered in the period March to May and final figures will be available later in the year. Ongoing concerted efforts are required to be made by all healthcare professionals and opinion leaders to improve and maintain the level of confidence in the HPV and all other vaccines.

Ireland’s first gender neutral HPV vaccination programme is due to be rolled out from September, and a communications plan is in development. The vaccine to be used is HPV9 which offers protection against an additional five cancer causing strains of HPV compared to Gardasil4 which is currently being used.

A key message from the national patient experience survey from our reviews of adverse incidents and complaints concerns the critical importance of listening and responding to patients. The national patient experience survey is under way for the third consecutive year. During the month of May 28,000 patients who have had an inpatient stay in hospital will be invited to give feedback on their experiences. Over 84% of respondents rated their experience of hospital care as either very good or excellent. I look forward to engaging directly on the surveys with
patients in the coming weeks. Some 83% of respondents stated they had been treated with
dignity and respect and that they had full confidence and trust in the staff providing care. Some
96% of respondents rated their hospital room or ward as being very clean. This year the survey
programme will be extended to maternity services. In February 2020, 11,000 women will be
invited to give feedback on their experiences. I personally intend to visit a number of hospitals
in the coming weeks to promote the patient experience survey and thank staff for all of their
valued hard work and commitment to the programme.

Chairman: I thank Mr. Reid.

Deputy Stephen Donnelly: I thank the Minister and his officials for giving of their time. I
wish Mr Reid the very best of luck in the not inconsiderable task he has been handed. There is
a huge amount of work to be done.

I will return to the question of access, but I will start by making two specific points. One
concerns the availability of Spinraza, an issue we have all been following closely. There are
families who are watching intently and will have noted that the NHS recently approved Spin-
raza for use. The clock is ticking for their children and they asked us to put the following three
questions directly to the Minister. Is there a definitive date on which a decision on funding will
be communicated? Is the answer “yes” or “no”? What is causing the delays in the decision-
making process relative to what is happening in other EU countries? Is there an explanation for
them? Is there a definitive timeline for how quickly access to the drug will be made available
if the decision is positive?

Deputy Simon Harris: I genuinely recognise that it is a very stressful time for families,
that they have been waiting more than patiently in very difficult circumstances and that they are
worried about their children in the context of the availability of this drug. It is also important
to recognise that the HSE has the statutory power to make such decisions. Neither I nor the
Deputy has that power. It is very clear that under the Health Pricing Act responsibility lies with
the HSE.

I am also conscious of the fact that it takes two sides to negotiate an agreement. The HSE
has been working to try to secure a good agreement, but I am very clear that we need to make
the drug available. The HSE is aware of my views on the matter. While being very respectful
of the processes that are being and have to be gone through, I am very clear that the drug needs
to made available. I ask the director general to comment on the specifics.

Mr. Paul Reid: I will ask the chief clinical officer, Dr. Colm Henry, to comment, but in
response to Deputy Donnelly’s questions, like Minister, I completely understand the concerns
of the families and children involved in raising this issue which is very real. To put it in the
context of drugs approval, 23 drugs have been approved by the HSE and the drugs committee
that oversees the process within a budget of €10 million. Decisions are made based on a num-
ber of criteria, one of which is cost effectiveness. On the availability of Spinraza specifically,
the drugs committee has gone through a process and by a small minority considers it would not
be cost-effective to make it available. It used a range of criteria in making that recent decision.
I have asked for that decision to be brought back to my leadership management team and that
will be done in early June. As the Minister has said, there is an ongoing process involving nego-
tiation and cost-effectiveness. I have asked for the issue to be brought back to my management
team in early June. I am very conscious of the NHS decision and where Ireland now stands in
that regard. Everybody wants to make the right decision about this drug, including me, and that
is the track I want to get us on. I just need space and time to bring the process back to my lead-
ership team and assess that decision. We will make the decision. That is exactly where we are.

Deputy Stephen Donnelly: That is fine. The second issue I would like to touch on is the decision to move the Coombe Hospital to the St. James’s Hospital site, which the Minister and I have discussed previously. I believe everyone understood at the time that tri-location was the main argument in favour of moving to the St. James’s site. I will put aside the question as to whether the St. James’s site was the right one, it came as a surprise to me to learn that planning and design had not started given that in 2015 the then Minster for Health, now the Taoiseach, gave a commitment that the development of the national children’s hospital and transfer of the Coombe would be progressed in parallel. The last time the Minister appeared, he informed the committee that no funding was available in this year’s allocations to even start the Coombe project. I asked him to give a commitment to see if he could allocate new funding to start the project. What is the current position? Has new funding been allocated to at least get the design and planning process under way?

Deputy Simon Harris: The Deputy has been pursuing this for some time so I will not go back over old ground other than to make two brief points. Under the national development plan, we are planning to move all of our stand-alone maternity hospitals to the site of an acute adult hospital. The Deputy will be aware of plans to move Limerick maternity hospital to University Hospital Limerick, Holles Street maternity hospital to St. Vincent’s Hospital, the Rotunda Hospital to Connolly Hospital and the Coombe Hospital to St. James’s Hospital. That is Government policy and all of those moves are funded in the national development plan. I am not suggesting the Deputy is doing this but some people, particularly those opposed to the national children’s hospital, have suggested that somehow we are not planning to move the Coombe to the St. James’s site. We are planning to do so, as I know the Deputy is aware. Tri-location is still the intention. In terms of capital projects in maternity services, we will go ahead with Holles Street first. We have secured planning permission and started the enabling works and the plan is to move Holles Street hospital to the site of St. Vincent’s Hospital.

There is an issue with logistics. We have obviously taken advice on this and even with all of the money in the world, it would still make sense to build the children’s hospital first rather than do two major projects on one site. I accept that the Deputy did not ask me to build two major projects on one site. The logistics or sequencing is that one builds the children’s hospital and then the maternity hospital, and I am satisfied that this approach makes sense.

The Deputy asked whether there is preparatory work we could do in the interim to avoid a major time lag between the completion of the national children’s hospital project and the move to the St. James’s site of the Coombe Hospital. That is a logical point and he has won the argument in that regard. When I met representatives of Children’s Health Ireland recently I asked them to think about what sort of preparatory work could be done by Children’s Health Ireland and the Coombe. As the Deputy knows, the Department is finalising its capital plans with the Department of Public Expenditure and Reform. I expect to be able to move ahead with some of the necessary preparatory work and I will inform him of progress once those talks have been fleshed out.

Deputy Stephen Donnelly: Access is the big issue. I acknowledge that some progress has been made on reducing inpatient waiting lists through the deployment of the National Treatment Purchase Fund, NTPF. That figure is beginning to come down, thank goodness. However, right across the system access is continually worsening. For the first time ever, we have more than 550,000 people on the outpatient waiting list. The number of people waiting for more than a year and a half is particularly striking. The figure, which was 13,000 about three
years, has climbed to more than 800,000 people. That is an 800% increase in just three years in the number of men, women and children who are waiting to see a hospital consultant. We all know that children around the country have been waiting up to three and half years just to get an initial special needs assessment and therapy in various areas. I looked at the current waiting lists while preparing for this meeting. As well as the longest outpatient hospital waiting list ever, they show massive geographic variance in waiting times. There is a postcode lottery that differs in different parts of the system. More than 40,000 people are waiting for an outpatients appointment in Galway University Hospital. In Limerick University Hospital, the figure is nearly 35,000 people. In University Hospital Waterford it is 40,000 and the figure for Tallaght hospital is more than 30,000. In other areas such as waiting lists for physiotherapy, there has been a big spike in Waterford, for example, where nearly 2,500 people are awaiting an initial physiotherapy appointment. In County Wicklow, more than 1,000 people are waiting for an initial assessment for occupational therapy. A postcode lottery exists depending on whether one needs to see a doctor, a physiotherapist, an occupational therapy or another specialist.

I have a broad question for Mr. Reid and the Minister. Given that there has been an unprecedented increase in healthcare funding, with nearly €3.5 billion extra provided in the past few years, why are people waiting longer than ever to be diagnosed by doctors and receive treatment? What is going on that these two things are occurring at the same time?

**Deputy Simon Harris:** I will start with the Deputy’s final question. The plan this year, for the first time in many years, is to have fewer patients waiting for an outpatient appointment by the end of the year than at the start of the year. I accept that is not a radical advance but it will be the first year in a number of years that we will end the year with fewer patients waiting for an outpatient appointment than at the beginning of the year.

We have talked about there being more people than ever on waiting lists. It is important to acknowledge that outpatient waiting lists were not kept and published until 2011 or 2012 so that is a new departure, which is good. Every year, the health service sees about 3.3 million outpatients so this number of people will go to an outpatients clinic this year. Only about 1 million of them will be first appointments, which means about 2.3 million will be repeat appointments. One of the challenges for us is to reduce the number of return appointments to the hospital that are needed. This means the patient will see the consultant, as necessary, but the ongoing management of the chronic condition will be done in the community. One of the big wins in the GP contract is that, over the lifetime of the agreement, 400,000 patients will be treated in the community who would have been treated in the hospital previously. The Deputy asked how we will fix this. We will do this by significantly reducing the number of people who must repeatedly return to the consultant by trying to have more of them seen in the community.

This is the first year for many years that we are using the NTPF to provide support for outpatients. We have asked, through the HSE, all hospital groups and hospitals how can we help them using a fund in the NTPF for outpatients. Until now, we have only used the NTPF for inpatient day cases.

I make this point because we must grapple with it. About 500,000 people missed their outpatient appointments last year. People do not miss appointments unless they have a good reason or the lists are inaccurate. We need to get under the bonnet and I have asked the HSE and NTPF to do some work on the matter through the central validation office. If 500,000 people or thereabouts were offered an outpatient appointment last year but did not turn up, what does that tell us about the waiting lists? We will do a number of things this year, primarily using the NTPF to provide extra support on outpatients for the first time in a number of years.
The strike definitely had an impact on the outpatient lists at the start of the year but it remains the plan that there will be fewer patients waiting at the end of the year than at the start of the year. We need to look at what we are measuring in terms of waiting if 500,000 people did not turn up for appointments last year.

Mr. Paul Reid: I will make a few general comments before asking some of my colleagues to make some specific points. In terms of what the Minister referenced, I have strongly heard from all across the organisation the requirement to conduct a deep assessment of the validation lists. As the Minister has touched on, we have kicked off that process with support from the NTPF. I am hearing it from consultants, staff, nurses, etc., that a wide assessment is needed and that process will help us.

Without doubt, and to state the obvious, the demographic pressures are all upwards in terms of requiring outpatient appointments and that has been well proven. Deputy Donnelly is right that there are certain demographic issues in terms of geography and different spread and some of the impacts on us.

I should also mention the new models of care. One of the big strategic intentions behind Sláintecare is the move to an integrated model of care whereby we increase capacity in the community. In my previous role I visited many primary centres and supported the building of them. There is no doubt that they have capacity for the future when we can invest in some of the diagnostics for them and so on. By continuously running with the same model, we will chip away at it but our real move has to be to transition to the new model of integrated care. My role is to work with the team in Sláintecare and with the Department in order to start moving us in that direction and, as the Minister stated, to leverage off the agreement with the GPs, and how that agreement can be deployed locally, and to leverage off the recently concluded nurses’ agreement, and how we can move to the implementation of that for the deployment of nursing care into the community in a stronger way.

Reference was made to the budget, which is a very real issue. I touched on it in my opening statement. The national service plan budget for the start of 2018 was €14.5 billion and the outturn was just over €15.2 billion. This year we have €16 billion. We have to assess how to deal with the upper pressures on the HSE, which are very real, with the demographic issues that press on the health service and with the move to the new model. It is a very challenging environment of assessing every cent and euro we have and where we currently put that money. It is my early assessment that if we continue to put it into the current system of congested acute care and outpatient care, we will make slow progress. I really want us to transition to the new model on a collective basis.

While the assessment we have kicked off primarily focuses on and relates to the winter programme and emergency departments, it will tell us a lot about where there are better processes for management of the patient through group hospitals and CHOs. I visited Waterford and Tullamore last week and I will be visiting other hospitals. One can see variance in respect of how outpatient progress is managed. I want to ensure that we have best practice and that we understand what is best practice. I am hearing a major call from across the service to really look at that. I am seeing some excellent practice, including in Waterford and Tullamore, regarding the management of the outpatient experience and the follow through. We will have to focus on all of these matters. I appreciate that it is a challenge. I shall ask my colleague to provide some specifics.

Ms Anne O’Connor: The Deputy referred to figures. From our March data, we are aware
that more than 94% of people who were referred to speech and language therapy and physiotherapy were seen within 52 weeks. One could argue that this is still a long time if one has a child waiting for a service, but it is more than 94% now, which is better than it used to be. We are definitely challenged in the context of occupational therapy and we are working on this. There are some important aspects to note. There are 100 posts, as the Minister indicated, notifications of which are going out to the CHOs this week. These posts are particularly for disability services and will help with some of those therapy waiting lists.

On shifting the model of care, we also have a therapy in schools project in CHO 7 in the Kildare area. We are aware that early prevention is key, especially with children, and the initiative has some 30 therapists working across all the schools. The idea is to pick up children much earlier in order that they do not require the service further down the road. This pilot project has proven to be very positive and successful. We are looking at models and building on this integration across our community services. Within the community we are not always that integrated, never mind between community and hospital, so our first step is to have the community services integrated. We will have nine learning sites for community health networks this year and that will allow us to apply a population view in how we deliver services. There is a lot of duplication with people sitting on different lists; the same child could be sitting on a number of lists. If we tackle it from the population perspective within the network, this will allow us to co-ordinate the delivery of care in a much more streamlined and effective way. We have a number of things going on but I take the point that was made. We are absolutely trying to improve access to community services.

Mr. Liam Woods: On the practical aspects, the Deputy asked about a potential way forward. Unfortunately, we lost approximately 13,000 outpatient appointments on each of the three strike days. We must work this back. That is the most recent significant negative shift associated with that. When we consider the specialties, the GPs and the specialist consultants in the ENT unit in Letterkenny, for example, have agreed a protocol of care, as Mr. Reid stated. They have undertaken an exercise to clear backlogs in waiting lists in order to guarantee priority access for urgent cases and to support that with diagnostics in the hospital. This is part of what is needed. This pilot worked and I believe the GP contract will enable that to work further. The orthopaedic programme has identified that musculoskeletal physiotherapists can remove 85% of the people from the waiting lists now. We are investing in that because it is a critical resource and a community investment. Those physiotherapists really need to be out in a community space. We are aware that there are some 4,000 hip fractures per year and a lot of work has happened to see how falls can be avoided. The outcome of a hip fracture is very difficult for individuals and we are looking at strategies around falls prevention, which will avoid the original need. This is very important.

A final example is ophthalmology. We are now looking at working with clinical leads and some of the hospitals, including the Royal Victoria Hospital in Belfast, to provide ophthalmology services at primary care centres. The crossover is important in order to begin to look at this as a whole system challenge and not an outpatient list sitting there in isolation. We are going to have to address it specialty by specialty. It is also a reality that the referral rate is higher than the treatment rate. There is no question that we must change this.

Deputy Stephen Donnelly: I thank Mr. Woods.

Deputy Louise O’Reilly: I welcome the Minister, his officials and Mr. Reid. As someone who does not have private health insurance, I genuinely wish Mr. Reid the very best because I am relying on him - as are many people - to do a very good job. I am sure he will.
The nurses were on strike for three days but the HSE has no excuse for the other 362 days. Every person who has spoken - bar one - mentioned the three days of strike as if this somehow explains the massive and ongoing waiting lists. I do not believe that is very fair.

I have some questions on the recent settlement reached with nurses and the ongoing issue around the recruitment of consultants. Has the HSE set itself any targets for this recruitment? The nurses’ strike took place in the context of what is known as the recruitment and retention crisis. I am aware that the word “crisis” loses a bit of meaning because everything is a crisis at the moment. Presumably, the settlement of that strike should result in additional staff being recruited. Has a budget been put aside for the additional staff? Has the HSE set any targets in respect, for example, of how many nurses it wants to attract home from abroad? Survey after survey shows that nurses leave Ireland after they graduate because they believe the health service in Ireland is not an attractive place for them to work. The purpose of the settlement - as I understand it - is to see more nurses in the service but we will not be able to quantify this unless targets have been set.

Mr. Woods and I have spoken several times about the setting of targets for the conversion of agency staff into directly employed staff. We are all going to agree - because we do agree - that the use of agency staff does not represent good value for money. Years ago, agencies were used a temporary stopgap but now entire shifts rely on agency staff. It is expensive and I believe that it is a form of outsourcing by stealth. Has the HSE set any targets for this in the context of recruitment? I had asked this question previously of the Minister and he indicated that he would get an answer for me. While the answer is not overdue, I just wanted to know if the Minister has a response regarding the urgent care centre at Connolly Hospital Blanchardstown. It was promised to be open from 8 a.m. to midnight seven days per week. I do not believe the staff will be in place to do this. Will we be fobbed off with a 9 a.m. to 5 p.m. service, a press announcement and a ribbon-cutting ceremony? I do not think is very fair. Is the Minister in a position to confirm that the staff have been recruited? If letters and start dates are not already in the pipeline or on their way then the service will not be able to operate as was promised from 8 a.m. to midnight seven days per week. It would only be able to operate on a short-term basis. If the staff are not in the pipeline, they will not be there for the scheduled opening date at the end of June. Can the Minister confirm that?

Deputy Simon Harris: I know that the Deputy would never mean to be flippant but regarding her comments on the ribbon cutting at Connolly Hospital, I answered a question on this last week and will repeat the response today. The opening of Connolly Hospital this summer, at the end of July, will result in an additional 6,000 children being seen through outpatient clinics there. Additional children will benefit from the opening of this facility this year. It is a facility which when it opens for a full year will cater for 33,000 additional appointments. It is not overdue and I appreciate the Deputy saying that. The answer remains as it was last week in that I am waiting to hear back from Children’s Health Ireland on its decision about opening hours. From memory of the question last week, all the nursing posts have been identified and significant recruitment has been made in the area of consultants.

Importantly, it is not just me, the Government or the HSE which is saying that the nurse’s deal will help with recruitment or retention; the INMO is also saying that. This was stated clearly at its annual conference in Trim two weeks ago, which I attended along with the director general. The union genuinely believes that this deal will help us retain our nurses, which is the metric by which we can measure the success of the deal, if we are honest. For the third year in a row we will offer every nurse graduate a full-time job in the health service, which is the easy
bit; the challenge is retaining them. As the INMO acknowledges, we are training more nurses than ever and we are training enough of them, but we are not retaining them. Where we offer every nurse graduating a full-time job we must ask how many are still in the health service after several months or years. That is how we will judge the deal’s success or otherwise. Now that the deal has been just accepted by the INMO we will move to the implementation phase. We will have to establish structures and these will have union representation. It is important to acknowledge that the deal includes nurses working in new and different ways. It talks about flexible working, changes to contracts and new contracts etc. ------

**Deputy Louise O’Reilly:** I am sorry but my question was about targets. Has the Minister set them?

**Deputy Simon Harris:** Yes, but the Deputy also asked how we would fund the deal. That is the point to which I am referring. The deal will be partially funded through some of the reforms to the nurses have signed up through acceptance of the ballot. I will ask the director general about targets and implementation.

**Mr. Jim Breslin:** I want to add a point on Connolly Hospital, as I know that the Deputy asked about the number of additional consultants in oral questions last week. There are approximately ten consultants and the Deputy had asked if they were all additional. We checked this. One appointee was an emergency department consultant in Tallaght who will become a paediatric consultant in Connolly Hospital but all the other posts are entirely new. A locum is in place to backfill the consultant from Tallaght. The staff going in are new additional staff.

**Mr. Paul Reid:** I very much welcome the settlement with the INMO. I have met its general secretary several times. We share a view and interest that the agreement be maximised and implemented to its fullest. Details of that will be discussed further by the Department and the unions involved.

To give some context on staff recruitment, in the first quarter of 2019, the total staffing numbers for the HSE increased by approximately 1,100 of which 550 are graduate nurses, so that is not included in the whole-time equivalent count. If one removes the graduate nurse recruitment, the figure is approximately 600.

**Deputy Louise O’Reilly:** Does that include final year students?

**Mr. Liam Woods:** The difference coming between 1,100 and 600 is the elimination of students as they come and go, as the Deputy will be aware.

**Deputy Louise O’Reilly:** Yes, but they used to be counted as 0.5 whole-time equivalent.

**Mr. Liam Woods:** They still are now.

**Deputy Louise O’Reilly:** They are still counted in that.

**Mr. Liam Woods:** They changed back.

**Deputy Louise O’Reilly:** They are there as 0.5 whole-time equivalent.

**Mr. Liam Woods:** Yes, human resources changed that.

**Mr. Paul Reid:** The overall point is that with more than 600 in the first quarter, we are currently recruiting 200 per month. The highest proportion of that 600 is in the nursing sector.
There has been significant recruitment throughout the year. The national service plan provides for approximately 2,000 overall in its budget for total staffing so there is a facility for further recruitment.

On the plan for the rest of the year, the Department has set out some of the challenges to coming in within budget but there is no recruitment embargo. All the individual areas and the current process will have to be approved in budget. That is continuing to happen. Recruitment, particularly in nursing, will continue for the rest of the year. It has been the highest proportion in the first quarter but approvals will have to be within budget.

Deputy Louise O’Reilly: My question was had the Department set targets. It might have been quicker to say, “No”.

As an aside, Ms Rothwell is welcome but her presence was not flagged to committee members in advance and was not referenced in any of the opening statements. I have some questions for her but we were not prepared or alerted to the fact she would be here and I assumed that there would not be a representative of University Hospital Waterford when I checked the opening statements prior to the meeting. If Deputies from Waterford had advance notice, they would have rearranged their schedules to be here. While we will have a separate session, I wanted to point that out. I do not mean any disrespect, but to say that, I had assumed there would be no representative here, although we had flagged that there might be discussion on University Hospital Waterford.

The issue of consultants who are not on the register is serious and we have discussed it previously. I had a detailed discussion on this with Ms Rosarii Mannion the last time we had a session. I am still at a loss to know whether anything has been done to prevent this from happening. We are all aware of the rights and entitlements of a person to a contract of indefinite duration. An increasing number of consultants are engaged in specialist activity who are not on the specialist register and they are being paid as though they are on the register while fulfilling those roles. Every day that goes by they come closer to a legal and lawful entitlement to a contract of indefinite duration. Those conversions are just being repeatedly rolled over. I asked Ms Mannion about this on the previous occasion. I pressed her on it and I will ask again. I ask whoever responds not to go on a tour of the houses; if the answer is “No”, that is fine. Is there any plan to deal with this issue? It has been raised in the courts and the officials do not need me to tell them it is a serious issue. Is a plan in place in advance of what has been done, because we can all agree that whatever was done in the past clearly has not worked because more consultants continue to be added to it? We all know how contracts of indefinite duration work. There are people who are currently on the road towards a contract of indefinite duration and the HSE will not be in a position to do them out of their rights, nor should it, but is there any plan to put qualified consultants in these posts?

Ms Anne O’Connor: I will take that and ask Dr. Henry comment as well. There is now a plan. A group has been established that I am chairing which is focused specifically on medical recruitment, supervision and patient safety. There are several work streams within that. The first relates to the issue raised by the Deputy where doctors who are not in the specialist division are employed as consultants. We will also examine non-training scheme doctors, the recruitment processes relating to non-consultant doctors and consultants, retention, and configuration of services. Taking the Deputy’s point, we know that we are very challenged on this. We have had a team working under Professor Frank Murray, which has gone around the country to assure itself of governance and to ensure adequate supervision is in place today and that there are no risks in this regard. Much work has gone on but we know that strategically we need a far more
robust plan which looks at how we address this now and in the future.

Deputy Louise O’Reilly: Ms O’Connor said that supervision is in place. Is that for every single consultant so that each consultant who is not on the specialist register but is paid and working as though he or she is comes under some form of supervision?

Ms Anne O’Connor: Yes, and we have had a report back.

Deputy Louise O’Reilly: Does that mean that they do not work on their own or how does that work?

Ms Anne O’Connor: Dr. Henry can speak more to this. There are clinical directors. We have been out to each area to check them. Consultants do not work under supervision per se but there is a governance framework within which they must work. We have been around and checked with executive clinical directors as to how that framework works in each area. The team is satisfied there is a process in place now in every area when there had not been. The process we have started is about developing a much more robust approach to how we bring in consultants in the first place. We know about the concerns and there was reference to courts etc. and we share such concerns.

Deputy Louise O’Reilly: When Ms Rosarii Mannion was here, I asked if there was a running total of people heading in the direction of a contract of indefinite duration and if it was being monitored. It did not appear to be. Does the presence of this new process and work streams mean the monitoring is now in place and that X number of consultants are on their way to a contract of indefinite duration and they will get it in the next year or two years?

Ms Anne O’Connor: There is a much stronger spotlight on this at a local level in managing this particular issue. We know that as part of the work that has happened, a number of consultants have left. We are encouraging anybody to go for registration and supporting them in doing that. There are reasons people cannot or will not do it. That work is really kicking off and Dr. Henry and I are co-chairing that because it is critical that we have the medical bodies involved as well. Dr. Henry might comment from the medical perspective.

Dr. Colm Henry: I will not take up much of the Deputy’s time. There are over 3,300 consultants in Ireland and off the post-2008 non-specialist register, there are approximately 106, with a third of those in mental health. It is important that patients or people relying on services understand that consultants do not work in isolation but rather as part of a team. They all report to a clinical director, whether or not they are on the specialist register. The difference with the specialist register is that it is a badge of quality following the enactment of the Medical Practitioners Act 2007. It allows us to know that somebody has been trained according to our training schemes and in line with other European Union training schemes.

Based on those site visits that Ms O’Connor referenced, no safety concerns were raised about the practice of these consultants. It is clearly our preference to move towards a position, as outlined in many reports, where we have no junior doctors who are not in training schemes and no consultants who are not on the specialist register. There are considerable challenges for us, not least the fact that these people were delivering unscheduled care in 26 sites around the country. In an environment right across Europe where recruitment is quite difficult, it is becoming increasingly challenging for us to provide unscheduled care on so many sites. There is a context in recruitment that requires understanding, and it is not just being felt here but in other European countries as well.
**Deputy Louise O’Reilly:** As unscheduled care is really the nature of the business these people are in, it should not come as any surprise. The Minister indicated there are 127 primary care centres that are fully operational. I have one in my area that I have referenced many times. Mr. Reid would be familiar with the one in Balbriggan. No additional staff were provided for that, despite the growing population, and no diagnostic equipment was provided either. I asked about this via parliamentary question recently and the answer I received was that there are no plans in place currently to provide additional diagnostic equipment. This is a local issue but it is extremely important if one has to travel to town all the way from Balbriggan for every little scan.

When will we see the capital plan published and will it contain references to the primary care centres and additional diagnostics for the primary care centres? The reply I got from the Minister’s office indicates there were no plans to put in place any additional scanners or diagnostic equipment into Balbriggan. While that was a response to a question on a local matter, is that response being replicated everywhere else or is there a plan in place to have diagnostics in primary care centres? Will additional staff be recruited? I have asked parliamentary questions on all the primary care centres and the answer is the same. I am sure much care and thought goes into it but it is really just the exact same words in every reply. The indication is that services will be provided from within existing resources, which is code for there not being new or additional staff. Is there a staffing plan for the primary care centres?

I am conscious of the time so I will be brief. I absolutely welcome the Damascene conversion to public provision of healthcare rather than private provision. It does not really gel with the National Treatment Purchase Fund but, that aside, how is this squared with the building of a private clinic within the proposed national children’s hospital if the plan is for private provision of healthcare to be phased out? We are really stacking in private healthcare and paying for the infrastructure in order that private healthcare can be delivered from within our public services. Now that the Minister has seen the light, that piece of infrastructure might be put to better use for the public service.

**Deputy Simon Harris:** If the Deputy thinks I am on the road to Damascus, some Members in the Oireachtas are still googling it to find out where it is before they even get on the road. I very clearly nailed my colours to the mast long before any de Buitléir report that I do not believe such a position was appropriate. Deputy O’Reilly would never do it but she could never cast any doubt over my position or the position of the Government on this matter. I want to see public practice in public hospitals. Quite frankly, what consultants do outside those hours in private hospitals is a different discussion but I want to see public beds used in public hospitals for public patients. That is how capacity can be increased and while it might make both me and the Deputy somewhat uncomfortable, it is something on which we genuinely agree. It is in the Sláintecare report. It indicated this should be mapped and we should work out how to do it rather than just jumping right in. That is what I have done with the de Buitléir report.

If the contracts and practice change, the use of any facilities will change as a result and it will be no different for the national children’s hospital either. Mr. Reid can comment on the staffing issue with respect to primary care. It is important and we are increasing staff right across the health service. We are continuing to increase staff in primary care and we have just referenced 100 more therapy posts as well. They will work in primary care and some will work in primary care centres. We are increasing those numbers and I will ask the HSE to come back with specifics.

The Deputy asked an important question about diagnostics. If we can put more diagnostic
equipment into primary care centres, we would decrease the number of people going to hospital and would be providing more services locally and at greater convenience to the patient, which makes sense. I am not talking about any specific primary care centre but we know there cannot be diagnostics in every primary care centre. There are different types of primary care centres, with some being larger or built for diagnostics while others are not. While some serve large enough catchment areas, there are clinical issues with respect to safety and the number of patients that are seen. Oversight must also be taken into account. I visited Castlebar primary care centre, which has an excellent radiology facility but the clinical governance is done by Mayo General Hospital. There is an exercise going on as part of Sláintecare to map where we should have our diagnostics within the community. There is no doubt that will require funding. The Deputy asked about the capital plan and it will show how we intend to advance that. I expect the capital plan to be published by the end of June.

**Deputy Louise O’Reilly:** The end of June is halfway through the year. It was reported that there would be a private facility within the national children’s hospital but is the Minister now saying that is not the case and this portion may be used for other services? It was not clear what the Minister said.

**Deputy Simon Harris:** Whether we are talking about a children’s hospital, a maternity hospital or an adult-----

**Deputy Louise O’Reilly:** I am specifically talking about that portion of the children’s hospital.

**Deputy Simon Harris:** That is fine. I am basically saying that regardless of the hospital, the rules will be the same. If the rule is that there should be no private practice in public hospitals, there will be no private practice in any public hospital, whether it is the children’s hospital or elsewhere. In fairness to people developing hospitals, that is not the position now and our consultants are not operating under those contracts, so private practice is taking place in public hospitals. I am saying that if the practice changes - I cannot pre-empt Government decisions on the de Buitléir report and all that stuff - the use of those facilities will change as well.

**Deputy Louise O’Reilly:** If it does not, we will be paying to build a private facility within that project. At some point we will claim back some money.

**Deputy Simon Harris:** That is not a fair representation. My understanding is the consultants will pay for the use of those facilities.

**Deputy Louise O’Reilly:** I do not see it as an unfair representation.

**Deputy Simon Harris:** I do but we cannot agree on everything. It would be very boring.

**Deputy Louise O’Reilly:** We do not agree on everything.

**Deputy Simon Harris:** It would be terrible if we agreed on everything. It would not do the Deputy any good.

**Mr. Paul Reid:** I have a few comments on the Deputy’s specific question on primary care. The Minister touched on the plan for further and current deployment. I relayed earlier some of the recruitment that has happened, and some of this is within primary centres. The 100 therapy posts have just been approved and they will be deployed to communities, specifically in primary care centres to enhance them. The intention has never been that diagnostics would
be in every primary care centre. It will depend largely on proximity to acute hospitals and it is intended for some. Primary care forms an element of our capital plan in terms of employment and the current service plan. Over €15 million is committed to service redesign, to which I referred earlier, to move it further into the community. We touched within that on community health networks, which are about people working at local level, specifically in primary care centres. That will form part of that €15 million investment in the service plan.

Chairman: I thank Mr. Reid. Our next contributor is Senator Colm Burke.

Senator Colm Burke: I thank the Minister and the new director general of the HSE, to whom I wish every success. I look forward to working with him. A great deal of focus this morning has been on healthcare in Dublin. I want to get the message across that healthcare is provided in other parts of the country too. In particular, I want to focus on Cork. I submitted a question to the health committee last November on the elective hospital for Cork. I was advised that no progress had been made on that matter in real terms. However, I received a document dated September 2018, which sets out that the HSE proposed the establishment of a project team. That project team has now met and consists mainly of people from the HSE. There are 12 people on the board, nine of whom are from the HSE, one is from the South Infirmary hospital and one of whom is from the Mercy Hospital. However, the South Infirmary is the main elective hospital in Cork, which suggests the board is not properly constituted. I want some explanation as to why the joint committee was not given the full information in November when the question was put in and as to what the proposal is now on prioritising the building of an elective hospital in Cork. There has been a huge growth in the population of Cork and the southern region generally. While we are building three new hospitals in Dublin, we need to focus attention on the regions also. I seek clarification on how it is purposed to move forward with the project team for this hospital, on the timeline for identifying a site and on the planning process. That is my first question. I want to ensure the focus is not totally on healthcare in Dublin. There are also places outside Dublin which provide healthcare.

My understanding is that there are more than 500 vacant consultant posts currently. People go on about waiting lists, but one will have waiting lists if one does not have someone available at the head of a team to conduct clinics and so on. Across Europe, one third of all medical practitioners are over 60 years of age. That is the figure for every country across Europe. As such, we are now competing for consultants in a world market. I understand that some consultant posts are being advertised in respect of which no applications are being received. How do we propose to review that issue to make it attractive for people to come back to Ireland or stay if they are already here? We are competing with New Zealand, Australia, Canada, the UK and the USA. What are we going to do over the next 12 months to make it more attractive for people to apply for posts being offered in Ireland?

We talk about waiting lists and hospital clinics. Over 12 months ago, I raised the issue of haemochromatosis and a very straightforward procedure for blood to be taken monthly to address high iron levels. I have worked with GPs in Cork who wanted to provide this service to avoid people having to attend hospital. I cannot understand how such little progress has been made on this issue. There are a number of other areas where GPs are prepared to provide services and, as a result, to keep people from having to attend outpatient clinics in hospitals. Has the HSE or the Department identified services which are currently being provided to large numbers of people in hospitals that could be provided in the community? In relation to haemochromatosis, the GPs involved had long discussions with UCC, the medical practitioners in Cork and the blood bank on co-ordinating a service. I ask the Minister and Mr. Reid to deal
Deputy Simon Harris: While I take the point Senator Colm Burke makes passionately about the importance of service outside Dublin, including in Cork, I must point out that we are talking here about national projects. While they might be located in Dublin, they are national services. For example, 3,081 sick children from Cork attended our children’s hospitals in Dublin over the past two years. As such, while the national children’s hospital and other major national projects are located in the capital city, as opposed to the real capital, other areas are benefiting from the investment in services.

Senator Colm Burke: I accept that.

Deputy Simon Harris: The Senator is not making the point, but it frustrates me when people suggest that all of the projects are in Dublin, when they are in fact national projects that will transform the lives of children, including children from Cork, whose parents have had to sleep on cold floors overnight. Every child will have a single en suite room and proper facilities. However, Senator Burke’s point about the elective hospital in Cork is important. We have the funding in place to deliver three new elective hospitals in Cork, Dublin and Galway, respectively. This will transform the delivery of scheduled healthcare in Ireland. I visited the elective hospital in Glasgow last year. Scotland had a similar outlook in its health service to Ireland. It is similar in population and there are similar demographic issues. However, it is not that long ago that Scotland had waiting lists of approximately two years for some procedures whereas it is now fulfilling the Sláintecare target of seeing people within 12 weeks. The hospitals in Dublin, Galway and Cork are three key pieces of infrastructure that will help us to realise our dream and to implement and deliver on Sláintecare.

We have heard very clearly from Oireachtas Members, including Senator Colm Burke, the South/South West hospital group, clinicians and many others in Cork of the importance of moving on with preparations for the elective hospital. The message is not to waste time or to wait until the profiling arrives for all of the capital for the hospital. We are being asked to do the preparatory work now. There are two distinct streams of work that need to be done here. First, the question arises as to what we are going to put in our elective hospitals because that varies from country to country. It might even vary from one part of the country to another. The question of what an elective hospital will provide is very important when working out where it needs to be located and what staff it needs. The second issue is site selection. While those streams of work are distinct, they complement each other. After considering this and having heard the feedback of Senator Colm Burke and others, including concerns about groups not being fully represented or boards being properly structured, the Secretary General of the Department of Health wrote to the chair of the South/South West hospital group in recent weeks. The letter noted that we want the group to do these two streams of work and to come back to us with the membership of the group’s committees. The group has sent in some draft membership documents and has been asked to come back with the final membership lists and to have those two work strands completed by the end of this year. That is the timeline to which we are working. We have not done this for the other elective hospitals. As such, we are recognising that there is an energy in Cork around this and a determination to get moving. The hospital group wants to get moving on it. I expect to have those two streams of work completed by the end of the year and back in the Department, which will leave us well placed to advance the elective hospital. I have two comments on the issue of consultants. I accept that we have a recruitment challenge in relation to consultants. It would be foolish to say anything else. However, I do not accept the narrative that is sometimes put out there that the numbers are declining because that
does not stack up. The figures show that we are continuing to see extra consultants working in the Irish health service. There have been significant increases in the number of people taking up consultant posts in the Irish health service albeit I accept there are still vacancies. I repeat what I said at the IMO conference in Killarney. We had a number of major HR and IR issues to work through in the health service. With the GPs, the job is done and a new agreement has been made. With the nurses’ dispute, the job is done in terms of them accepting the agreement, which is being implemented. Logically, the next group with which we need to sit down is consultants. I made a commitment at the IMO conference that the Government would follow the recommendations of the Public Service Pay Commission and put in place a process. As Senator Colm Burke was right to say, we live in a globally competitive world and we need to attract consultants to our country. We need to get some of our Irish consultants to return while keeping others here. I will be working with Government colleagues to work out what that process will look like. We need a process and to engage with consultants in the same way as we must engage with GPs and nurses.

On the point made about haemochromatosis, I am pleased that under the new GP agreement, GMS patients with the condition will no longer have to attend hospital for therapeutic phlebotomy. Instead, the service will be provided locally by a GP. This will obviously be more convenient for the patient. It will benefit about 7,000 to 8,000 patients who normally require three therapeutic phlebotomy sessions per annum. It is taking approximately 7,000 to 8,000 patients out of hospitals and transferring them to the primary care service. The Senator is correct that GPs wanted to do this. They, rightly, only wanted to do it when resourced to do so. That is fair. We now have resourced them under the new agreement. It will see a transfer, a real shift of approximately 7,000 to 8,000 patients out of the hospital setting into the community setting. I do not know whether Dr. Henry wishes to add anything to what I have said.

Mr. Paul Reid: I will make a few comments. The Chief Medical Officer, Dr. Henry, will then say a few words.

I reassure members that I am very conscious of the service provided by all our staff throughout the country. In my first week I spent time in Tullamore and Waterford and plan to be in Mullingar next week and also Sligo. I am fully conscious of the work that is taking place across the service.

Specifically on consultants, reference was made to some of the vacancies. I will give some up-to-date information. Overall, there are 3,388 consultant posts, of which 3,029 are occupied by permanent and non-permanent staff. We had a discussion on contract holders. There are 359 posts unoccupied across the country. The consultant posts unoccupied are across a range of specialties and hospital groups. Psychiatry is the specialty with the most posts unoccupied. As the Minister said, we are working on the challenge. Let me give a figure for last year. We are up by 119 consultants by comparison with the figure in March last year, which represents an increase of 4%. The process is ongoing. We are up by a further 16 since the start of the year. It is a process we are working through, challenging though it is.

I ask Dr. Henry to comment on the haemochromatosis issue.

Dr. Colm Henry: In my previous role, working with Mr. Woods in the acute hospital division, we produced a model of care for the treatment of haemochromatosis working with the Irish Haemochromatosis Association patient representatives. Their main concern was access. It is an interesting example of the shift we need to make in healthcare. There are patients who are travelling from counties Kerry and Donegal to avail of a phlebotomy service in Dublin. It
service could be provided in a GP’s surgery, but it also could be provided in a blood transfusion service van at the side of a road. As anybody knows, giving blood is not a difficult procedure. It is very welcome for the model of care and the patients involved that we now see, under the GP contract, that this is a line of work that they will be expected to do in engaging in chronic care services. It is an example of what we have to do in dealing with other chronic diseases. We need to take out of hospital work that does not need to be done in it, clogging access and increasing waiting lists. We need to bring it into the primary care service and the community, working not only with GPs but also, as in this case, with the Irish Blood Transfusion Service.

Senator Colm Burke: I return to my point about taking work out of hospitals. On the growth in staff numbers in the HSE, there was 17% growth in the numbers involved in administration. There was 3.7% growth in the number of public health nurses. If one wants to take patients out of hospitals, one has to grow the number providing public healthcare services. That is the very area where the number of staff has not grown in the past four years.

I have a question which I believed had been received by the clerk to the committee. I wanted to receive up-to-date figures for all staff numbers in the HSE on 30 April. I will submit the question and will be looking for an answer to it. There was much talk about the embargo and the recruitment of staff, but very little information was given on the real growth in numbers in the past four years. I am concerned about disproportionate growth in some areas and, in particular, how the number of public health nurse numbers has not increased. Why has this not occurred if we want to keep patients out of hospitals?

Ms Anne O'Connor: It is interesting that, in regard to public health nurses and community nurses, there was a conference recently involving community health nurses who represented many in the public health nursing community. There were some very active individuals involved in the conference from north Lee in Cork. Their most consistent request was for more administrative support because they believed so much of their time was devoted to administrative tasks, thereby preventing them from doing other work. There is a balance to be struck. Some clinicians in the community argue that they spend a lot of their time performing administrative duties. They would prefer to be using their high-end clinical skills. It was an interesting debate at the conference and we are going to look into the matter in more detail.

Senator Colm Burke: An increase of 3.7%, by comparison with a 17% increase, is totally disproportionate. There was an increase in the number of administrative and managerial staff of 2,600. In the same period approximately 50 additional public health nurses were recruited, which is disproportionate.

Mr. Liam Woods: It is happening that hospital staff are reaching out. Advanced nurse practitioners and the enhanced nurse role are coming as part of the recent arrangement. In areas such as epilepsy services and orthopaedics we have physiotherapists reaching out. One will see more staff along the continuum of care based on clinical planning, rather than on the institutional or geographical component.

Senator Colm Burke: Let us take dieticians, for example. They are not visiting nursing homes. If a person in a nursing home wants to see a dietician, he or she has to be taken to hospital. When are we going to change this? There are dieticians who are not being paid travel expenses to visit nursing homes. Why can we not change this, rather than require patients to go to hospital?

Mr. Liam Woods: One of the things we did over the winter was support increased invest-
ment in dieticians. We actually found that it was very beneficial in the community, as the Senator is suggesting, and in a primary care setting outside hospital. It is using hospital resources and we will be seeing more of it.

We have just started pilot work on blue light or National Ambulance Service calls where falls are involved. On appropriate triage, we are sending occupational therapists and potentially physiotherapists to people’s home from hospital, with a view to determining whether we can address issues there. The data are very new. It has happened on 40 occasions and 28 patients did not need to go to hospital. That kind of work, to which the Senator is pointing, is exactly where we need to go and we need to do more of it.

Senator John Dolan: I welcome the Minister, the Minister of State and the officials. I wish Mr. Paul Reid all the best in his new role. If I was to suggest to my daughter that I take a certain initiative, she might reply, “Best of luck with that”. I wish Mr. Reid the best of luck way more empathetically. He has a difficult chalice in his hands.

I was struck by Mr. Woods’ response on dieticians, occupational therapists and physiotherapists. Since the HSE was set up 15 years ago, we have been hearing about transformation and reform. We had beautiful documents depicting butterflies flying around. There were also enhanced transformation programmes. As we have had all these, I cannot figure out why we keep talking about this issue. I am not trying to blame anyone, but there is something really wrong if, 15 years on, we are only training 25 dieticians per year in one college, quite a number of whom enter private industry. That is just one example which I did not have in my head before Senator Colm Burke mentioned it. There are major issues and we keep talking about reform and change. The Minister has stated there is no place to hide for people who are not getting on the reform and change bus, but they have been somewhere for the past 15 years. Is there something with which we are not getting to grips in introducing some simple reforms?

I listened to the statements made by the Minister and the director general of the HSE, Mr. Reid, and was struck by what was absent in both. They both went through the industrial relations processes, reforms, Sláintecare and so on but there was no mention of disability. It was almost 10 a.m. before disability was mentioned in this room and it was brought up by Ms Anne O’Connor. We have a cohort of people who are return users of services. They need clinical services for chronic conditions. Three chronic conditions were mentioned but there are more chronic conditions than I would name in a week. Some of them, thankfully, do not have many people suffering with them but an enormous amount of work is needed in this area.

A very important statement was released yesterday on behalf of the Rehab Group, which provided relief for more than 3,000 people. They have been given an assurance that the services they receive from Rehab will continue. It is interesting that there was no mention of that this morning. There was no mention of the work that has been going on with regard to the section 39 organisations. We ratified the UN Convention on the Rights of Persons with Disabilities in April 2018. We have been told repeatedly that almost €2 billion is going into the disability services programme every year and yet it does not merit a particular reference in all of the documentation before us.

It has been suggested that the word “crisis” is overused because there seems to be one all of the time. It is only when one puts the term “crisis” alongside going into the public space and protesting that something actually happens. Rehab has been talking about its funding shortfall for a long time and other disability organisations and community groups have been talking about underfunding and deficits but it was only when one group decided to go public that €2
million was somehow found. I am not making that point to have a go at anybody. I submitted two questions late last week and I am sure I will receive a response in due course. They related to the issue of the quantum of need and the amount of unmet or only partly met need in the context of disability services and connecting that up with very useful things that were mentioned by the Minister at the start of this meeting. He spoke about amelioration, prevention, population health and so forth. These are critical issues for people with disabilities and their families but we do not seem to be able to turn the corner. I go up and down the M7 regularly and have watched as the motorway is significantly upgraded while the road is still in use and the service is maintained but that seems to be impossible to do when it comes to health.

The letter that Mr. Reid sent us was written on his first day of service in the HSE which in itself, is a very significant event. I wish to speak about the mindset of a person with a disability reading that letter. The letter refers to living within budget, which is not a bad thing to do. Mr. Reid also refers to the need to ensure the quality and safety of the services being provided to people. Under the feudal system, one built a big stronghold which was the castle. If one was inside the gates, one had protection but if one did not get to the gates in time, one could be knocking on those gates for a long time. We do not have the honesty or the information to show how much unmet need exists or we are not making those data available.

The cynical view would be that Mr. Reid is the Department of Public Expenditure and Reform’s man in health. We keep hearing from that Department and others that approximately one third of the public purse is spent on health. The implication of that statement is that there is plenty of money in health. I will make no judgment on that but if there is plenty of money, why are so many people not getting services? The Minister of State, Deputy Finian McGrath, and I, as well as others, were engaged just over a year ago on the issue of personal assistants. The departmental officials and the Minister accept that personal assistants support a person’s independence. That requires more than half an hour in the morning to get a man to the toilet, shaved and so on and another half an hour at night to get him back into bed. A personal assistant can enable a person to get out of the house but the average service provision is less than two hours per day. Out of a total of around 2,500 people, only 65 get 40 hours per week. It is a lie to say that is a personal assistant service. It is a bum steer.

A range of organisations are now in very severe territory with regard to governance and funding. Rehab came out publicly about this. I ask Mr. Reid and the Minister to respond to the statement I am about to make. It is my view, based on what we know about unmet need in the sector, that we will not get to the end of this year without the system cracking open. What happened with Rehab has opened up that possibility. Other organisations will now be saying that they should have done the same thing because they have deficits and unmet need. They will be lining up, one after another, looking for a meeting. How will that be dealt with?

Some work is being done on the pressures in the section 38 organisations with regard to staff churn and so forth. We also have the very specific issue of the underfunding of the disability services programme to the tune of €16 million. That programme was based on what was delivered last year but there were some deficits in that. While I would love to be wrong, I cannot see how we can get to the end of this year without some very serious cracks appearing in the disability services programme.

**Chairman:** I will ask our witnesses to respond to Senator Dolan’s questions now.

**Senator John Dolan:** Okay. I will come back then and finish.
Deputy Simon Harris: I thank Senator Dolan for his questions. I will respond to some of the issues raised and I am sure my colleagues from the HSE, as well as the Minister of State, Deputy Finian McGrath, will also respond. The Senator makes a very interesting point about reform and transformation. He points out that the HSE was set up 15 years ago and asks why we have not got there yet. While Senator Dolan has not done so, it is very easy for Members of these Houses to blame the HSE. Indeed, it might even be a popular thing to do from time to time but-----

Senator John Dolan: I have not done that.

Deputy Simon Harris: No, the Senator did not do, as I already said. He asked why reform and transformation have not happened after 15 years. Having been three years in my current job, I want to give the Senator my perspective on that question. It has not happened because of a failure of collective political leadership and a failure to both make and stick with decisions on health. In fairness to people in this room, including the Chairman of this committee and others, the first time we did that was with Sláintecare. We can have the debate about whether setting up the HSE was a good or a bad idea or whether it should have been done differently but if we park that, over the past 15 years political parties, including my own, were talking about abolishing the HSE, about the Dutch model of healthcare, about going back to the old health board system and so on. There has not been a certainty of policy direction in relation to health care for a generation, up until now. People ridicule new politics and minority Governments and sometimes I share the frustration with new politics but one of the good things that has come out of the lifetime of this Oireachtas is the fact that on a cross-party basis, we have an agreed policy direction for health. This means that when I am no longer Minister for Health and Fine Gael is back in government after the election with a new Minister or whatever else might happen with an election, we will still have a clear plan with which all the parties agree with the exception of People Before Profit and Solidarity. Everybody in this room agrees with the direction, which means that the people sitting to my right, all the people they represent and all the people who work to them now have a clear policy direction. I believe that for the first time in a generation, we have a chance to crack this. What we are not going to do is what we have done far too many times, namely, start a bit of reform, change a Minister, have another bit of a different reform plan and go off in that direction. We have a clear reform plan to which we have all signed up. We have all said that regardless of politics, the name of the Minister or who is in government, this is what we are doing, which is a massive opportunity and prize for the health service and, most importantly, for the people of our country.

Regarding what is and is not in my opening statement, as members can imagine, when one is Minister for Health, one can only touch on so many issues in an opening statement or I would still be delivering it. Disability was mentioned on page four of my opening statement with regard to the extra 100 therapy posts to help deliver access to services for people with disabilities but I take the broader point made by Senator Dolan. He asked a very important question, namely, how disabled people or any of us read a letter issued by the director general or me or a comment made by any of us regarding fiscal prudence and living within budgets. What I would say to those people is that I hope and believe they should read the letter this way because that is the way it is intended. The opportunity cost to service users - to citizens - of a budget overrun is significant. Again, I am not apportioning blame but imagine if we had a situation where we did not have to find €600 million for an overrun. Imagine what, as a country or as a health service, we could have done with that money. What the director general is correctly doing is saying to everybody, and I know he said it in his opening statement, that if we can make a real push here and a real collective effort to deliver services but remain within budget, it means that the extra
investment we will inevitably receive in budget 2020 can actually deliver more services and begin to address some of that unmet need referenced by the Senator.

Senator Dolan referenced Rehab, the broader sector and the implications for that. The first thing I want to say is that the Minister of State, Deputy Finian McGrath, co-chaired three meetings on this. This was a very intensive process that is ongoing. There is still intensive ongoing engagement. We continue to engage with sectors. We do not just have a conversation. Our priority was service users and making sure services continued to be delivered. It is not a case of “come on over and receive additional funding”. That is not the case. The case is that if there was an acute pressure that would have damaged services or detrimentally affected service users, we wanted to work constructively together to try to address that. The broader issue of the section 38 or section 39 bodies will require a forum, process or engagement. The report by Dr. Catherine Day has been quite instructive and helpful in that regard. That is a matter for the Minister of State, Deputy Finian McGrath, who will comment on that. There needs to be a conversation about the voluntary sector and the public health service, how they interact, mutual respect, clear understanding of roles and a clear understanding of funding. I might ask the director general to comment.

Mr. Paul Reid: We have provided answers to the questions posed by Senator Dolan and will make sure they go directly to him as soon as possible. We have some detail on the responses and I am happy to pick them up with him. Regarding finances and the memorandum referenced by the Senator in terms of my own communications, as I said in my opening statements, it was not my only message on day one but I appreciate that it will get wider attention. There were three messages. The first one very strongly focused on patient safety and care, in particular valuing the work across the health service and the people who work in it, what they do and their commitment to that, but it also focused on strengthening controls and governance issues that have been highlighted and that we must address. The second issue, on which the Senator touched, concerned the reform agenda to which I wish to return. The third one was a wider message around building trust and confidence, one aspect of which will be moving to managing within budget. That will build trust and confidence not just on the part of our funders - the public, the Oireachtas and the Government - but on the part of our patients and in terms of our capacity to invest in the future.

Regarding the comment about the perception that someone from the Department of Public Expenditure and Reform is in the seat, I have worked full time since I was 16 for 39 years. I spent less than three years in the Department of Public Expenditure and Reform. I have had a very successful career in the private sector, the not-for-profit sector, central government and local government so my career has spanned a wide range of sectors. I am a committed and passionate public servant. That is why I want to be in this role. As I said in my opening statement, one can make no greater impact in the public service than in the sector that is committed to people’s lives and safety. That summarises who I am and I hope it provides a more rounded context. The Minister touched on my next point. I know I have two very clear mandates, one of which concerns what the Minister touched on, namely, an agreed Sláintecare strategy. The appetite for that within the service is very strong. A lot of organisations talk about reform and restructuring a lot and one can get weary saying the same thing but since the announcement of my appointment six weeks ago and since I took it up, I have spent a lot of time talking to people in the service. There is passion and appetite to move to a new model of service. The fact that we have a model approved by the Oireachtas into which staff buy is a great factor. Staff need support and help in terms of change management and how we get to implement that but I sense a strong desire for people to move to a new model.
There are two mandates. One relates to the SláinteCare change plan while the second is our overall service plan and budget. At the start of 2018, the national service plan had €14.5 billion and the outturn was €15.2 billion. We have €16 billion this year so we are up €2 billion overall on the original national service plan for 2018. That is the budget within which I must manage. In doing so, I must deliver quality services and deliver on our commitments in the national service plan. Like many of the other sectors that are under pressure such as justice, education and local government, from which I have come, I feel the wider pressures for us, particularly given that it impacts on people’s lives. It is a challenging issue. I have a mandate, budget and change plan and must work towards all of them. No public servant, myself included, has a mandate to spend overall above what is committed to him or her. That is my challenge. I am committed to public services, want to get value for money for them and want to deliver quality services. I may have referenced Dr. Colm Henry as the chief medical officer. My apologies if I did. The chief clinical officer and the team are working very closely on this as we work through in terms of delivering to the budget. How do we do it in a manner that delivers services and provides good-quality care and safety? That is a very strong driver as we work through this process. Ultimately, I am clear and as a public servant, I know the funds that have been committed to me. I do not have a mandate to spend beyond them. I want to bring the whole organisation along with me. Long before I arrived, the team here, including Ms Anne O’Connor, who has been interim director general, took some very good actions in the first quarter that I recognise. They took some really good actions that I hope are beginning to constrain the overrun we saw throughout last year and set us on a way forward for the rest of the year to make some decisions and difficult choices we will have to make to work through that process. We will do so in a balanced way and that is the message I want to communicate clearly.

**Deputy Finian McGrath:** I assure Senator Dolan that there is a plan and strategy to develop and progress services for people with disabilities. We have to accept that in the HSE service plan for 2019, €1.904 billion is being invested in social services for people with disabilities. This is a significant investment in our disability services, the highest amount in the history of the State. This means that, as I speak, 8,600 people are in residential places, 27,000 people are in day services, there are 182,500 residential respite support overnights, 1.63 million hours for personal assistant services, 3.08 million hours for home support services and approximately 160 people who are now in institutions will be moving out of them. While I acknowledge there are problems in disability services which we are trying to fix, it is also proper to acknowledge the tremendous work being done by the HSE on this.

Senator Dolan’s earlier point on disability was correct. I am smiling privately because we are discussing disability at 11 a.m. I have been at many committee meetings where we did not get to discuss disability until 12.30 p.m. or 1 p.m., three or four hours after the meeting had started. This is a reflection, and I have seen this in research from the National Disability Authority, of the need to make disability more mainstream in society. There is a lot of talk about disability but in broader society and the political system disability needs to be brought further into the centre. This is my job as the Minister of State and I try to do it every Tuesday at the Cabinet table. Every Minister has a role to play in this regard.

With regard to Senator Dolan’s questions on unmet needs in disability services, we are updating the data as part of Transforming Lives. We all accept we need to plan the services and they need to be provided in a structured way. A total of 13.5% of our population, which is 643,000 people, have some form of disability. This is the reality. Most do not require disability services because their needs can be met in the primary care services, which is good. The figures Senator Dolan spoke about include the 60,000 people who have their needs recorded
for the next five years. A total of 1.6% of these are aged under 65. We need to plan for these services. What amount of money are we speaking about? A residential place costs in the region of between €100,000 and €500,000 per annum. The figure of €500,000 is for high dependency adults with disabilities. A day place can cost as low as €5,000 per annum per year and up to €50,000. I make this point with regard to the funding.

What I believe is required over the next five years to meet unmet needs is additional funding of €10 million for respite services. We have done a fantastic job this year with the opening of 12 new respite houses but over the next five years we will need another €10 million for respite services. We also need €90 million to develop support needs for people with disabilities in day places and other places. We also need another €6 million for therapy posts. We have 100 therapy posts this year but I know from speaking to people what we need. Personal assistant services and home support hours need an additional €30 million. They are part of the plan over the next couple of years. To be upfront about it, the figure we are looking at is in the region of €286 million in additional money over the next five years.

To answer the points on Rehab, the organisation provides a very important service. I thank the Minister and the HSE for the tremendous support they have given me on the resolution of the issue with Rehab. They have been very supportive of the 3,000 people with disabilities involved and their families. The Minister makes the point that the work goes on. We are looking at the report from Dr. Catherine Day. We have a deficit issue, about which I speak to Senator Dolan regularly. We will come back with a plan on this. We have to deal with these issues. We will work constructively with all of the service providers because we need proper plans and proper budgets. As the Minister of State with responsibility for disabilities, I will always be looking for extra money. Sometimes I do well and sometimes I do not but the bottom line is we have to make the overall view. When we ratified the UN Convention on the Rights of Persons with Disabilities last year it helped to change the mindset. We still have a long journey to go to bring this human rights approach to our disability services. These are citizens, many of whom now work, which is a good thing, and more have the ability to work. They pay tax and make a contribution to society. They should not be left behind in any way. From this point of view, much work has been done but, of course, we need to do more.

Chairman: I thank the Minister of State. I must move on but I will bring Senator Dolan back in for a second round of questions if we all remain disciplined.

Senator John Dolan: I had not finished my questions.

Chairman: I understand that but we have devoted almost a half an hour to the Senator’s contribution.

Deputy Bernard J. Durkan: I will stay within half an hour, seeing as that very helpful precedent has been set. I welcome Mr. Reid and wish him well. He will need all of the good wishes and help he can get. He has a formidable task, one which has not been successfully achieved so far. That is not a reflection on any of Mr. Reid’s predecessors but simply a statement of fact that the objectives some of us saw as being primary and necessary have never been achieved. For instance, staying within budget is one thing that has not happened so far. I agree with Mr. Reid that if there is no budgetary structure he can rely on and that he knows from the beginning of the year will be available and capable of discharging the services required, he is going nowhere. He cannot run an organisation in that manner.

Another issue I have raised in the past, as the Ministers know, is the efficacy of the struc-
tures of the HSE. I know this is being changed and the Minister will have regionalised authori-
ties within the system. I have always been of the opinion that the amorphous mass of the HSE, which replaced a regional system, has not worked and will never work. I hope I am wrong but I have not yet seen proof to the contrary. My point is that it is like building a wheel in that the further we go from the centre, the less clear the remit becomes and the greater the difficulty of ensuring the outer reaches are capable of operating in the way it was intended and that they are committed to it. For example, the team needs to pull together. Everybody needs to be heading in the same direction at the same time. If we are to run a proper service capable of meeting the needs of the Irish people, we do not need to have different opinions emerge daily as to who should do what, when and how often. Simplicity should be the order of the day as we proceed because complications lead to various culs-de-sac into which everybody will sneak from time to time and emerge when it is opportune. This has to stop. If we do not have a chain of command where responsibility comes from the ground up and the top down, we will not be able to provide a service that meets the requirements of the people of this country or provide a reliable, safe, available and cost-effective service.

I want to revert to cost-effectiveness briefly. Cost-effectiveness comes in many shapes and forms. It comes in the administration of the services in general, the administration of purchasing and the approval of drug refunds. Something we seem to get bogged down in from time to time is a debate on whether we should do a particular thing on the basis of it being too expensive. If it is too expensive, that has to be taken into account and it should not enter the equation in the first place. If we cannot afford it, we must state publicly that this is a very expensive issue and will have to tax the public somewhat further in order to ensure we are capable of doing this. There comes a time when the buck must stop somewhere.

On the chain of command, I firmly believe it must apply, particularly in the health services where decisions made at the top of the HSE are carried out and applied at ground level without exception. If people are going in different directions, thinking their own thing and identifying different objectives, that chain of command weakens and we will have more explosive issues appearing daily. Incidentally, from 2004 until 2012, one could not debate, discuss or raise a question about the day-to-day running issues of the HSE. Many people have forgotten that, but I have not. I was one of the people who tabled questions daily to challenge that on the basis that we should know whether the system is working properly and within budget and its remit. It is a matter of history that I was ejected from the House on at least 20 occasions on that issue. People think that is funny, but it is not. I was seeking information that should have been available. The matter was smothered at the time. As a result, we have a situation whereby we daily debate the internal running of individual aspects of the health services to such an extent that the chain of command is no longer in command. That is how it works. I am a mechanically minded person with a reasonable understanding of the integrated working of the gear system. The new director general also has a knowledge of that area. The gear system works in a way such that if one element is operating at variance to the rest, nothing happens and everything goes backwards. I wish Mr. Reid well. I hope it goes well for him. He will certainly receive the full support of everybody I know in the system because everybody wants to make it work.

The Minister promised to regionalise within the HSE, a step which is long awaited and greatly anticipated. I hope that is done in the very near future and that with it will come responsibility at regional level. Sadly, responsibility at that level has been missing since the abolition of the health boards many years ago. I did not get my wish back in the discourse that took at the time, nor did I get it at the Sláintecare committee, of which I was a member. Whatever reasons were behind the abolition of the health boards, people do not wish to go back to them. That
may be a good thing or a bad thing. We may have to reconsider it in the not too distant future if
the system does not work. I am not convinced by some of the excuses for not being able to go
back to that regional system, such as that it did not work. Things happened more quickly under
that system. If an issue was raised, it was dealt with quickly. If it was not, one knew what the
problem was.

I wish to briefly refer to the issue of waiting lists. There is an ongoing requirement within
the system. Whenever a waiting list occurs, two things must happen: one must remove some of
the people from the waiting list - which is being done effectively and, I hope, efficiently - and
one must deal with new people joining the waiting list. If that is not done, we will be forever
beset by waiting lists. The problem is that we seem to accept that waiting lists are inevitable
and go on forever almost everywhere. That is not the way to deliver services. It does not work
that way.

The Chair thinks I should resort to a question. At this time in my life, I have the answers to
most of the questions I have asked, and I am still waiting hopefully for answers to the others.
The Chair will be glad to know that I will not go into that today. I do not wish to take up any
more time. The Minister and the delegates will answer in due course. I stayed within the half
an hour guideline.

Chairman: Shall we allow the witnesses to address the issues raised by the Deputy?

Deputy Bernard J. Durkan: I was going to conclude if the Chair so wished. I do not
mind. I am staying well within the half hour allocated.

Chairman: We indulged Senator Dolan, but I do not wish to set a precedent. Shall we ask
the Minister to respond?

Deputy Bernard J. Durkan: I wish to add a final question before the Minister replies. The
National Treatment Purchase Fund, NTPF, has been reasonably successful in dealing with some
waiting lists. Have all the referrals gone outside the jurisdiction or have some been dealt with
within the jurisdiction? If so, how many? Are there facilities in the private or public sectors
within the jurisdiction that could deal with some of those on waiting lists? I do not have an
ideological hang-up about people receiving services in the public or private sector as long as
they receive the required service at the required time and are not told that if they wait for four
years, something will be done for them.

Deputy Simon Harris: I am almost afraid to endeavour to answer the questions consider-
ing that the Deputy answered some of them more ably than I could. I reassure him that it re-
mains my position to advance the restructuring of the health service in line with the Sláinte-
care report. Regional integrated care organisations - we will not call them RICOs because that re-
lates to racketeering in South America - will achieve the aim of having integrated structures that
deal with acute hospital care and primary and social care. There will be one structure in each
region rather than multiple structures. It is my intention to go to Cabinet before the summer re-
cess to seek approval for those structures in line with the Sláinte care report. That will be a very
important moment for the health service because one does not change structures for the sake of
it; one changes them if they will be enablers for change and reform. There is no doubt in my
mind that one cannot reform the health service while continuing with two separate structures
in the hospital groups and the community health organisations. We must have one structure
that provides an opportunity, as alluded to by the Deputy, for greater devolution to the regions,
a smaller national centre and HSE, more devolved responsibility to the regions and more ac-
countability and oversight at regional level. I do not mean this as a criticism, but it is often a source of great frustration to Deputies that they must ask questions on certain issues on the floor of the national Parliament. They would prefer to get more efficient and localised answers from a regional structure. The bringing forward of those proposals before the summer recess will be a very important moment in terms of advancing Sláintecare and ensuring there is no going back, that the Sláintecare train has left the station and everybody needs to get on board.

The Deputy referenced chains of command, governance and so on. I reassure him that it is still my intention that the new HSE board will take office in June, which is very important. At this and other committees, Mr. Reid’s predecessors and other HSE representatives have alluded to the somewhat bizarre governance structure which is in place and which needs to be reformed. The new board will take office in June, subject to the Oireachtas doing its business. I hope to have the co-operation of the Dáil and Seanad in that regard.

On the issue of waiting lists, as we all know, there will always be a list because as soon as one person is treated, another will need treatment. The issue is how long people wait for treatment. We are making good progress. I accept that we have a significant amount to do in the area of outpatients - there were some good exchanges earlier in that regard. It is important to note that there are 9,119 fewer of our citizens awaiting a hospital operation or other procedure at the end of April this year than at the end of April last year. That is a direct result of some of the investment decisions we made in recent times.

I will revert to the Deputy in writing with the exact breakdown on the NTPF. Almost all NTPF expenditure is within the jurisdiction. A very small number of procedures for scoliosis and so on were carried out elsewhere, but almost all procedures occur within the jurisdiction. Importantly, a higher percentage of the NTPF budget is now being spent within the public health service. I always remind my HSE colleagues that the NTPF should not be seen as just a fund for private hospitals. That may have been the case in the old days. There is every opportunity for public hospitals which have capacity. We have capacity to do more, particularly sometimes in our smaller hospitals, and we have seen some exciting proposals in that regard. I refer to the €1 million we gave to the NTPF to open a new cataract theatre in Nenagh hospital last year. In that instance, we used a public hospital and NTPF money to sort out cataract waiting lists in the mid west. Perhaps Mr. Reid might like to add something.

Mr. Paul Reid: I agree on how important it is to deliver on the funds committed to us in our budget. I reiterate the Minister’s point that in going through this process we will need to invest in transformation in the future. I have never been involved in any major transformation that did not need investment. Everybody understands that and it is explicit in Sláintecare. I am wise enough to state that we first have to do what is necessary to strengthen trust and confidence and then invest funds in the future model. I am committed to doing that. The Minister remarked on the structures of the HSE. I welcome the new board and, although not yet appointed, I have met all of its members individually. They will bring great expertise as well as a level of challenge to the executive structure. We look forward to working with the chair and the board on our current priorities and also on those that the board will set for us, in conjunction with the Department and the Minister.

Reference was made to the making of just decisions in situations where things are too expensive. We have to make those decisions. As I stated earlier in the context of the discussion on Spinraza, I thank the drugs committee for doing fantastic work overall and making those difficult decisions for us throughout the year. The committee makes decisions using a wide range of criteria and has approved drugs that would not be cost effective but that are necessary
for the people impacted. Many of the 23 drugs approved this year have not been cost effective. We have to make some decisions, therefore, in the public interest.

Turning to the chain of command and regionalisation, I agree completely that people in any large complex organisation, particularly the workforce, mostly identify with their local unit, manager, hospital or primary care centre. A stronger identity will emerge, therefore, as we move to a regional model. It is a model derived from the policy of the HSE and the Department of Health. As we move to that model, in respect of central policy making, involvement, employment and particularly achieving consistency, the last thing the public and the public health service need is a regional model with different models applying in different areas. That is my view and it is also reflected in Sláintecare. It will be regional and that will encourage people, and in particular the workforce, to buy into the service while a level of consistency and control is retained at the centre. That is the model we all want to see.

The Minister also referred to the NTPF and its impact on waiting lists. I see the NTPF as a great lever. Many local managers in our acute hospitals, including Ms Grace Rothwell who is here today, are leveraging and using it in a proactive way to address waiting lists. In Irish private and public hospitals, people travel overseas under the auspices of the HSE and not the NTPF. It is deployed in our public and private hospitals.

**Chairman:** I thank Mr. Reid and I call Deputy O’Connell.

**Deputy Kate O’Connell:** I welcome Mr. Reid and I wish him the best of luck in his job. His employment history demonstrates that he is a dedicated public servant. I hope he will deliver in his role for the people of Ireland. I agree with my colleague, Deputy Durkan, that many have failed in this same role before. I also believe we have political buy-in to the ten year Sláintecare plan. Some of us here sat on the committee that produced it. I also agree with Mr. Reid that buy-in is needed from the public and that confidence is a prerequisite. There will be a lack of confidence if it appears to the public that we are not in control of a budget and that there is not a steady hand on the reins. I wish Mr. Reid the very best in his new role.

I do not want to rehash some of the previous comments regarding governance. In many of the recent crises and scandals, or whatever word we use, however, there has been a constant narrative regarding a need for a change of governance structures. That has been the case not just in the Department of Health but also in other Departments. A new board is being appointed in the health service in June and that will represent the required change in governance structures. Governance has often been blamed for failings in the past. If the governance will now be right from June, there will be no excuse anymore in that regard, as far as I am concerned. I do not expect to have to come in then and listen to governance being blamed for whatever incidents might happen from June. I refer to there being a proper chain of command, the spokes on the wheel not being too far from the centre and there being appropriate accountability.

A number of eminent general practitioners, GPs, addiction specialists and consultant psychiatrists wrote a fairly clear letter in the newspapers during the week. I do not have it in front of me but it concerned the effects of the recreational use of cannabis. As the Minister is aware, I and the Chair spent much time working through the Bill that was before this committee a year or more ago. Despite the massive volume of legal advice to not proceed with the Bill, it somehow managed to proceed to the next Stage. I know it has now been halted by the absence of a money message. Eminent psychiatrists, GPs and addiction experts are stating one thing. It would be helpful if Mr. Reid would outline the difference between legalisation, decriminalisation and harm reduction. I really object to the word “medicinal” being used in respect of can-
nabis. It is a controlled drug. Until it gains evidence to justify the medicinal name, then we are just dealing with a schedule 1 drug.

My focus regarding this issue has always been on protecting our citizens. I also want to focus, however, on protecting our regulatory processes. No drug is allowed onto the market unless deemed safe by the Health Products Regulatory Authority, HPRA. It would never allow any drug get onto the market via a regulatory process that was circumvented for whatever reason. Doctors, in particular Dr. Walley, have spoken in the media about the prevalence of this issue in the business pages of newspapers and the push towards allowing investment in this area. The Minister is familiar with this area. He took the lead on the compassionate access programme and some 15 or 16 patients are benefiting from that scheme now. Given that level of take-up, we as legislators and people in charge of our health service have to stand back and ask questions.

If only 16 patients have been granted use of this product by the consultants allowed to prescribe it, why is there such a big push in the business world regarding legal changes in respect of this drug? We are in a precarious position as legislators. Those of us with a medical background feel strongly about big business being able to negate the existing body of evidence. That body of evidence underpins what was stated by medical professionals regarding this issue in newspapers and other media this week. I ask Mr. Reid to outline where we are on this topic. The message circulating at the moment seems to suggest that everyone is going to be legalising drugs. Parents are concerned, as are people who have experienced this issue with their children, teenagers and adolescents. They feel strongly about this matter.

I also want to address the issue of vaccination and the worrying decrease in the uptake of vaccines for measles, mumps and rubella. We have spoken about measles in recent months. That illness has rightly been the subject of publicity internationally and domestically. Measles is a serious illness which can cause life-altering conditions and even death. A number of GPs have told me that there is a huge upsurge in cases of mumps. I refer to mild forms of mumps. Children who have been vaccinated are presenting with symptoms that may be retrospectively recognised as a mild form of mumps. The HSE needs to work on education in this area. Children who have been vaccinated and are exposed to mumps can be left deaf and have other complications throughout life. With respect to those parents who are responsible and make their informed decisions based on the evidence about their children’s health, there is almost a belief, although perhaps I am reading it wrong, that if one vaccinates one’s child, he or she will be grand but that is not the case. If one has a child who is immuno-compromised with cancer or who is simply vulnerable at a particular point or if one is an older person, if they get a measles or a mumps infection they can be very seriously ill and that can have lasting effects.

The Minister was doing some work with the Attorney General on the mandatory vaccination. If it was as easy to force everyone to vaccinate, this would have been done back in the day when Jenner discovered the smallpox vaccine. I agree with him that moves need to be made to prepare in the event of an epidemic to address what we should do if we were to end up in a situation such as in the United States where people are not allowed leave their homes or there are issues in airports. We need to prepare for the worst-case scenario. With respect to where we are on the issue of mandatory vaccination and bringing people along with us, based on my experience it is not a lack of information that results in people failing to vaccinate their children rather it is oversupply of the wrong information. People often make informed decisions but the information on which they base their decisions is not scientific. I am concerned when I hear views on this issue from people such as Andrew Wakefield, the discredited doctor, who
apparently is currently dating Elle Macpherson. There is a celebrity element to this. Kim Kar
ardashian’s baby’s birth by surrogate had a CBD theme. The Minister probably did not know that. He is probably too busy running the health service. A celebrity element is coming into issues that have a serious effect on our public health. We as legislators must be strong on this. If we let the Kardashians or Andrew Wakefield into the mix on this, issues in respect of which there has major investment in our universities and our institutions over the years can be diminished by a reality TV star, not into getting into the President of the United States while we are at the health committee. However, I feel strongly about this and about the impact of social media on people’s health and bad information.

Chairman: I might ask the Minister to respond to those questions?

Deputy Kate O’Connell: I have a few more brief questions. I have raised the issue of folic acid with him previously. Have anything been done to provide free folic acid supplementation for pregnant women and babies? Ireland has the highest rate of neural tube defects. The incidence here is increasing at greater rate than anywhere else in Europe. There is a cost in terms of money and on families but providing education on this is a simple thing to do. It would not require too much money. I gave the Minister the figures on how cheaply it could be done. A first step would be to provide free folic acid for everybody sitting beside a pregnancy test in a doctor’s surgery or in the newsagents. I do not care where they sit once people have access to folic acid.

What is the status of the group dealing with the issue of providing free contraception? Members of the Committee on the Eighth Amendment of the Constitution parked the idea of exclusion zone legislation because we wanted the service to be provided as promised from 1 January. We are now heading towards the summer. As the Minister will be aware, families are experiencing negativity in various centres and GPs are under pressure. If we do not get a handle on this soon, GPs will give us doing it. It is not worth it. There are some things that are not worth it in one’s life if one is being attacked on one’s way to work everyday.

Chairman: The Minister might respond to some of those questions.

Deputy Simon Harris: I will do my very best. I thank the Deputy for these questions. I am grateful to have the opportunity to discuss cannabis because there has been a great deal of coverage of it. It is important for me to set the record straight on this. There are no plans to legalise cannabis or any other illicit drugs in our country. What there are, though, are two important and distinct streams of work. The first relates to a compassionate access programme for cannabis for medicinal reasons. I intend to set that up over the summer months. I expect to sign the statutory instruments in the coming weeks. A great deal of work is being done with HSE colleagues to prepare for that. That programme has been designed in consultation with clinicians and clinical guidelines have been published, which are available on my Department’s website. It came about after I asked the Health Products Regulatory Authority to carry out the first ever review in Ireland of the potential use of cannabis for medicinal purposes. It reported back indicating there were three areas it could be used for: multiple sclerosis, MS, certain types of epilepsy and vomiting and the likes from chemotherapy. There will be a scheme set up before that and that is a separate and distinct matter which I believe we are supportive.

The second issue is one in respect of which we are fulfilling a commitment in the programme for Government and a commitment of a former Oireachtas committee, which was chaired at the time by Deputy Stanton, who is now a Minister of State. There is also our national drugs and alcohol strategy, which deals with how we can take a health-led approach to drug addiction. It
is not about legalising drugs, but when we come across somebody with a drug addiction should we be giving them a helping hand or a handcuff? It is wrong, stigmatising and dismissive of our obligations to people with an addiction if we take only a criminal justice approach to that. It is about recognising the fact that behind every addict is somebody’s son, daughter, mother, father, brother or sister and that the war on drugs around the entire world fails. If we want to break the cycle of addiction, we must take a health-led approach. Deciding that the only thing we will do for a drug addict is put them in touch with the criminal justice system will not break addiction. That approach would be a failure in our duties in terms of a modern health service and a compassionate, tolerant society that wants to look after and care for people in difficult times. When it comes to drug addiction, there but for the grace of God go I. It is not about legalising drugs; rather it is about being compassionate and offering the helping hand rather the handcuff to people who are addicts.

The Minister of State, Deputy Catherine Byrne, and I have established a working group on this issue with colleagues from the Departments of Justice and Equality and Health, the HSE, drug addiction services, An Garda Síochána, and so on. It has reported and we will consider that report and bring it to Government in the coming weeks. There are no plans to legalise cannabis but there is a plan to have an access programme to it for medicinal reasons and a plan for how we can tackle the underlying issues of drug addiction, recognising than no one is born wanting to be a drug addict. Many people become drug addicts by circumstances of birth. We must ask why are people taking drugs and how we can break the cycle of addiction. I hope that clarifies what I believe has been a misrepresentation by some and, in fairness, a genuine concern on the part of our medics and medically qualified people that their voices were not being heard on this. I assure them we will continue to work closely with clinicians on this and even on a medicinal programme. Clinical guidelines have been drawn up and an excellent body of work done in that regard.

Deputy Kate O’Connell: In terms of education, the Minister needs to work the Minister for Education and Skills, Deputy McHugh, on this. If the message in the past week has been corrupted to such an extent, the messages our young people are getting are subject to corruption. There is work that could be done in the early stages of secondary school where the facts are put out. Children today are good at accessing and deciphering information and they put a great deal of faith in their teachers.

Deputy Simon Harris: Yes.

Deputy Kate O’Connell: Delivery of this through the education system is key. I apologise for interrupting the Minister.

Deputy Simon Harris: I fully agree with that. I believe the Deputy and I agree on this. The lock them up mentality has dominated many of our debates on tackling difficult social issues - lock them up, brush the problem under the carpet, pretend it does not exist and send it abroad. We have heard all sorts of different versions when people have come upon hard times in this country. We must face up to drug addiction. That does not mean we should legalise drugs. Educating our children about the serious dangers of taking drugs is key. They are dangerous and can destroy one’s life but responding to a person who has become an addict with more than simply a blue siren is important.

I am passionate about the issue of vaccinations. Later today, we will bring my baby to get her latest vaccinations. Vaccinations save lives. We have to start pushing back against the misinformation in this area. I want to set up an alliance to be proactively on the pitch because
when we are not on the pitch; all those people the Deputy mentioned and others are on the pitch spreading this misinformation. We need healthcare professionals, patient advocates and policymakers working together on this. I have a number of meetings this week on the issue. I hope to be in a position to announce a new alliance to promote vaccination, just like we successfully did together in respect of the HPV vaccine. The director general referred to the really excellent increase. There is a 70% uptake rate. Therefore, it is possible. We will do it. Issues relating to mandatory vaccination, etc., will be examined. Many of my colleagues are looking at those. Members will have heard the comments from my UK and German counterparts. Ireland needs to be involved in these discussions because they are happening right across the globe. However, no decisions have yet been made. The alliance absolutely needs to happen because, unfortunately, diseases that we had thought had become confined to the history books because of the success of vaccination are now creeping back and having a devastating impact on some people. I expect that we will make progress on that in the coming weeks.

On the issue of folic acid, that will be looked at in the context of the women’s health action plan. Work is under way on that plan.

On the issue of contraception, the working group has been established and is under way. I had a good meeting with colleagues from the HSE’s sexual health unit last week on that and I expect the working group to report to me in September in time for me to try to make provisions in the forthcoming budget.

On the exclusion zones, I am pleased that the number of GPs signing up to provide termination services continues to rise. It is well above 300 now. It was 160 when we started the service. There is a need for safe access zones. I am absolutely committed to bringing forward that legislation. I expect to bring the general scheme of a Bill on that to Cabinet before the summer recess.

Chairman: I thank the Minister.

Deputy Kate O’Connell: Is there provision in the budget for the folic acid? Is it the folic acid the Minister meant as part of the women’s health action plan?

Deputy Simon Harris: Folic acid is part of the women’s health action plan and the contraception working group will report to me in September, both in advance of the budget.

Deputy Kate O’Connell: I thank the Minister.

Chairman: Before I call to the non-members, Deputy Brassil and Senator Conway-Walsh, I have a question for Mr. Reid and Ms O’Connor on the HSE Service Plan 2019, which is the plan to which we are operating. The plan contains a strong reference to changing the model of care and reorienting the health service away from hospital-centred care. The current model of care is not capable of meeting the demands on the system. That is reflected in the service plan. There are issues regarding the level of care in the hospitals, particularly at weekends. We tend to move from a different level of care Monday to Friday to weekend care. There is a deficit in the hospital services whereby there is a lack of diagnostics and access to specialist consultant care at weekends because of the model of care we are using. We do not have a 24-7 model. We tend to have a five-day-week model at one level and then a model of care weekends that inhibits the flow of patients through the system. Perhaps Mr. Reid and Ms O’Connor might comment on that.

The national service plan also indicates that the allocation of funding this year will be chal-
lenging in the context of meeting the service level provided in 2018, particularly under the existing models of care, and that we need to innovate and have integrated models of care. Perhaps Mr. Reid and Ms O’Connor might expand on how they see that being delivered. Sláintecare is strong on that matter.

As a result of increased demand, with a 5% or 6% increase year on year in attendances at accident and emergency departments, elective beds are being flooded by emergency care patients. We will soon move to a level of care whereby we can only provide emergency care through accident and emergency departments. Emergency cancer care and elective care are being pushed out of public hospitals. I have been contacted by a number of consultants who are providing more care through the NTPF in private hospitals than they are able to deliver through their work in public hospitals, particularly in circumstances where hospitals are operating to 95% capacity. There is a reference in the service plan that the national cancer control programme allocation for 2019 will not allow the services to match referral demand in areas such as radiotherapy, rapid access cancer clinics and diagnostics. In the context of the HSE’s move to remain within budget, which, of course, is absolutely correct, how can it match the demands that are being placed on the system while remaining within a budget, which, even the service plan states, will give rise to challenges in the context of delivering services?

The development of elective-only hospitals is absolutely essential. This needs to be prioritised within the capital budget and within future service plans. Unfortunately, we cannot have acute hospitals delivering acute care and also expect them to deliver elective care in a timely manner. We need to move to putting in place elective-only hospitals as rapidly as possible. Mr. Reid and Ms O’Connor might comment on those points.

Mr. Paul Reid: I will make a few comments. I might ask the chief clinical officer, Dr. Henry, to come in on a couple of them.

The first point the Chairman mentioned relates to the challenge of delivering the service plan in light of increased service pressures. That is a matter on which we are working through with the team. In terms of the processes that have kicked off, I will get a review back from all areas. That review will include proposals to come in on budget but within an overall framework of quality and safety. When I get all of that information, we will be in a position to review and assess the overall commitments on the plan that we will set out to deliver, which areas of the service are under significant pressure and what choices we must make. It is a process that we are working through. The Chairman summarised it well. It is a challenging process because of the upward pressures that exist.

On the overall perspective of the service plan, moving to new models and innovation, I referred earlier to the community health networks that are being set up across the nine areas. That is the start of the process to examine the issue of acute hospital services and community and primary services working closer together. It is a pilot programme across the nine sites. Ultimately, it is at a micro level and the model that we are moving towards will be at the macro level. We will assess the benefits as we move forward.

The Chairman summarised where matters currently stand, namely, we have an acute service under pressure in terms of capacity and demand and a community service that is under pressure in terms of the availability of step-down facilities, etc. Those are some of the areas we want to look at in greater detail in the context of facilitating better alignment and with regard to the working relationship between the acute facilities and the community side. Overall, it is, as the Chairman described, very challenging.
On elective care, earlier I summarised that there has been some progress. The NTPF has been part of the solution, but so have our own services and the work of consultants. Dr. Henry may want to add to that overall.

In summary, it is a very challenging process. We will be working through it over the next few weeks in the context of looking at the outturn for the year, providing a safe quality framework and making judgments in terms of how we prioritise within the budget for this year. Notwithstanding the challenges we face, we have significant extra finances available this year as a result of uplift we have been given by the Government. We want to ensure that we use this money in the most focused way possible.

**Dr. Colm Henry:** The Chairman is absolutely right. The models of care are key. In the absence of a model of care for chronic disease - be it congestive heart failure or chronic bronchitis, which are well known to the Chairman from his other career - we are going to continue to invest in the wrong way, namely, waiting until patients arrive in hospital and join waiting lists or are placed on trolleys in emergency departments. We need to invest in the whole spectrum of care. We spoke about vaccinations earlier. I refer to self-care, self-management and creating hubs of care in the community built around increased capability of nursing to deliver care long before people reach hospital. The key to this is a reform of public health. This is a piece of work that is being undertaken by my office in conjunction with the Department. We want to build up the capacity of the public health workforce to deal with health service improvement. When we are looking at models of care, we do not rely on the expertise of hospital clinicians alone; we look at the entire spectrum of care required, from prevention and promotion right through to specialist care.

On elective care, there has been a move in recent years, perhaps out of necessity but also, going back to the model of care design, to work with the national clinical programme of surgery - led by Professor Frank Keane previously and now by Mr. Ken Mealy, who is with the RCSI - which has done sterling work. What we have seen is a dramatic increase in the number of day cases. We have seen a shift from procedures being done over a few days now being performed on a day-case basis. Some 20% or more of day cases do not need to take a full day, they can be done in outpatient surgeries or even GP surgeries. That is the context in which the GP contract and enabling primary care are really important. We are putting the pieces in place, namely, a stronger public health workforce focused on health service improvement, a stronger more resilient primary care model and building hubs of care in the community rather than waiting for patients to arrive in hospitals and join queues. That is key to reform.

**Chairman:** With regard to the attempts to come in under budget in the HSE, Mr. Reid mentioned that there is also increased funding to allow this. We have spoken about moving to changed models of care, where everything can be done more efficiently. There are many processes within our hospital structure and the clinical and management element of hospital services that quite often inhibit patient flow through the system. If we allow certain practices to continue in our hospitals, we will be promoting them. Many structures within our hospital system do not work in the best interests of patients. That is where efficiency and cost effectiveness can be applied. Our hospital structures are not in keeping with modern medicine delivery and many of them are 20, 30 or 40 years out of date. Those models are inhibiting patient flow through the system. If there are to be visits to hospitals on a regular basis, we should examine the way hospitals function as there is much inefficiency in that process.

**Mr. Paul Reid:** I apologise as the Chairman asked about innovation and I meant to touch on it. The winter plan review process that we have kicked off across nine hospitals has been
broadened, with the agreement of the Minister, to consider best practice in respect of a range of issues. This does not just take in emergency departments but the relationships between emergency departments, acute and community care. There has been strong feedback from clinicians, nurses and the general work force about variability of processes across acute care. There can be significant variance in decision-making in emergency care. There is some good practice and the winter plan demonstrates where that is. We need to capture that, and this relates to the issue we touched on earlier with respect to consistency in models. Last week. I spent a little time in emergency departments and one can see different practices, including some really good examples. It is about getting the best and making sure those practices are implemented. I will not be able to do that in all hospitals but the process we have kicked off will give us a greater depth of insight and best practice.

Mr. Liam Woods: We are undertaking some work post winter, as the director general has just mentioned. There was mention of weekend working and over the course of the winter we specifically funded access to diagnostics on the weekend to encourage or enable flow. We will learn from that. The National Treatment Purchase Fund will work with us now in acquiring diagnostics and it is something it started doing over the winter. It is happy to do that as part of supporting emergency flow. That is quite important for us, as the committee will understand.

In terms of process we need optimum discharges on a Friday, as hospitals with a high clearance rate on a Friday tend to get through the weekend in reasonably good shape. Difficulties arise when that does not happen. We are looking to learn from this winter with respect to flow and we are doing substantive work using both international and local expertise. That will inform where we go for the coming period and the approaching winter.

Chairman: I thank Deputy Brassil for his patience.

Deputy John Brassil: There is no problem. It is enlightening to have listened to what everybody has said and I have removed all the questions I had that have been asked. I welcome Mr. Reid and wish him the best of luck in his new role. I have great admiration for him for taking on the challenge, and the fact that he is willing to take it on demonstrates that he is a committed man. I wish him every success. Following the Minister’s comments, there is a unique opportunity here and the witnesses have been given a political “free pass” in the form of Sláintecare. If they implement that policy, nobody in this room could fault them in any way. Any time anybody might try to do so, we can be referred to the document that we in this room produced, which was endorsed by the entire Oireachtas membership.

Senator Dolan is on my immediate left and I will start with disability matters. The Minister of State, Deputy Finian McGrath, is present and I endorse the point made about Rehab. I am delighted that matter has been resolved but I anticipate a number of other organisations awakening to those events. The Kerry Parents and Friends Association, which does excellent work in County Kerry, issued a statement indicating its budget is severely challenged for 2019. I might speak a little more about that offline. The disability sector is an area for which we must continually fight as those involved are so tied up trying to look after their loved ones and care that they do not have the time or energy for it. It is always left to us to advocate on their behalf and the Minister of State knows I will continue to do that. I have brought to his attention a number of individual cases and he has made time to meet those people. I thank him for that but I would like some follow-up so I will speak to him offline in that regard.

I will comment on Mr. Reid’s opening statement and the letter he sent about financial control. I greatly welcome that and it is a good starting point. I will throw into the mix the €100
million overrun that he is seeking to avoid but there is also €100 million available in savings in biosimilar drugs. I have been going on about it *ad nauseam* for three years now. This biosimilar policy is meant to be coming and money could be saved. The HSE is looking to make savings and they are available. Mr. Reid should not take any more excuses or reasons for deferral; the money should be taken because we need it. When the Minister of State is looking for €1 million or €2 million and there is €100 million available, is it not time to avail of it?

I am aware of a review of Ireland’s reimbursement process in its entirety that is ongoing and I have some very specific questions on it. I might ask them afterwards.

I would like progress on group recruitment for hospitals. The recruitment area is in itself a minefield. I am most familiar with the hospital in Kerry and trying to recruit for a slightly isolated hospital when doctors want to go to a centre of excellence in Cork. There should be recruitment on a group basis across the board and if there is a shortfall in one hospital - perhaps a category 3 or category 2 hospital - the category 4 hospital should intervene and send people to those facilities. Along with that is the consultant pay discrepancy, and I do not foresee any resolution to the recruitment crisis until that is dealt with. Sláintecare recommends that we do that.

I have stated many times that savings could be made as the budget for the fair deal scheme and home care packages are dealt with separately. The cost of a patient in a fair deal scenario is at least double, if not triple, the cost of keeping him or her at home. In most cases the person would want to be kept at home but he or she is dealt with under two budgets. When a family seeks home care, the district nurse will ask if they have considered the fair deal scheme because he or she wants to hold on to the budget. Those budgets should be in one pot, as this would generate significantly better value for money.

The Minister met pharmacy representatives at their recent conference. I understand there was a very positive exchange. The advancement of the minor ailments scheme would provide great value. There is the issue around the provision of contraception, which is another area where significant savings are to be made.

I am a pharmacist and will declare my conflict of interest, but we have not yet dealt with financial emergency measures in the public interest, FEMPI, restoration for pharmacists. As a group, they are a very underutilised resource. It is only fair they get the same treatment as every other healthcare professional. Will the Minister look at that?

With regard to ophthalmology in my area, as far as I am aware, the National Treatment Purchase Fund does not cover ophthalmology for patients in the Cork and Kerry region, for some reason. If I am mistaken, that is fine, but I do not think I am. I would like it to become available because there is a very large waiting list for ophthalmology in the Cork and Kerry region which I very much wish to be tackled.

On the recruitment issue again, by way of an example, this time last year the cardiologist in University Hospital Kerry handed in his notice. Following parliamentary questions and so on, we were told the recruitment process had begun. Following up almost 12 months later, I got the same answer except it was said that the advertisement for the job would commence shortly. Therefore, 12 months after the person handed in his notice and we were told the recruitment would start, the job has not even been advertised. When Kerry Deputies met University Hospital Kerry management recently, they were as frustrated as we were. It is a systems failure. It just goes up to the national recruitment agency and seems to go round in circles. Nobody seems to have responsibility and, as a result, it has not happened when it should have happened. In the
early part of his role, will Mr. Reid try to come to grips with that recruitment issue and to cut out whatever red tape can be cut out?

I would ask a similar question about nurses. How many nurses are in the system and how many nurses are needed in the system? Again, when we met management at University Hospital Kerry last week, I was pleasantly surprised that the number of nurses recruited in the past 12 months has been significant, but that message perhaps does not get out there and gets lost in all the different controversies. I would like to know the facts as to how many nurses are in the system compared with how many we need. It is sometimes easy to make political points but they might not be entirely accurate.

I will leave it at that for the moment. I will come back to the witnesses in my second contribution on the specific issue of the review of the reimbursement process.

Deputy Simon Harris: I acknowledge Deputy Brassil’s genuine interest in, and advocacy for, the need to do something on biosimilars. We need to pick up the pace on this and we will take away what he said on that. I assure the Deputy it is a priority for us collectively because, as he said, there is a chance to make significant savings for the health service while also doing the right thing by patients.

On the pharmacy-specific issues, to recap briefly, I addressed the Irish Pharmacy Union annual conference in recent weeks and I also had a very fruitful meeting with the IPU at the Department of Health. We agreed there is definitely scope to do an awful lot more with the minor ailments scheme, very much in line with Sláintecare. I very much see our pharmacists as a potential shopfront in many towns and villages for accessing Sláintecare and for providing services in the community. We have suggested to the IPU that it needs to do a piece of work with the Health Research Board on what that scheme would look like and, crucially, how we record the data in terms of making sure we are seeing the benefits. Nobody wants just to duplicate services and we certainly do not want to pay for the duplication of services. We want to pay for services either in terms of moving them to a more appropriate location or bringing additionality, and the Health Research Board could help with that. The IPU is aware of our position on that.

On contraception, I am aware the IPU is going to make a submission to the working group and we will see where the expert view comes to. It has been very helpful in providing expertise and guidance, for which I am very grateful. In particular, it provided an international perspective on what other countries have done.

As I said at the conference, and I am happy to say it again, on the issue of FEMPI we are happy to begin the process of engaging on contract talks by the end of this year, so we will do that. I also made the point that, sometimes, when one sector sees another sector getting something, it becomes a little misrepresented or there are Chinese whispers. The GPs agreed to do a lot of new and different things in return for sustained increased investment. That is the sort of space we will need to be in collectively, but I think we can have very productive talks, which we will start this year.

Mr. Paul Reid: On the question concerning nurses and midwives employed within the system, overall there are 38,260 whole-time equivalents, although there may be more people than that. In March 2017, there were 36,700, so there is an increase of 870 over that period. The Deputy’s point is well made. It may not always be understood by-----

Deputy John Brassil: Perhaps the increase is 1,870.
Mr. Paul Reid: To give the exact figures, it was 36,777 by December 2017 or the start of 2018, and, as of March 2019, there are 38,216.

Deputy John Brassil: That is 1,500 of a difference.

Mr. Paul Reid: Yes. The Deputy made very helpful suggestions in regard to the primary care reimbursement service, PCRS, and savings in regard to biosimilars. I spent an afternoon last week in our PCRS centre on the northside in Finglas. It is an excellent centre and is as good as many centres I have seen operating in the private sector. It is staffed entirely by HSE staff and they certainly have some excellent data in terms of the use of biosimilars, and they are capturing better data as they go along. The Deputy raised the issue about policy change but we can certainly see the variance in the use of it around the consultants and across all the different hospitals. We can see an opportunity in that regard and, as the Deputy said, it is part of our savings measures, given there are some areas we have to deliver on this year. The Deputy also mentioned the reimbursement process overall.

On the issue of using skills across the groups, I agree with the Deputy that it is a question of how best to use them within the group in regard to deployment, and the nurses agreement certainly facilitates and supports that further. That is simply a good use of resources across the group.

On the recruitment issue, we are looking at dealing with clogs in the system. As I have mentioned, there is certainly a lot of recruitment going on. Sometimes it can be done directly through the Public Appointments Service, which is dealing with a significant number of sectors and pressures on recruitment. We are happy to look through that and get back to the Deputy in regard to any logjams we see in the system overall.

Dr. Henry might want to comment on ophthalmology and care.

Dr. Colm Henry: One of the issues brought up was pay disparity, but there are other reasons for the problems in recruiting in model 3 hospitals, not least the size of some departments, especially for single-handed specialists, and also the complexity of the work. Trainees now want to work in bigger centres dealing with cancer or more specialised work, for example, in cardiology with primary PCI. We see a gravitation of trainees coming out who want to work in bigger centres. I do not believe it is just an issue of pay.

Deputy John Brassil: That goes back to my point about recruiting as a group.

Dr. Colm Henry: That was my next point. The hospital groups represent a very good vehicle for group-wide recruitment. Instead of having a department of cardiology for Kerry, there should be department of cardiology for the south west, which would see an integrated approach to cardiology and standardised care. Most importantly, it is about patients, after all, and standardising the care for patients in Kerry, Waterford, Clonmel and Cork. It is not based around the needs of doctors based in one specialised hospital but based on the needs right across the region. I completely agree that is the way we need to go and, to do that, we have to recruit across group lines. That represents one way we can mitigate the effect of trainees not wanting to work and not applying for jobs in model 3 hospitals.

Mr. Liam Woods: There was a question about ophthalmology.

Deputy John Brassil: It was specifically about the National Treatment Purchase Fund, NTPF. I do not seem to be able to get traction for constituents coming into my clinics.
Mr. Liam Woods: The NTPF applies throughout the country and it has acquired ophthalmology services in Cork, although I am not sure about Kerry. I might follow up with the Deputy on the particular circumstances. It sounds unusual to me that a point like that would be coming up. I think the other points were covered.

Senator Rose Conway-Walsh: If the Chairman does not mind, I will get an immediate response to each of my questions rather than piling them all together. I will do my best to conclude in ten minutes if I get short answers.

I also wish Mr. Reid well in his new appointment. I hope he can make the changes that are needed to be made. Deputy Donnelly raised the issue of Spinraza and I have two follow-on questions on that. Did the HSE meet on Spinraza last Thursday as we expected?

Dr. Colm Henry: The drugs committee met recently; it could have been last week. It was not the first time the committee had met to consider this drug.

Senator Rose Conway-Walsh: I understand what happened before last week but I need specific answers. The HSE met last Thursday.

Dr. Colm Henry: The drugs committee met. It advises the HSE leadership. The committee met, as we explained earlier during these questions-----

Senator Rose Conway-Walsh: I am fully up to speed with that. What is the next step?

Dr. Colm Henry: The committee, by a narrow majority, rejected the drug based on cost-effectiveness.

Senator Rose Conway-Walsh: The committee rejected it last Thursday.

Dr. Colm Henry: Yes, it rejected it last week based on cost-effectiveness. Given the importance of this issue, the fact that other jurisdictions have approved the drug and the absence of treatment for the particular cohort suffering from type 1 spinal muscular atrophy, the HSE leadership will deal with this in June.

Senator Rose Conway-Walsh: That is huge. Has it been communicated to the families that Spinraza was rejected on Thursday?

Dr. Colm Henry: That was discussed at the beginning of this hearing.

Senator Rose Conway-Walsh: Yes.

Dr. Colm Henry: The latest judgment of the drugs committee, by a narrow majority, was not to accept the drug based on cost-effectiveness. The matter will go to the HSE leadership in June.

Senator Rose Conway-Walsh: Our guests are aware of the ruling in Britain last week. Did they take that into account? Was the HSE getting the same deal as the NHS is getting in Britain?

Dr. Colm Henry: The National Institute for Health and Care Excellence, NICE, judgment had not come out by the time the drugs committee met last week. That came out afterwards. It is in light of that NICE hearing and the fact that most countries in western Europe are now providing this drug-----
Senator Rose Conway-Walsh: Except Estonia.

Dr. Colm Henry: ----and are facing the same difficulties as us in terms of pricing it and locating the funding for it that we will be bringing it back to HSE leadership next month.

Deputy Simon Harris: That is an important point.

Senator Rose Conway-Walsh: I am shocked by this.

Deputy Simon Harris: To be clear, the HSE leadership team did not reject Spinraza last month. It deferred the decision to early June. The HSE leadership chose not to reject or accept but to come back to the issue.

Mr. Paul Reid: Let me clarify. As we touched on earlier, Dr. Henry has correctly summarised the decision by the drugs committee which has made many decisions throughout the year and has approved-----

Senator Rose Conway-Walsh: I understand that. Is the same price being offered to this State as was offered to the NHS when it made its decision?

Mr. Paul Reid: We would like to continue the discussions with the provider. It would be a commercially sensitive issue to share the price here and, as I said, we are bringing the decision back to the leadership group. We fully understand the finding in the UK last year. The UK, by making its decision, has left us in an isolated position. We want to do the right thing in terms of approval of this drug. We need to bring it back to the management team and also talk to the Department.

Senator Rose Conway-Walsh: When can parents expect a decision on this?

Mr. Paul Reid: We will make a decision in early June and consult the Department on relevant funding and the challenges posed. We expect a decision in June.

Senator Rose Conway-Walsh: Will it be in early June?

Mr. Paul Reid: It will be early to mid-June.

Senator Rose Conway-Walsh: Mr. Reid knows why I am asking.

Mr. Paul Reid: Absolutely.

Senator Rose Conway-Walsh: Time is of the essence, particularly for the two children in County Mayo. Obviously, I am concerned about all of the children involved but I see the two children in Mayo and the way in which they are shutting down. We are all parents.

Mr. Paul Reid: I want to reinforce the point that we fully appreciate how awful the situation is.

Senator Rose Conway-Walsh: Spinraza is part of the BeNeLuxA agreement and arrangement. Is that correct?

Deputy Simon Harris: No. I signed Ireland up to BeNeLuxA. What is correct to say is that the other countries in BeNeLuxA, through their own processes, have bought it. It is not correct to say BeNeLuxA has bought it and we have opted out. The Senator is right that the other BeNeLuxA members have reimbursed the drug through their own processes.
Senator Rose Conway-Walsh: It would be wholly unacceptable if it was deemed to be cost-effective in Britain and was not deemed cost-effective here. I need the right decision to be made as quickly as possible.

I will ask about the valproate response project and the rapid assessment report. I was disappointed that the Minister, or a representative of his, was not at the recent conference with the HSE and the Organisation for Anti-Convulsant Syndrome Ireland, OACS. It was a very good conference. I will go back to the point I made to the Minister some time ago about the need for a judge-led public inquiry into this. We have had 40 years of this and we really need to know who knew what and when and on what basis Epilim was approved for the treatment of epilepsy and bipolar disorder. That was approved for pregnant women.

Does the Minister agree that there are issues of accountability here as to who knew what and when, particularly prior to 2014? That was when the European Medicines Agency, EMA, implemented the first series of risk reductions. The time path can be followed all the way along as the effects of Epilim in pregnant women became more certain. There are now between 43 and 95 children with major congenital malformations and another 1,200 children who have been impacted. It is very important that we have an inquiry into that as soon as possible and all of the documentation is made available. OACS Ireland, through Karen Keely, has obtained a lot of documentation. In the international context, there are hundreds of cases being brought before the French Government for consideration. There is also an investigation ongoing in the UK as to how this drug was prescribed. Will the Minister comment on the need for an inquiry into valproate?

Deputy Simon Harris: I will call on Dr. Henry to respond in a moment because he has a good knowledge of the HSE’s response to this. I had a good meeting with OACS Ireland. I have told OACS in person and in writing that there are three priorities. The first has been to ensure that Ireland acts speedily on the EMA advice and warnings, which we have been doing and I think considerable progress has been made in that regard. The second has been the overall response team and the work that has been done by the HSE in that regard, including the response project and the conference to which the Senator referred. The third has been to focus on putting in place supports for the people who have been impacted.

We need to ask if there is a need for an inquiry to look backwards at what happened. I have kept an open mind on that and neither the Department nor the HSE has reached a decision on the matter. Our focus, from a sequencing point of view, has rightly been on putting supports in place for the people impacted and also making sure the EMA advice is acted on. I keep an open mind on that and have not made a decision.

Senator Rose Conway-Walsh: I ask the Minister to keep an open mind on the matter but I would like a decision to be made on it as soon as possible. Imagine the anxiety of mothers and parents who knowingly took Epilim and the impact it had. The causation and links have been clearly established in the British Medical Journal and in other published writings and documents. The impact that Epilim had on babies is beyond doubt.

Deputy Simon Harris: I agree. The issue that needs to be considered before we establish any inquiry is whether it would provide any added benefit considering this was not a specifically Irish issue.

Senator Rose Conway-Walsh: Yes.
**Deputy Simon Harris:** I need to consider that.

**Senator Rose Conway-Walsh:** I have many more questions to ask.

**Chairman:** The Senator needs to concentrate on asking them.

**Senator Rose Conway-Walsh:** We need to get to the bottom of these issues because they are really important. I am also concerned about the number of misdiagnoses I am coming across. Let us take the example of a woman who is diagnosed with depression and finds out, after months of treatment, that she has stage 4 cancer. I come across this almost daily. It is apart from the CervicalCheck scandal that continues. As late as last week, other women have presented with symptoms after clear smears. Even beyond the CervicalCheck situation people are being misdiagnosed left, right and centre.

**Deputy Simon Harris:** I do not know the specific case to which the Senator refers but we need to be careful about the difference between misdiagnosis and the limitations of medicine and of screening and diagnostic tools. We are beginning to have a big debate on this. I am starting to wonder if we are reaching a point in modern medicine where doctors use the tools available and some of those tools have limitations. That is a separate point to when things go wrong and there are mistakes which is a different matter.

**Senator Rose Conway-Walsh:** Maybe if we can be clear on how we capture the data to measure it.

**Deputy Simon Harris:** There is a responsibility on us to be very careful we do not represent something that may be a limitation of medicine. We have been talking about screening for a long time. We know that a false positive or negative is not a misdiagnosis or a missed cancer. Similarly we know there are limitations to medicine. Dr. Henry, as chief clinical officer in the HSE, may give the Senator more specifics.

**Dr. Colm Henry:** There has been much discussion on this recently, with a focus on screening but also diagnostic pathways. The fact is that screening programmes are at best 80% to 90% sensitive. That is more effectively communicated to people now. In breast screening, for instance, the best-case scenario is 90% sensitivity in picking up. We had a useful discussion at a hearing here before on the importance of people not seeing screening programmes as a diagnostic pathway. An all-clear from a screening test does not mean that symptoms are insignificant. It is really important that people understand that about the development of symptoms, even if someone has received an all-clear. The two are completely different.

**Senator Rose Conway-Walsh:** I do not want to concentrate only on screening but the difficulty is when they go back and say they have symptoms and this is ignored and ignored and then they find out they have cancer. The difficulty in misdiagnosis to which I refer is the number of people who are turned away from hospitals; these are people who present and are told to go home, and they present again because of symptoms and this can go on over weeks. I have been to funerals where this has happened where I was told that people were turned away from hospitals. I am worried that because of staff shortages, ambulances lining up and all those things, vital diagnoses are being missed out on and people are losing their lives.

**Dr. Colm Henry:** There are two issues there.

**Senator Rose Conway-Walsh:** I need Dr. Henry to answer this.
Dr. Colm Henry: Impaired access could never be defended in terms of people getting access to opinions and diagnoses. The fact is that screening and diagnostic pathways are not 100% sensitive either. As the Chairman will know, when a doctor is faced with a clinical scenario, he or she makes a decision and assessment in real time based on the information available. Sometimes looking back there is what we call a bias looking back where, with the benefit of knowledge, everything becomes clearer. We know, for example, in radiology where there are good standards in radiology, if one looks back with the knowledge of a cancer developed, for example, one will see something in 5% or 10% of cases that had not been seen at the time. Unfortunately we cannot provide 100% sensitivity in the care pathways we provide. That is not to defend poor practice or appointments or impaired access but while clinical medicine is improving and is safer now than ever, it is not 100% perfect.

Senator Rose Conway-Walsh: I am concerned about patterns and the trend.

Chairman: I am conscious that the Minister has indicated. If he needs to go we understand as he indicated he would have to leave at 12.30 p.m. We will go into a second round of questions. The Minister may have to leave but his officials and the HSE representatives will remain. Ms Grace Rothwell is here from the South/Southwest Hospital Group. There were issues in relation to the mortuary in Waterford. If anyone has questions on that, they might include them in this round.

Deputy Simon Harris: If I may comment on the Waterford mortuary situation before I leave. I am very grateful to Ms Rothwell for being here today and for her leadership in the hospital in Waterford. She has taken very swift action to improve the situation including putting an interim solution in place. It is now on site and is greatly assisting. It is important that the new HSE director general visited the hospital and met with pathologists and saw the situation for himself. I appreciate that he did that. I want to make two points here. The new mortuary facility will be going ahead in Waterford. Permission to tender has issued and that is something people will see as advanced. We know that it will take some time to build the mortuary and that is why it is important that the interim facility is in place. I did make the point that it is important that there would be some form of review. This was a view shared by Ms Rothwell, the HSE, and the South/Southwest hospital group to look at internal processes and pathways on where remains are received, retained and released from the mortuary and to review management and governance arrangements for the mortuary to ensure that they are consistent with contemporary practice. This morning we signed off on the terms of reference. While I have been here a letter was sent to Oireachtas Members from Waterford outlining the terms of reference and the proposed membership of the review team. It is expected that the final report will be available and finished in September and will inform the short and medium-term arrangements for the mortuary facility and its effective operation, and any broader learning for the health service.

Chairman: I call Deputy Donnelly.

Deputy Stephen Donnelly: Will the Minister be able to stay for the questions or must he go?

Deputy Simon Harris: I can stay for about five minutes.

Deputy Stephen Donnelly: We might have a chat as a committee about timing. The length of time per person has been quite a lot.

I will run through some questions quickly for the Minister. On the report of a private en-
trance to the children’s hospital, can the Minister state if this is true? I was appalled on an ethical basis that there would be any private, separate entrance for people with private health insurance. Is this for real and, if so, can we agree to scrap it and have it designed out of the hospital?

**Deputy Simon Harris:** I am looking at my HSE colleagues. I am not aware that there is a private entrance. I was aware that there were some rooms that would be used and that consultants would pay for.

**Deputy Stephen Donnelly:** It was reported that there was a separate entrance.

**Deputy Simon Harris:** Can anyone answer this?

**Mr. Liam Woods:** I am not aware of this and if there was such an entrance, I should be. I will check this out.

**Deputy Stephen Donnelly:** That is great. Can we agree, at least in principle, that if it is true that is in the design that it is absolutely repugnant to the entire philosophy that we are trying to bring into the country with Sláintecare?

**Deputy Simon Harris:** I agree that there should not be a private entrance. There is not a private entrance to any children’s hospital today and there should not be.

**Deputy Stephen Donnelly:** It would be outrageous if it were true. That is what has been reported but hopefully it is not true.

**Deputy Simon Harris:** I will take that away and will write to the committee on it.

**Deputy Stephen Donnelly:** I thank the Minister. It was said earlier that non-specialist consultants were being overseen, however I understand that they operate as fully-fledged consultants, and therefore while they might report into a clinical director their work has not been checked. In the review that the Minister is talking about, has anyone done a review of their caseload and their work to date to ensure that there is not a risk to patients?

**Deputy Simon Harris:** Is Dr. Henry best placed to answer?

**Dr. Colm Henry:** Professor Murray, on behalf of two of the hospitals concerned, asked the management and clinical management if they had any safety concerns over these doctors and none has emerged to date. Indeed, many have accrued a great deal of experience not only here but also abroad; it just so happens that experience and expertise is not aligned with the criteria required to be on a specialist register, hence the difficulty. Currently, no systematic themes on safety issues in relation to these consultants are coming through. That does not take away from the fact that we need to be in a position where all consultants who are called consultants can be on the specialist register, which is a condition of employment since 2008.

**Deputy Stephen Donnelly:** Representatives from the dentists’ professional body were before the committee last week. One point they made, and they did not hold back, was that regardless of the pros and cons of the new oral health strategy, they were not consulted. Does the Minister accept their position on that? If so, why would an oral health strategy be launched that did not consult with either the dentists or their professional body?

**Deputy Simon Harris:** No, I do not accept their position. Consultation did take place with the Department. I also have an email form the Irish Dental Association welcoming the strategy.
I am happy to show that letter to the Deputy. I want to be constructive on this, however, and it is fair to say that we will have to negotiate how we will pay dentists to deliver the strategy. Consultations were held with my Department and with representatives of the Irish Dental Association. Now that the policy is agreed, the normal negotiations will take place.

Deputy Stephen Donnelly: I thank the Minister. We have been waiting for a Government or HSE-approved costing for Sláintecare for about two years. Sláintecare came up with its own fairly rough and ready figures to begin with. We disagree on whether the amount allocated to date is closer to €20 million or €200 million. We probably all agree that it is significantly below the Sláintecare figures, which called for about €500 million or maybe a bit more for the first year. Does the Department, the HSE or both actually have a set of figures for implementing Sláintecare? I am referring to year-on-year cost.

Deputy Simon Harris: I am happy that we have come back to Deputy Donnelly on this. I know what the Deputy wants and I am happy to provide it to the Joint Committee on Health, namely, the cost of delivering the individual elements of Sláintecare. The reason there is no single document outlining the costs is that several parts of Sláintecare present different options. There are also several parts of Sláintecare on which negotiations must take place. For example, I refer to the de Buitléir report on removing private practice from public hospitals. First there is the question of whether we should do it. I have made my view clear, but there a cost arises whether we do it or not. Then we must determine how to do it. There are costs there too.

Moreover, a massive body of work on eligibility is ongoing. The Sláintecare report does not say everything should be free. The exact phrase is “either free of charge or at a low cost”. Costs depend on where we land on the eligibility question. There are several forks in the road which will determine the overall cost. If it is helpful to the work of the Deputy and the committee to know what each of the elements will cost, we can certainly ask the Sláintecare implementation office to provide a note. There need not be any secrecy around that. I am simply making the point that there are some figures we cannot provide with absolute certainty as they will depend on policy options and negotiations.

Deputy Stephen Donnelly: I wish to ask one final question if I may. It should be quite quick. I refer to staffing of the national children’s hospital satellite clinics. They are due to open this summer.

Deputy Simon Harris: At the end of July.

Deputy Stephen Donnelly: That is welcome. However, I am hearing directly from paediatric consultants who express very real concerns. We are in the middle of a recruitment and retention problem with consultants. We have about half the number that we need. We are about 40% below the average for Organisation for Economic Co-operation and Development, OECD, countries. Children were marching in Cork today or yesterday because they have been waiting for two years for a paediatric consultant specialising in diabetes. There are a lot of issues around a lack of consultant specialties and subspecialties. One of the concerns raised with me in the last few weeks is that in order to get the satellite clinics open, consultants and paediatricians within the three existing Dublin-based hospitals are being encouraged, some might say pressured, to move from the three Dublin children’s hospitals out to the satellite clinics. Can the Minister give an assurance that no such pressure will be applied? I wish to make sure the service level provided within the three children’s hospitals will not be disrupted or pressurised in order to get the satellites open.
**Deputy Simon Harris:** I have heard similar concerns. I met Children’s Health Ireland, CHI, on this recently. To make the obvious point, outpatient clinics will be provided in the satellite centres that are being provided in the children’s hospitals today. Obviously Dr. X, who provides a service in one of the hospitals, will go out to the new outpatient centre to provide his clinics. That movement will take place but that is not what the Deputy is talking about. Thus far ten additional consultants have been hired for the centre at Connolly Hospital Blanchardstown. The Secretary General confirmed to Deputy O’Reilly earlier today that nine of them are new consultants. One of them has come from Tallaght Hospital. That post is now being backfilled. My understanding is that all the nurses who need to be in position are in position. In response to an oral question last week I said that in one or two areas, such as radiology, the clinics are working on a contingency plan or locum cover in case they cannot get a permanent post. The HSE remains convinced that this facility will open at the end of July, which I presume means 31 July. This year it will provide just over 6,000 more outpatient appointments than are provided by the current system. Those ten additional consultants have been hired. I am happy to ask CHI to send the committee a note to that effect-----

**Deputy Stephen Donnelly:** Is the Minister satisfied that staffing the satellites, which we accept needs to be done, will not put the existing service provision under pressure?

**Deputy Simon Harris:** Yes, I am satisfied that it will bring additionality rather than pressures.

**Deputy Louise O’Reilly:** The Minister said that the consultants will pay for the private wing of the hospital. How much will it cost, and how will the Minister get the money from them? Is the Minister just guessing that he might get the money back at some point?

**Deputy Simon Harris:** Not at all. It is a matter for Children’s Health Ireland. Perhaps Mr. Liam Woods has details on the arrangements.

**Mr. Liam Woods:** I can come back to the Deputy with the detail. I do not have it in front of me but I can certainly get it.

**Deputy Louise O’Reilly:** To be specific, I want to know how much it is going to cost and how the Minister is going to get every shilling of it back. Of course it would be better if we were not spending on that, but that is the Government’s own business and its own ideology.

I have a few very quick questions. A couple of weeks ago my colleague, Deputy Funchion, filled in for me and the Minister made a commitment to give us an update on the CervicalCheck backlog. Can he give us that update now? What additional laboratory capacity has been sourced to clear the backlog? Where is it, has it been quality-assured and is the Minister confident that it will make a real difference to the backlog?

**Deputy Simon Harris:** I will start and I might ask some colleagues to contribute. The backlog is decreasing. From my memory it was above 80,000. The last figure that I saw was about 71,000. Earlier I confirmed this in writing to Deputy Donnelly. I will get Deputy O’Reilly a copy of that letter today.

**Deputy Louise O’Reilly:** I would be grateful if the Minister could do that.

**Deputy Simon Harris:** I am pleased to say that the backlog is finally beginning to decrease. I said at this committee before and I am happy to say again that I expect the backlog to continue to significantly decrease over the summer months. We will achieve much better
turnaround times. Additional capacity has been identified by the HSE. That capacity is with Quest Diagnostics. It will ensure that the programme can continue to operate at 100% and will prevent the need for a pause in it. The legal details are being finalised. I do not know if HSE colleagues have anything further to add to that.

**Deputy Louise O’Reilly:** Given that the capacity has been sourced from Quest Diagnostics, there were issues about-----

**Deputy Simon Harris:** I apologise. the Deputy asked about quality assurance.

**Deputy Louise O’Reilly:** People believed testing was carried out in one area and then it turned out to be done in Honolulu. Could we get a bit of clarity on where exactly the labs are?

**Deputy Simon Harris:** Formally the negotiations are still ongoing. The labs that will be used have been quality-assured. I have asked if they have been quality-assured in line with the Scally report and I am told that they have.

**Deputy Louise O’Reilly:** Does that mean they have been quality-assured to Irish standards and not American ones?

**Deputy Simon Harris:** Yes.

**Deputy Louise O’Reilly:** That is good. Perhaps the Minister will provide could confirm the labs’ exact location in writing.

**Deputy Simon Harris:** I am more than happy to do that. It might take a few days while the negotiations are finished.

**Chairman:** Could the Minister send that to the committee?

**Deputy Louise O’Reilly:** That is a better idea.

**Deputy Simon Harris:** If it is helpful, I have a specific figure on the backlog which I may as well put on the record. It was above 80,000, as the Deputy will remember. On 9 May it had decreased to 77,000 and on 13 May, it was 71,361.

**Deputy Louise O’Reilly:** That is still more than 70,000.

**Deputy Simon Harris:** Yes, but it is down from 80,000 and is beginning to decrease.

**Deputy Louise O’Reilly:** If it has gone from atrocious to awful it is still awful.

**Deputy Simon Harris:** Yes, but let us get it to good. That is the plan we have been working to put in place.

**Deputy Louise O’Reilly:** Very well. I have my fingers crossed.

**Ms Anne O’Connor:** MedLab is only handling the backlog.

**Deputy Louise O’Reilly:** I thank Ms O’Connor.

I refer to the issue of the misreading of scans at University Hospital Kerry. That is now back in the media, which is unfortunate and very regrettable. We have seen that more patients have very regrettably and unfortunately passed away. Does the Minister have any idea when the investigation into this will be concluded? Will the Minister go to Kerry to meet the families that
have been impacted? It has been reported that they made a request for a meeting.

**Deputy Simon Harris:** I certainly will be going to Kerry. I hope to go there by the end of June. I am sure we can look into making those arrangements. I am not suggesting that people have not requested a meeting but a request has not been brought to my direct attention.

**Deputy Louise O’Reilly:** That is fine. There is no issue with the Minister meeting the families if he has to.

**Deputy Simon Harris:** No. There is no issue.

**Deputy Louise O’Reilly:** I am sure they would be delighted.

**Deputy Simon Harris:** Perhaps the HSE might update us on the implementation of the recommendations in the look-back review.

**Mr. Liam Woods:** I have a brief report on the recommendations of the look-back review and their implementation. It includes a two-page summary. I can make it available to the committee after the meeting.

**Deputy Louise O’Reilly:** That would be good. I thank Mr. Woods. I have a question for the Minister on the third-party reviewer for the drugs approval and procurement process. Has that person been appointed and if so, who is it?

**Mr. Jim Breslin:** I cannot confirm that individual. I do not have the name but I can get that for the Deputy.

**Deputy Louise O’Reilly:** If Mr. Breslin could that would be good. Has that person started work?

**Mr. Jim Breslin:** I believe so. That person has been engaged. I have not met the individual yet. I am due to do so.

**Deputy Louise O’Reilly:** The Minister has announced the setting up of a contraception working group within the Department of Health. Will the Minister confirm if this up and running?

**Deputy Simon Harris:** The group is up and running and due to report to me in September.

**Deputy Louise O’Reilly:** Will there be engagement with stakeholders? Has the Minister reached out to them or is it expected that they will have an input into the process themselves? How are they to be involved? I am referring to such organisations as the Irish Family Planning Association, IFPA.

**Deputy Simon Harris:** Yes. I understand that the contraception working group has started reaching out to stakeholders and there will be an opportunity for submissions to be made to the group. I met the Irish Pharmacy Union, IPU, which is making a submission, and the HSE sexual health unit. I am aware that there are a number of family planning organisations that will be contacted and given the opportunity also.

**Deputy Louise O’Reilly:** They will be contacted. That is fine. That was my question.

**Deputy Simon Harris:** They will all be given an opportunity to submit.
Deputy Louise O’Reilly: I have two very brief questions for Ms Rothwell. I repeat that we were not expecting her to be at this meeting and therefore the Deputies from Waterford have not had a chance to get here, which is very regrettable. It was not-----

Deputy Simon Harris: I do not want to interrupt the Deputy but it is my understanding that the committee was informed that Ms Rothwell was coming. Perhaps this was lost in-----

Deputy Louise O’Reilly: It was not flagged in either of the opening statements, which would give me to understand that there was not going to be a representative here from the Waterford hospital. The opening statements detail who will attend the committee meeting. When I read those statements I took it to mean there would no such representative attending.

Chairman: For clarity, we had flagged to the Department that the committee would like representatives here so-----

Deputy Louise O’Reilly: That is different, Chairman. The committee had told the Department that we expected the representatives to be here but the opening statements did not indicate that there would be such a representative here. All the information we had to go on was that we had made the request, not that the request had been acceded to. While I have Ms Rothwell here, I have two very quick questions, if that is okay.

Will Ms Rothwell advise as to when she first became aware of the issue around bodies decomposing and all the issues that have been referred to in the media? Was she aware of these issues in March when she met the consultant pathologists? The contents of the October letter, which is now in the public domain, brings into sharp, unfortunate and regrettable focus the awful and horrific treatment of people who have died, and of their families. When Ms Rothwell had the meeting with the consultant pathologists in March was she aware of that? The letter referred to the pathologists having raised the issues over a long period. Separately, there is also a contention that senior management was not aware of it. This lacks credibility but maybe this is me just being a bit cynical. Will Ms Rothwell let the committee know if she was aware in March?

Ms Grace Rothwell: First, I would like to say that if any staff or pathologist feels that the issues they raised have neither been acknowledged nor heard, I apologise for that. I have already apologised to the pathologists in the hospital.

I started in post on 14 January. I received an email from one of the pathologists on 29 January, and I met them on 11 March. At that stage it was flagged to me, specifically in the context of a lack of refrigeration capacity and particularly in advance of the summer. I took action on that in the form of linking with technical services to secure additional refrigeration. That was my knowledge of it at that time until the media controversy.

Deputy Louise O’Reilly: Ms Rothwell would not have been aware of the issues around bodies decomposing and deceased persons requiring closed coffins because of-----

Ms Grace Rothwell: No, not to that extent. Absolutely not. The consultants flagged to me the issues around refrigeration capacity and they suggested it specifically in advance of summertime. That is what I took action on.

Deputy Louise O’Reilly: Was that just on refrigeration? I am not a scientist but I certainly know what happens to a dead body if it is left out in the open without adequate refrigeration. Would Ms Rothwell also have been aware of this, as any one of us would be? Maybe she was
aware but just did not like to think about it, which was a luxury the families did not have, unfortunately, because they had to deal with it.

Ms Grace Rothwell: In addition to the specific actions that were taken, I also looked at the mortuary. I very quickly learned that it has been there since 1991. I have no issue with the fact that the facility is no longer fit for purpose with regard to post mortems. I discussed with the group the approval to go to tender for the new build for the mortuary, which was received before the end of March.

Deputy Louise O’Reilly: I understand that the State pathologist is not using the mortuary any more for post mortems and is not sending bodies there. Is that still the case?

Ms Grace Rothwell: Yes.

Deputy Louise O’Reilly: That is known and is in the public domain, but is Ms Rothwell confident and happy that it is a safe place for staff and visitors given that the State pathologist is not utilising the service and is bypassing the facility at Waterford? This is not exactly a ringing endorsement. Nobody wants to have to go there. Except the staff who work there and have no choice, none of us wants to have to go to that part of the hospital with regard to our loved ones. The State pathologist is not happy with the facility. Is Ms Rothwell confident that it is a decent and safe place to work for staff and visitors?

Ms Grace Rothwell: There are three specifics things I have initiated, one of which is the additional refrigeration capacity. Second, we have a senior anatomical technician starting next Monday. There would be such a post also in other mortuary facilities, and this person, in effect, takes charge of the mortuary to ensure that policies, procedures and protocols are in place for receipt of, storage of and release of remains from the facility.

Deputy Louise O’Reilly: Is that post not there already?

Ms Grace Rothwell: The third element is the commissioning of the review. The real purpose of the review for me, the group, the national system and the public and users of the hospital and our service is to provide that the facility is fit and safe for purpose pending the new build.

Deputy Louise O’Reilly: My question relates to today. Is Ms Rothwell happy today that the facility is a safe and decent place for people to work in, and for visitors who, unfortunately, have to go there? Is she happy about that today? Ms Rothwell referred to an appointment that will start on Monday to put in place policies and procedures. Is the witness saying that those policies and procedures are not in place currently?

Ms Grace Rothwell: I am happy today that there is adequate refrigeration capacity, that it is an appropriate place for relatives to view remains, and that we have put in place immediate procedures to ensure that it is a safe place. I am also mindful, however, that the structure was built in 1991 and, in the context of post mortems, the post mortem room is not fit for purpose. I believe that the primary concern of the Office of the State Pathologist relates to potential contamination of evidence. The post mortem room is not in accordance with air conditioning and air handling. That is the specific issue for the State pathologist.

Deputy Louise O’Reilly: That is an issue for the staff also. If there is a risk of contamination, it is not just the evidence. It also affects the people who work there.

Ms Grace Rothwell: Equally, just this week I have secured air conditioning and air han-
duling units that will be installed over the coming weeks.

Deputy Louise O’Reilly: Has the Office of the State Pathologist said that it will use the service from now on and that it is happy with the facility?

Ms Grace Rothwell: No, not at this time.

Deputy Louise O’Reilly: No. The Office of the State Pathologist is still unhappy with it but people are still working there. I have to tell Ms Rothwell that I would not fancy working there and I do not think she would either. It is not great. We were not prepared for this discussion because it was not flagged in the opening statements. Sin é.

Chairman: Will Ms Rothwell indicate when the terms of reference will be made available for the review and who will be in charge of conducting the review? The Minister has said it would report in September. When will we see the terms of reference?

Ms Grace Rothwell: My colleague might answer that.

Mr. Liam Woods: The terms of reference are in completed form and today we are looking to confirm the chairman for the review. We have also already identified two histopathologists, a laboratory manager, a pathology technician and a group director of nursing to sit on the review. They come from elsewhere in the system nationally. We are looking to appoint the chairman over the course of today and tomorrow. The terms of reference will then be made public and we can send them to the committee.

Chairman: I thank Mr. Woods. We now move to Senator Durkan as a sitting member of the committee - apologies I mean Deputy Durkan - and then on to Senator Dolan.

Deputy Bernard J. Durkan: With no disrespect to the Senators, I hope the Chairman is not clairvoyant.

Chairman: It is the Upper House.

Deputy Bernard J. Durkan: I have two or three questions that come to mind with regard to the Waterford issue. What are the applicable standards that apply at present in other mortuaries throughout the country? What degree of supervision continues and what action has, or can be, taken to prevent a recurrence? It was a most embarrassing and insensitive occurrence from the point of view of the relatives of persons who were in that mortuary or who had gone through it. What is the position with the others?

Ms Grace Rothwell: There are various guidance documents available from both the Health Protection Surveillance Centre and abroad that provide guidance in respect of mortuary facilities and standards for air conditioning, temperature control and so forth. There are also health building notes. When that premises was built in 1991, it complied with the building notes at the time, but the building guidance has since been updated so our facility does not comply. The building that will be on site within the next two years will comply fully with the health building notes that are available. I have met the pathologists in the hospital and have asked them to identify anything else I can do in the interim pending the new build. Equally, the review process will determine any required actions or improvements that we can implement pending the new build.

Deputy Bernard J. Durkan: I thank Ms Rothwell but that does not address the issue. What standards apply in all the other mortuaries in the country? Have they been examined to
assess whether they are compliant with modern regulations? Is there a system in place whereby it can be reported that a location is no longer fit for purpose? Has any action been taken or will action be taken?

Mr. Liam Woods: There are a couple of elements in the answer to that question. One is that we have a design and dignity programme with the Irish Hospice Foundation. It is for end-of-life care, including mortuaries, so it is other facilities for families and the bereaved. That programme has invested in 13 mortuaries over the last period of time, with 41 projects in total. Through our estates function we have also looked at mortuaries nationally, their condition, what the investment programme is, whether there has been investment in mortuaries over time and what we think will be needed. I suggest we get a briefing from the estates function so I can revert to the committee with its view on that, but such work has been undertaken.

Deputy Bernard J. Durkan: Chairman, this is where I refer to my oft repeated mention of the chain of command. We do not have a chain of command. The morning after that issue became public, a message should have gone out to all posts that this had happened, what the cause was and stating what action was being taken nationally to deal with a potentially similar issue. It is not enough to say it is being looked at now. The HSE has either been monitoring this or it has not. If it has not, some questions have to be asked. The distress of relatives has been mentioned. It is a serious issue. It is also a serious issue of disrespect for families in a very sensitive situation.

I will return to my question. I do not believe a review is necessary. We should have a report now, and the HSE should have the report weeks after the issue arose, outlining the standard and quality of the accommodation available in all the mortuaries in the country. There is no sense in having this issue hanging about in the background and suddenly there is an embarrassing situation and the Taoiseach and the Minister are doorstepped to deal with it. That is not the way things should work. There is a simple way to deal with these matters - there is either ongoing supervision and appraisal of the quality and standards of conditions applicable at the locations or there is not. If there has to be an emergency every time we decide to improve the situation, that is unacceptable. Has any communication gone to the various authorities to whom we might apply to ascertain whether there are similar situations pending in other areas and, if so, to what extent?

Mr. Liam Woods: I did not mean to suggest that there would be work done now. The estates function of the HSE, as the Deputy correctly suggests, is aware of the state of the capital infrastructure of the HSE. There is already knowledge about that. All I was referring to was that the estates function is not represented here today. However, there is such an assessment so it is not the case that the HSE needs to go out to understand it. On the wider issue of end-of-life care and the condition of mortuaries, of course there is an alertness to the issue, but that is already determined at the level of capital planning, as one might expect it to be.

Deputy Bernard J. Durkan: What worries me is that I have heard capital planning mentioned three or four times. This is all supposed to have been dealt with in the context of capital planning if we are doing our job. We must have advance planning. If we do not have it, we will not know what we are going to do, what will happen down the road, or what embarrassing situation will pop up out of the woodwork. I am sorry to have to say this but that is not acceptable. That is a very serious flaw in the administration of the system. If anything else in the HSE is being dealt with in the same fashion, there will be further and more embarrassing issues arising in the future. I make my appeal again, and I do not want the capital plan as the response. The Waterford issue should have been dealt with in the capital plan, and presumably it was, but there
was some type of glitch in the system.

I deal with glitches in the system every day. I do not report them all but many of them should not occur at all if we are running business the way it should be run. That means there should be nothing pending which is likely to present a flaw in the delivery of the services that we are expected to deliver. Going back to 20, 30 or 40 years ago, at least we could do something about it then, and if a report was done last week, it would all be done and dealt with. I realise there was a response to it, but there should have been a response long before this happened. I cannot understand why that did not happen.

**Chairman:** Thank you, Deputy.

**Deputy Bernard J. Durkan:** Perhaps somebody might tell me how I might be made to understand how it did not happen.

**Mr. Liam Woods:** Part of the purpose of the review would be to comment on some of that. The HSE is operating within its available capital envelope. It lists priorities and this was one of the priorities.

**Deputy Bernard J. Durkan:** I do not wish to labour the subject, but the response is unsatisfactory. The capital programme at all times should reflect the potentially sensitive areas within the system and it should address them. If that cannot be done, we are operating on a wing and a prayer and not dealing with the job.

**Chairman:** Thank you, Deputy.

**Deputy Bernard J. Durkan:** My last point relates to the children’s hospital. I am not aware of the source of the publicity that suggested there should be a separate entrance, but I would like to find it. If it was a deliberate part of a plan by somebody to create apartheid in the health services, it is unacceptable.

**Chairman:** Thank you, Deputy.

**Deputy Bernard J. Durkan:** I am conscious of the time so I will not go back into that subject again, but like everybody else, I have a view and I am entitled to express it. That is what I am doing. With regard to the provision of private accommodation in the children’s hospital, I do not have an ideological problem with a crossing over between the public and private sectors provided that is necessary. If we are building a very modern hospital, the like of which has never been embarked on previously in this country, I hope nobody is suggesting that we should exclude private patients if the services in the hospital are appropriate to their needs. Private patients pay tax as well. That must be borne in mind. Playing around with the situation in that area is not acceptable. We have a serious requirement on hand to provide a modern service and a children’s hospital comparable to anything available globally. Any attempt either to segregate people or prevent them from gaining access as required is unacceptable.

**Mr. Jim Breslin:** We have undertaken to fully establish this, but my understanding of the plans is that there are approximately eight rooms that are cheek by jowl with other rooms in this part of the hospital. I cannot understand how access to those eight rooms would be through one door while everyone else has to go through a different door. We will establish the position and confirm it with the committee, but I do not want this to be taken as fact. I believe it is probably not the case.
Deputy Bernard J. Durkan: Mr. Breslin might look into the allegation as well.

Mr. Liam Woods: I took the precaution of briefly checking this during the course of the meeting. All services are accessed via the main door of the hospital. That is the message I received from the hospital group. I will confirm in writing to the committee the exact position, as agreed with Deputy Donnelly.

Senator John Dolan: I suggested that people with disabilities might be thinking that Mr. Paul Reid is the Department of Public Expenditure and Reform’s man in the Department of Health. Is Mr. Reid referring to the former Department when he mentions the funders of the health service having trust and confidence in the HSE and that this is a bedrock or foundation from which to progress? My issue is that we now have a certain level of services in the disability programme. It is clear that some people getting those services have a greater need than is now being met. Mr. Reid mentioned a figure of 5% per annum and the criteria or scope around the service plan for this year. Given demographics, people are going to have enhanced needs. Some 15% of the parents of users of St. Michael’s House in Dublin are aged over 70 and they have sons and daughters living in the community with them. The same is the case all over the country. While we are waiting for the Department of Public Expenditure and Reform, or the funder, to have trust and confidence, there are people with needs who are practically hostages. Their needs are increasing and they are going to be waiting until that imprimatur is given. That issue must be fixed now and triaged.

I asked the Minister of State a question about the €16 million deficit in the disability services programme. After yesterday’s news, has that figure increased to €18 million? That was all done in the knowledge that there are soft areas where there are deficits. I made a statement, to which I have not received a response, that as things stand there will be a major crisis in terms of the delivery of services committed to in the service plan. That is to say nothing of the people who are waiting.

The Minister of State also mentioned that 160 people have come out of institutions. This is not news to the Minister of State - he knows this fact well and is concerned about it - but there are 1,300 people under the age of 65 in nursing homes. None of them should be in nursing homes populated by people over the age of 80 who are in the last two years of their lives and quite fragile. None of these people should be in those institutions. The HSE is putting people into these institutions while taking a couple of hundred out of other institutions. That must be admitted. I suggest that this is happening not because of the bag of community-based tools - I refer to personal assistants, home supports and a range of other services - that can postpone the day people have to go to these places, or indeed stop them from having to go to them in the first instance. Recently, a 33 year old man went into a nursing home in north Dublin on the basis of having previously been admitted to hospital for a number of weeks. While he was in hospital, the few hours of home support and personal assistance he had were swiped from under him and are no longer available. There are crazy things going on.

I would like the officials to deal with those three points. I thank the officials, and Senator Rose Conway-Walsh in particular for raising the Epilim issue. Karen Kealy from my organisation provided support on this issue at the very start, and it is great to see other people taking it up now.

Mr. Paul Reid: The funder is ultimately the Exchequer, as approved by the Oireachtas in the budgets that we get. That is the process. The point I was making was that after that budget is approved, we do not wait for more funding to arrive. We are committed to delivering the
funding that has been committed to us for this year. We are not waiting for that €16 million. We are carrying on and delivering the services within the budget we received.

Senator John Dolan: As I understand it, the HSE does not have that funding at the moment. It has a deficit.

Mr. Paul Reid: We have our ultimate funding, as approved, for this year for the service plan.

Senator John Dolan: It does not include that figure.

Mr. Paul Reid: We have what has been approved for us this year in terms of the €16 billion and the various services committed in the service plan against that budget. We are proceeding with it.

Senator John Dolan: The HSE is proceeding with an amount that is €16 million less than what is required to provide the services it provided last year.

Mr. Paul Reid: The €16 billion we are providing for this year-----

Senator John Dolan: I am talking about €16 million for the disability services programme.

Mr. Paul Reid: Perhaps one of my colleagues can provide specific answers to the Senator. Ultimately, we are getting on with the service plan, with a significantly enhanced budget compared with last year. That is my challenge, as I set out earlier.

Ms Anne O’Connor: We recently put a placement improvement project in place. The Senator has correctly stated that many people are managing in very difficult circumstances. Some people go into placements, while we try to support other people through respite and different types of home support. We are very conscious that we get very different responses across the sector in terms of the placements we purchase. We are now conducting a review of all placements. The costs of placements in the disability sector increased by 22% between 2014 and 2018. The range of costs for placements is very wide and we are very focused on trying to provide very good quality and person-centred care and standardising placements around the country. In different parts of the country there are different practices and different reasons for putting people into placements.

Senator John Dolan: Is Ms O’Connor talking specifically about young people going into nursing homes or broadly about the disability services programme?

Ms Anne O’Connor: I am talking about all placements in disability services. The review is being headed by a consultant in the west who has carried out this work in the UK with therapists. We will review placements, consider the decision making around placements and examine how we can get the best placements for people so that their needs, which are often very complex, can be met. That work has only kicked off very recently. We are hoping to get a much better view of placements on its completion. At the moment, we are often responding in emergencies. We do not always have providers available and it can often be some time before placements are made available. This initiative is considering all of those issues because we are conscious that there is a major need out there that we cannot meet with the resources available. We can, however, satisfy ourselves that the resources we are currently putting into placements are providing the best approach to care for some people. We want to look behind all of that.

Deputy Finian McGrath: There is a link between congregated settings, nursing home
issues and young people in nursing homes. The reality is that there are 2,200 people in congregate settings and we are trying to move 160 people out this year. We would like to do more, of course. Young people in nursing homes is an issue that is closely linked to the debate around personal assistance hours and home support hours. It is also linked to the broader issue of the cost of having a disability. I work closely with the Department of Employment Affairs and Social Protection on the issue and we are carrying out a study at a cost of approximately €300,000 to deal with the high costs for persons with a disability who must buy aids, medical equipment, drugs and so on. The plan is that the research will be completed by the end of December, with an interim report due by the end of August. Therefore, we are taking action on the matter which we take as the reality. It is linked with the Senator’s strong point about people living in the community. When trying to keep people out of institutions and help them to live independently, a value for money argument must be made. That is part of my role. The bottom line is that for people living in nursing homes to whom the Senator referred, we must design services in their interests. That is the direction in which we must move to ensure an inclusive Ireland, but we must also convince others that it makes economic sense for people to live independently with support in their own home.

Senator John Dolan: The State is paying for such persons to be in a nursing home. There is already a significant budget for them, although I will not say whether I consider it to be enough or comment on it.

Deputy Finian McGrath: When we carry out the examination and calculate the figures, we must be creative and examine exactly what is happening. Nevertheless, we need to ensure extra funding will be made available. We must fight for it. That is part of my job.

Senator John Dolan: Is the Department or the HSE suggesting I am largely wrong when I say there will be a crisis in the funding of disability services this year? I refer to funding for people currently receiving services, not to mention those outside the door who are seeking them.

Mr. Jim Breslin: When the Minister of State spoke about Rehab, he acknowledged that broader issues would need a process and engagement. We are all committed to trying to manage the matter. There are particular pressures in the disability sector, but it is not unique in having to cope with additional demands within a finite budget. We must be clear and establish where the money is being spent. That process has been undertaken with Rehab to ensure it is all incurred properly and in line with what we expect. Any effort to examine the matter will require a process, rather than a one-off approach, but the process with Rehab is continuing. It will not simply be a meeting to decide on an outcome, rather it will have to involve a continuing commitment by both parties to work in the collective interest of clients. It must not try to impose the problem on either party. Instead, it must be a genuine effort to resolve issues that will involve both parties challenging each other and reaching an outcome in the best interests of clients, rather than those of either party sitting across the table from the other.

Senator John Dolan: The value for money review for the period 2009 to 2012, inclusive, was concluded seven years ago. We went through a recession when the scalpel and filleting knife were taken to everything. I am not against reviews, but while they are in progress, circumstances get worse for people. How much can be learned from a review, given what I have outlined? It could be marginal, although if it is greater, that is brilliant, but we are sliding past the fact that people are still going without services and I am concerned there is not a simple, honest acknowledgement of it. Dr. Henry referred to self-care management, early intervention and public health. A great deal could be done in that regard. Many organisations work in that space, although there is no magic pill and such a change could take three, five or ten years.
Many people suffer badly every day, despite all the talk of reviews and so on.

Mr. Jim Breslin: There are, however, two issues. There is no lack of acknowledgement of unmet needs or of the requirement to plan for needs before they arise.

Senator John Dolan: There is a lack of acknowledgement.

Mr. Jim Breslin: There is not. There has been such an acknowledgement in the replies to the questions the Senator has asked the Department and the HSE, as there has been during this meeting.

Another question concerns the cost of running the current service before unmet needs are addressed. The HSE would be in a better position to explain, but many of the issues that have been presented to it relate to the cost of the current service before additional clients are brought in. That is another issue that needs to be focused on. I do not fully subscribe to the fact that just because the value for money review took place some time ago, the job has been done. I ask the disability sector whether all of the recommendations made in the value for money review have been fully embraced and whether it has gone to the last to ensure it is as well organised as it can be in delivering current services. There were recommendations made in the value for money review that asked questions about that such as in respect of back-office arrangements and organisational overheads. There has been no transformation on that level. There has been incremental change. In fairness, some providers have made changes, but we have not moved decisively towards something that looks very different from when the recommendations were made in the value for money review. I would not say the job has been done. If the current cost of the service is cited, the HSE is quite entitled to ask what are the overheads that do not add value for the client and that could be met in a different and more efficient way such as by sharing services with another disability service provider or linkage with other disability service providers. There must be a two-way conversation. It simply cannot be the case that somebody presents a problem and somebody else solves it because that will not be possible.

Senator John Dolan: That is not my understanding of the reality. Disability organisations, including the Disability Federation which I know quite well, have been involved under the bonnet in the implementation programme. Ultimately, the HSE is the funder. Since 2013, it could have driven the questions the Department is asking. Again, I am hearing talk of insurance costs and procurement. I sat with representatives of the HSE in 2013, as did representatives from the other umbrella organisations and groups, to discuss utility costs such as oil, heating, insurance costs and so on. They are not new issues. Two of us have engaged, although how well we have done so might be a more useful question to ask. Perhaps the engagement has been episodic, but I do not accept that there has been none.

Mr. Jim Breslin: I said there was further work to be done. It is the job not only of the HSE-----

Senator John Dolan: There is work to be done by the two bodies. I did not suggest one side should lob issues to the other side and say the other side should resolve them.

Mr. Jim Breslin: Neither is it only the HSE’s job to manage costs within the organisations.

Senator John Dolan: Yes, it is the organisations’ primary job.

Mr. Jim Breslin: The two organisations must work together in that regard.
Chairman: I thank Mr. Breslin.

Deputy John Brassil: I return to the review of the reimbursement process. Will Mr. Breslin confirm that a third party reviewer has been appointed? Who is it?

Mr. Jim Breslin: Deputy O’Reilly asked the same question, but I did not know the answer at the time. It is Mazars.

Deputy John Brassil: Has that work commenced?

Mr. Jim Breslin: The firm has been engaged. As I stated, I have not yet met it, but I am due to do so. I believe the process is under way. The target is to complete it three months after its commencement.

Deputy John Brassil: While I welcome the review, I am concerned that it will take only three months to complete because it is a significant body of work. I am anxious that consultants, clinicians, patients and the industry all be consulted to ensure an effective process.

I am also concerned about the terms of reference. If the review concerns only the Health (Pricing and Supply of Medical Goods) Act 2013, an Act which has flaws, one could come to the conclusion that the Act is being properly implemented. That may well be the case, but given that the Act needs to be reconsidered, the terms of reference should also be reconsidered and expanded.

Mr. Jim Breslin: I can give the Deputy a summary of the terms of reference, if it is useful. It does not involve a review of the Act; we would not give that to Mazars to do as it is a policy piece. However, it does touch on more than the Act. The terms of reference include examination of the governance arrangements, including systems, structures and processes; and the resources that support the decision-making process for pricing reimbursement applications such as the use of expert advice in the assessment process, including clinical, pharmaco-economic, commercial, financial, procurement and legal expertise. The review will examine the approach to securing the best value in terms to the HSE through commercial negotiations and procurement policies and procedures. It will examine procedures for detailing agreements in written contracts. Finally, it will examine arrangements and supports for the HSE directorate in making reimbursement decisions in line with the 2013 Act. It is about the resources that are brought to bear on the problem, the expertise and skills that are brought to bear on it, how knowledge is brought into the dialogue between firms and the HSE, how cost effectiveness is assessed, how pricing is arrived at and, ultimately, the function of the HSE leadership to sign off on those decisions.

Deputy John Brassil: The terms of reference should also include examining processes in place in other countries, particularly Scotland and Sweden. The review might also examine whether the 2013 Act directly blocks us from adopting the practices in those countries, from which we could learn. Does that need to be changed? Does the review include a specific mandate for improving access for patients? Did I pick that up in what Mr. Breslin said? I reiterate that there does need to be significant consultation with clinicians, patients and the industry for it to be effective. It should not be an iterative process. It should evolve and should not be a once-off review.

Senator Rose Conway-Walsh: I want to come in on a couple of primary care issues. I agree with Dr. Henry about the alignment between primary care and front-line care. Until we get proper congruence there, we are not going to have an effective system. Indeed, it will be a
waste of money because people will present at acute hospitals when they could be looked after in primary care. A lot of it comes down to home help and decisions that are being made in that area and the criteria that are used. Let us take, for example, an elderly woman who has broken many bones. She has broken both her hands, her leg, her wrist, her toes and her hip. She has suffered a shattering of her knees. She has diabetes and is a high fall risk. She cannot stand for any longer than ten minutes. She is also a coeliac with an overactive thyroid, high blood pressure, anaemia and severe dermatitis that gets infected regularly such that she has to be hospitalised. She also has poor hearing and poor eyesight. The response back from her application and its appeal is that she does not meet the criteria. Do the witnesses not think that somebody with all of those conditions in a high-risk situation should meet the criteria for home help?

Ms Anne O’Connor: I would have to know the details. I have listened to what the Senator has said. If she wants to give me the details, I can look into it. I do not know.

Senator Rose Conway-Walsh: I will give Ms O’Connor the details, but that is an example of what is coming back to me from people who are being refused. That is apart from those who have been approved as needing home help but cannot access it. I am out canvassing the doors at this time and I met somebody who was born in 1929 and said, “If I could only get another 15 minutes...”. She has half an hour for four days a week. She said 15 minutes would do the extra bits she needs. It is not right at all.

Ms Anne O’Connor: There are certain areas in the country where we are very challenged in home support. There is no doubt about that. We are currently having to work on the basis of recycling hours and all of that. We have an unrelenting demand for home support but certainly if the Senator wants to give me the details of the case she referenced I can certainly see.

Senator Rose Conway-Walsh: I will do so, if Ms O’Connor does not mind. It is not even about recycling hours; it is about recycling minutes. There was a good home help system in place where people were allocated hours and home help staff were directly employed by the HSE. They were paid properly, paid for their mileage and all of that. Now we have home helps criss-crossing country areas to do minutes here and minutes there. It is not a good use of anybody’s time. I would ask Mr. Reid to examine the home help system as well because it is saving thousands. We talk about money, having to work within a budget and whatever is allocated but it is not even about that. It is about the use of time if somebody has to spend time taking up an acute bed in a hospital.

I am also concerned about the out-of-hours coverage linking to primary care. I refer to the Erris region in particular, where one doctor is responsible for the care and safety of patients. Doctors are covering 1,000 sq. km day and night without a break from Friday to Monday. The population and the size of the area demands a much greater number of doctors. Doctors are going above and beyond the call of duty and they cannot access the out-of-hours service. I believe the service there was cut from 26 to 20 weekends per year. There has been an announcement about a new primary care centre that is to be built and expressions of interest have been invited. Does that mean the money has been allocated for it? What is the next step in that process?

Ms Anne O’Connor: I apologise that I do not have the specific details. I will have to look into it. In respect of the Senator’s first question, was she referring to the GP out-of-hours service?

Senator Rose Conway-Walsh: Yes.
Ms Anne O’Connor: GP out-of-hours services are generally provided under service arrangement with the providers. I will have to look into that. I do not have the detail. It is often a challenge for the providers to get GPs. We know that in certain areas it is difficult to get people to cover. I would have to check that out.

Senator Rose Conway-Walsh: That puts people’s lives at risk but it also puts people in the situation where they have to call ambulances.

Ms Anne O’Connor: There is no doubting the value of GP out-of-hours services but I just need to look into the details.

Senator Rose Conway-Walsh: If Ms O’Connor would do so, I would appreciate it. Has a capital allocation been made for Bangor Erris primary care centre?

Mr. Paul Reid: We will come back to the Senator specifically on that.

Senator Rose Conway-Walsh: I would appreciate if Mr. Reid could come back through the committee secretariat. I also want an update on the audiology misdiagnoses in Mayo and Roscommon, the scandal that took place there. Do the witnesses have any update on that? I am aware of parents who are still not able to get medical cards and basic things to support the children who were victims of those misdiagnoses.

Ms Anne O’Connor: Again, I apologise. We do not have that with us but we can find out for the Senator. We will make a note of her questions.

Senator Rose Conway-Walsh: I will ask for a full update on that as well, across all HSE departments. The Minister of State, Deputy Finian McGrath has left. I wanted to ask him about the personal plans.

Chairman: He had to go to the Chamber to take Topical Issue matters and he offered his apologies for his absence.

Senator Rose Conway-Walsh: The Chairman might tell him I miss him.

Chairman: The Senator might address him privately or though a parliamentary question.

Senator Rose Conway-Walsh: I will.

Chairman: As that concludes our business this morning, I thank the witnesses for attending. I congratulate Mr. Reid on his appointment and wish him the best of luck in his position.

The joint committee adjourned at 1.30 p.m. until 9 a.m. on Wednesday, 29 May 2019.