

DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Déardaoin, 16 Eanáir 2014

Thursday, 16 January 2014

The Joint Committee met at 9.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Ciara Conway,	Senator John Crown,
Deputy Regina Doherty,	Senator Marc MacSharry,
Deputy Robert Dowds,	Senator Jillian van Turnhout.
Deputy Peter Fitzpatrick,	
Deputy Seamus Healy,	
Deputy Billy Kelleher,	
Deputy Sandra McLellan,	
Deputy Mary Mitchell O'Connor,	
Deputy Dan Neville,	
Deputy Caoimhghín Ó Caoláin,	
Deputy Robert Troy,	

DEPUTY JERRY BUTTIMER IN THE CHAIR.

The joint committee met in private session until 10.05 a.m.

Update on Health Issues: Minister for Health and HSE

Chairman: I remind people to ensure their mobile telephones are off or in aeroplane mode. If those in the Visitors Gallery would switch off their mobile telephones as well, it would be most appreciated. This is one of our quarterly meetings at which we get an update on health issues. It is a bit like Groundhog Day. We seem to be here again. I welcome the Minister, Deputy Reilly, and the Minister of State, Deputy Kathleen Lynch. I thank them for being here this morning. I thank Mr. Tony O'Brien and his officials for being here as well. Apologies have been received from the Minister of State, Deputy White.

Members have submitted written questions and the responses to these questions have been circulated. I would like to bring to the attention of the Minister and Mr. O'Brien that members of the committee are concerned that the responses were not given to them until yesterday, which was a very late stage ahead of this meeting. We would prefer to receive replies five days in advance of the meeting, which is what happens in the case of the Department of Children and Youth Affairs. We did not get them until yesterday, which was a bit late for members. If the process could be streamlined to ensure we receive responses five days in advance, we would appreciate that. Perhaps Mr. Goodman might bring that back to the Department and Mr. O'Brien might bring it back to the HSE.

Witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected to the matters under discussion should be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official by name or in such a way as to make him or her identifiable.

I welcome the Minister, Deputy Reilly. I apologise for our late start. We had to deal with some private business. I ask the Minister to make his opening remarks.

Minister for Health (Deputy James Reilly): I apologise for the responses to members' questions being delivered so soon in advance of this meeting. We will certainly endeavour to ensure this does not happen again. The members of this important committee should have time to consider the responses they get.

I am grateful to the Chairman and the committee for inviting me to discuss health services here today. As the Chairman pointed out, I am accompanied by the Minister of State, Deputy Kathleen Lynch, and by senior officials from my Department, including Mr. Fergal Goodman and Dr. Siobhán O'Halloran, who is the chief nursing officer. This is the first time a chief nursing officer has been appointed at the level of assistant secretary in the Department. It is important for the health services that the voice of nursing can be heard at the highest level in the Department. I am also accompanied by Mr. Tony O'Brien and his team, including Ms Laverne McGuinness, Dr. Áine Carroll, who is the clinical director, Mr. Ian Carter, who is the director of

hospitals, Mr. Stephen Mulvany, who is the director of mental health, and Mr. Pat Healy, who is the director of social care.

Earlier this week - less than 48 hours ago - we discussed the 2014 Health Service Executive service plan. It is clear that 2014 will be a very challenging year. Perhaps it will be the most challenging year for the health services we have yet had to deal with. Despite the many challenges we have faced up to now and will continue to face in the future, it is important to reflect on the considerable progress that has been made, especially in the essential task of reforming our health services. I remind the committee that just over a year has passed since I launched Future Health, which is our blueprint for the reform of our health services. As members will know, the Government's policy is to end the unfair and inefficient two tier health system and to introduce a single tier system supported by universal health insurance. Future Health provides the blueprint for the steps on the road to universal health insurance. Among the many measures in Future Health, we stated we would establish hospital groups. This has been done and last year we published the reports which set out how the groups would be organised. Considerable work was done to ensure agreement on the composition of the hospitals groups. I thank all those involved in the process, including officials of the Department and of the Health Service Executive and Members of the Oireachtas. We have appointed chairpersons for each group and we are recruiting chief executive officers, with interviews taking place as we speak. Work will continue in 2014 to fully establish the groups on an administrative basis.

The creation of hospital groups is a critical step in improving hospital performance and, ultimately, patient outcomes. In the short term the groups will harvest the benefits of increased independence and move away from the traditional command and control style of the HSE. We want to devolve as much independence as possible to those who best understand local needs and conditions.

In 2013, we published Healthy Ireland, our strategy for improving the health of people and enhancing our health and well-being. This is an ambitious strategy which aims to embed health and well-being across public policy and services. In 2013, as part of the Healthy Ireland framework, we published Tobacco Free Ireland, our strategy for making Ireland tobacco free by 2025. A general scheme for the Public Health (Standardised Packaging of Tobacco) Bill 2013 was approved by Government on 19 November last. I was particularly pleased that at European Union level, the tobacco products directive was agreed during the Irish Presidency. This is a significant development and was a priority for me during our successful Presidency. The directive is a crucial step in protecting public health and harmonising the marketing of tobacco products at EU level. I am aware of the joint committee's close involvement in this issue and members will be aware of my particular interest in making progress on it. I note also that the committee will hold further hearings on the legislation later this month.

In 2014, we will establish a Healthy Ireland council, for which we have invited expressions of interest for membership. We will also establish a research and data plan, an outcomes framework, a positive ageing implementation plan and a national physical activity plan.

In July 2013, we established the directorate of the health services under the Health Service Executive (Governance) Act, which also abolished the HSE board. We started the process of bringing the HSE Vote back to the Department with the publication of the Health Service Executive (Financial Matters) Bill. A finance reform board is in place and a chief financial officer has been appointed in the HSE. The individual in question attended a meeting of the joint committee two days ago. A new financial and cost management system has been identified and is being costed. We will progress the legislation and continue to work on the management system

during 2014.

In 2013, we published the phase 1 report of the chair of the consultative forum on health insurance. The chair is proceeding with phase 2 and will report back to me in three months. As members are aware, we must continue to address issues in the private health insurance market as a basis for the introduction of universal health insurance. They will also be aware of my concern about the high cost of private health care. I have received a draft of the White Paper on universal health insurance which I hope to publish shortly. Universal health insurance is fundamental to the reform of our health services and goes to the core of Future Health.

At the same time as focusing on the future of the health services, we are focused on making a real difference to people today and tomorrow. We have made good progress in addressing the costs of drugs and medicines. With the passing of the Health (Pricing and Supply of Medical Goods) Act 2013, we have a robust system of reference pricing and generic substitution. We have reduced the cost of atorvastatins by approximately 70%, with more reductions set to follow in 2014. This saves patients and taxpayers money and allows us to focus on maintaining front-line services. I read a newspaper report this morning which indicates that pharmacists are taking this matter into their own hands and becoming much more competitive in terms of the mark-up being applied in their businesses. This is a welcome development.

Another key element of Future Health is the concept that money follows the patient. The introduction of the new funding system on a phased basis lays the foundation for universal health insurance. Following a pilot study in 2013, the system is being introduced across the health services on a phased basis in 2014. The money follows the patient principle will provide the funding framework for improved and enhanced outcomes for patients as well as the professionals who serve them. Put simply, if there is no patient, there will be no payment.

Despite the challenging financial circumstances, as part of budget 2014 we will introduce free general practitioner care for children aged five years and under. In 2014, work will continue on the development of options for the provision of a GP service without fees to the entire population by early 2016. Those who query the wisdom of providing free general practitioner care for children while there are wider difficulties with the medical card system fail to see the overarching importance of the move. The Government is committed to a major enhancement of primary care services as part of the move to universal health insurance. This step of a phased introduction of free GP care must be seen in that context.

We must move away from the current over-reliance on hospital care and make proper use of primary care given that all available evidence shows the latter can meet 90% of medical needs. The true significance of providing GP care without fees to children under six years is the commitment it represents to enhancing primary care services in general. We will develop more dynamic and efficient health services with better outcomes through universal health insurance. The Minister of State, Deputy Alex White, is unable to attend because he is chairing a major conference in Dublin Castle.

In December, we published the Health Identifiers Bill and launched our e-health strategy. Technology can enhance health care, improve outcomes and drive efficiency. To implement the strategy, e-health Ireland will be established, initially in the Health Service Executive, and will be headed by a chief information officer for the health service who will be recruited through an open competition. Priority areas for initial development include e-prescribing, online referrals and scheduling, telehealth and the development of summary patient records. Again, on a day-to-day basis, the judicious use of technology brings greater efficiencies. In the long term,

the use of technology gives us more information and enables us to make better health care decisions, thus saving lives and money.

Health service staff are high quality, dedicated people. The Chairman, members and I are always at pains to point out the great work done daily by the women and men working in the health service. They deserve high quality, dedicated facilities to support them in their work. Despite the significant financial challenges we face, the Government has, since 2011, progressed 34 primary care centres and a further 12 have been approved for building. As resources permit, this network will be expanded.

Our aim in respect of the national children's hospital remains to secure planning permission by December 2014. As to the relocation of the National Maternity Hospital, Holles Street, to the St. Vincent's University Hospital campus at Elm Park, a project team has been appointed and we expect a design team to be appointed shortly. We are also making progress with the relocation of the Central Mental Hospital from Dundrum to Portrane. I am sure the Minister of State, Deputy Kathleen Lynch, wishes to say a few words on that issue.

The Minister of State also published a national positive ageing strategy in April 2013. This is being implemented. Regulations to allow for the registration and inspection of residential services for older people with disabilities were signed on 30 October 2013. The Health Information and Quality Authority is now empowered to register, inspect and monitor such services.

As well as looking to the future, we sought to address legacy issues. In particular, the State Claims Agency is implementing a redress scheme for women who had been excluded from the 2007 Lourdes scheme on age grounds alone. I commissioned a research report on symphysiotomy and Judge Murphy has been appointed as mediator. When she reports, I will consider her report and bring proposals to Government for approval. I thank all members from all parties for their support and role in helping to address these issues, which have caused so much pain to so many.

Since taking up office, I have been driving improvements in unscheduled care targets and hospital outpatient performance. While these winter months bring an increase in demand in emergency departments, it is clear that we have made significant progress in reducing the numbers of people on trolleys and waiting lists for appointments. In 2014, we will continue to reduce maximum waiting times and develop better information systems, including the unscheduled care information system for hospitals. As I noted, we are joined today by the director of hospital services, Mr. Ian Carter, who can discuss these issues in much greater detail. Linked to this, the patient safety agency will be established on an administrative basis and a licensing system for public and private health service providers will also be developed. I thank the Chairman and members for their attention. We will be pleased to take questions.

Chairman: I thank the Minister. I invite Mr. Tony O'Brien, director general of the HSE to make his presentation.

Mr. Tony O'Brien: I thank the Chairman. Obviously on the issue of questions we will work with our colleagues and with the committee to see what we can do to increase the speed with which they get replies.

Chairman: I thank Mr. O'Brien.

Mr. Tony O'Brien: We will be happy to deal with follow-up questions to those today. Given that we were together just 38 hours ago, I will limit my opening remarks to issues that

were not covered the day before yesterday. In regard to service plan activity, my remarks relate to the first 11 months of 2013 as we do yet have the fully validated data for the full 12 months. Those first 11 months saw the HSE maintain or increase levels of service activity compared with 2012 despite the significant challenge of maintaining the budget and reducing employees. The overall waiting list growth trend seen in the first half of the year had been reversed by the end of November, with a 5% reduction in the total number of patients waiting for admission compared with July. A significant effort has gone in to increasing the number of new patients seen at outpatient departments and the numbers have increased by 5% in that period. Emergency admissions for the 11 months up to November numbered more than 350,000 and were broadly in line with the previous year. A total of 945,836 elective admissions, inpatient and day, were carried out in our acute hospitals during those first 11 months of the year. Some 25 intermediate care vehicles and 73.4 whole-time equivalents have been introduced into the National Ambulance Service in 2013. GP out of hours contacts, at 882,000 up to the end of November, were slightly ahead of 2012 nationally, but there was a significant increase in activity in the north east which is over 6% ahead of their expected level of activity. This service plays a very important role in pre-hospital emergency care. At the end of November, 1,983,572 people were covered by a either medical card or GP-visit card. In that month 23,833 long-term public and private residential places were supported under the nursing home support scheme compared with November 2012 when the figure was 22,985. More than 14,000 referrals were received by the child and adolescent mental health teams, nearly 1,000 or 8% more than projected in the national service plan for 2013, and 70% of those referrals were being seen within three months.

There have been reports recently in the media in relation to delays in ambulance response times. The continuous improvement in ambulance response times is a key priority for the ambulance service and a performance improvement action plan is in place focusing on a number of key areas as follows: call taking and dispatch, use of intermediate care vehicles for inter-hospital patient transfers, introduction of a single national control centre, and turnaround times at emergency departments.

A review of recent incidents has shown that at some emergency departments ambulance vehicles have been delayed for longer than the 20 minute target time. This in turn has an impact on response times. An enhanced escalation procedure is being developed in relation to delays beyond 20 minutes. This enhanced escalation procedure will provide for an RAG, - red, amber and green - rating whereby such delays can be treated as an adverse incident.

During 2013 and 2014, there has been significant investment in ambulance services. Last year, €25 million was allocated, which included capital investment to provide for a single national control centre as well as for the purpose of 25 new intermediate care vehicles. These new intermediate care vehicles are now in place. This year a further €3.6 million has been provided to progress the single national control centre. These investments will allow for significant improvements in response times as well as being able to cater for an increase in the volume of emergency DELTA calls which are currently about 10% more than the same period last year, the equivalent of about 1,000 extra calls per month.

Turning to 2013, the deficit for the HSE prior to the application of supplementary funding of €219 million was €205 million, a €14.1 million Vote surplus after supplementary. This compares with a Vote deficit of €337 million for 2012, prior to the application of supplementary funding of €360 million. This deficit is also inclusive of any once-off savings, mainly in pensions, available in 2013 which will not be available to the HSE in 2014. The deficit is a reflection of the overall challenge within the HSE in 2013 when account is taken of the risks

that were set out in the national service plan for that year. These included the Haddington Road agreement, HRA, which took effect from 1 July 2013, the potential value of the risk in terms of projected deficit which has undergone a detailed review, and an assessment of the likely 2013 savings that are expected to be delivered. Some €46 million of the HRA target has not been achieved in 2013.

The private patient charges provisions were originally due to take effect on 1 July 2013 and generate €60 million for the latter half of the year. These measures took effect on 1 January 2014 and therefore there was no generation or collection benefit in 2013 to the HSE. The financial impact of the delayed implementation of the legislation started to materialise in July 2013, with an increase in deficits being reported by relevant hospitals. This deficit includes shortfalls in the four key risk areas which the HSE had previously identified as follows. In the primary care reimbursement service, PCRS, where the target was €353 million, a deficit due to the delay in implementation of the financial emergency measures in the public interest, FEMPI, regulations amounted to €41 million. A dental treatment service scheme had a deficit of €13 million. A shortfall on a non-FEMPI target of €303 million amounted to €49 million. A reduction in the number of items claimed on medical cards has offset these deficits. The PCRS is expected to deliver a final deficit in the region of €70 million. The effect of the delayed implementation was to increase deficits by 2013.

Unusually, today, HSE officials are appearing simultaneously before two Oireachtas committees. With the Chairman's permission, it might be worthwhile to say a little about that. Obviously the Committee of Public Accounts is focused on the follow-up to the audit carried out within the HSE in respect of remuneration of section 38 organisations. That is obviously the subject of an inquiry by the committee and is receiving considerable attention. The committee will also be aware that in 2013, for the first time, we required section 39 organisations to return to us details of the pay levels of all personnel above grade eight and, consequently, a full validation process is under way in relation to the information received. A question has been tabled today on that issue. Clearly, the issue of appropriate compliance with public sector pay policy by section 38 organisations, where personnel are fully public servants, and section 39 organisations, where they are not public servants, is a key issue for us at the moment. The organisations are asked for full disclosure and to have due regard to public pay policy.

From a financial performance perspective, when account is taken of the four key risk areas which I have mentioned for 2013, which were outside the direct control of the HSE, a break-even position on direct services, that is, hospital and community services, was delivered. This is after the application of once off surpluses which primarily related to lower than expected retirements in 2013.

Chairman: I thank Mr. O'Brien. I thank him for referring to the ongoing issue regarding section 38 organisations. Under Standing Orders, this committee is precluded from dealing with the issue because the Committee of Public Accounts is dealing with it. As the Joint Committee on Health and Children of the Houses of the Oireachtas, we feel we should have information on the issue and I thank Mr. O'Brien for raising it as part of his remarks. I invite the Minister of State, Deputy Kathleen Lynch, to make some opening remarks.

Minister of State at the Department of Health (Deputy Kathleen Lynch): I will be very brief. The most significant development so far as my areas of responsibility are concerned would have been the appointment of the two directors in recent months, Mr. Stephen Mulvany, who has sole responsibility for mental health, and Mr. Pat Healy, who has responsibility for disability and older people, all very sensitive areas. In recent months, since their appointment,

the level of inquiry and engagement between the services and the directors has been incredible and has made an enormous difference to how we will plan to deliver service into the future. In terms of mental health, the question has always been asked about posts, and rightly so. We need people with a particular expertise to work in the system. I have found over recent months that while we are concentrating on the professional side of the service, we must also look seriously at administration. People cannot deal with the person sitting before them and simultaneously be expected to write up the report and develop that part of the service.

The 900 people working in the mental health service are very important and I believe we would face a far more difficult task without them, particularly if we had to bring in all new people. These people are the bedrock of the service and other people coming into the service must fit in with them and into the new structure. Mr. Stephen Mulvany will speak about this later. One of the important issues facing us is the need for a structure in the area of mental health. We need an IT system that will provide information on where people are working, what they are doing, what we want them to do and how the service is being delivered. The barriers to effective working need to be removed. Achieving this will be a key role for the director. If we succeed in this, we will have a service that will be robust enough to stand alone, no matter who is in charge. This would be a significant legacy.

In regard to older people and to disability, we are developing a clear view of what direction we want to take. The budget for this area this year is €1.5 billion. Mr. Pat Healy has set out what we need to do for those aged from birth to 18 years, where most development needs to take place. We also need to provide for school leavers. I am sure members have heard me say that we cannot come in here every May, June or July to discuss the issue of people due to leave school or their training places. This does not happen because it is a crisis, but because of the lack of foresight. Now, for the first time ever, we have a budget and a plan in place to deal with people who will need to move to a different space. I try not to use the jargon that has been used in the past in discussing disability and mental health. Language is important and we should try to move away from the kind of language that defines people.

The two major developments in the area of disability and mental health are the appointments of the two directors. Senator van Turnhout has consistently spoken out about the importance of a director and I am glad to say that the appointments have brought all the benefits we thought they would and I am convinced they will continue to bring benefits.

Despite the circumstances in which the country finds itself, we continue to make developments. When the country was awash with money, we did not know what to do with it other than give it back to people in the form of tax relief. We should have been putting infrastructure in place then, but we are beginning to do that now. We will have a new Central Mental Hospital in Portrane and it is well advanced in terms of planning and design. We will also have four new emergency care units, ECUs, throughout the country, in order that patients from the Central Mental Hospital may be able to move nearer their homes to make visiting easier for their families. Our plan is not just to examine the service, but to develop it and move forward.

Chairman: I thank the Minister of State and wish her a healthy 2014. It is good to have her here.

Deputy Billy Kelleher: I welcome all our guests and thank them for outlining the position on the issues not covered yesterday. I wish to focus on some key areas. In the Minister's opening statement, he outlined progress to date and the strategy since the Government came into being in 2011. One of the key issues is universal health insurance and its roll-out and we await

the publication of the White Paper on universal health insurance.

When the Minister published Future Health in 2013, hospital groups were to be established and chairmen and CEOs were to be appointed. There is concern in the community about this. We have the small hospital frameworks and the primary care strategy and now the hospital groups, but there is a concern behind all of this. People fear that when hospital groups are established and budgets are squeezed and under pressure, there will be pressure on them to reconfigure and streamline services. However, talk about streamlining and reconfiguration of services is often a coded message for the downgrading of services in a particular area. How will we be able to monitor this? We have seen the amalgamation of some services and yesterday mention was made of shared services and streamlining of back office services. This practice often creeps into front-line services. We have seen this previously in some areas, for example, in Nenagh and Ennis, where there was to be a beefing up of certain services in these hospitals following reconfiguration in the mid-west, but this did not happen as progressively as it should.

Anything that makes services more efficient is welcome, but there are concerns. For example, in the area of maternity services, there is concern in some communities that some of the maternity hospitals will not be considered fit for purpose and that following the reconfiguration and the establishment of hospital groupings, they will see a closure or downgrading of some of these hospitals. We must remain conscious of this concern and must be honest and upfront in regard to what a hospital group is, what it means and its obligations, particularly when we move to more independent type budgeting when boards are established. Who will monitor these individual trusts to ensure they provide the services expected, as opposed to being profit driven and self-financing? Who will ensure they will fulfil their obligation to provide care?

We do not want to be constantly critical of Ministers, so I compliment the Minister on the initiative he is pushing of a tobacco free Ireland and a European directive in this regard. This is positive.

The Minister mentioned the Healthy Ireland council and also highlighted the issue of obesity. We must all do more to reduce obesity. If we look at the figures from Britain, it is alarming to see the rate of increase in obesity, in particular childhood obesity. While we have talked about the issue, we must address the issue of the foods we eat and target and focus on the issue. My age generation is probably a little overweight and should be targeted, but we need to target young people in particular and do more to address this issue.

The Minister mentioned that primary care will be the bulwark for the provision of health services in the years ahead and said it is the most efficient and cost-effective way of delivering health care. I am not quite sure whether the Minister is aware, but from speaking to individual GPs and communities, it appears GP services are in crisis. Making this statement is not being alarmist. This is a statement being made by the various organisations that represent GPs. It is also evident that many of these services and GP practices are on the brink of financial collapse, which will leave gaping holes in some communities. Also, many younger GPs are leaving this country. Emigration of GPs only happens when they see no future in general practice. We must be very conscious of this as we could quickly end up in a position where we will not have enough consultants to lead our clinical care teams or enough GPs to provide the primary care that is so much talked about by the Minister. It is politically populist to point out that doctors are making large sums of money and are doing very well, but the reality is very different and the witnesses must accept that at this stage. This is not about representing doctors, something I was accused of by the Minister of State, Deputy Alex White, but about ensuring we have a primary care resource in communities providing the best of care. Without general practitioners that is

simply not going to happen. While the Minister refers to rolling out primary care centres and the primary care strategy, the fundamental principle is to have teams that are GP-led in communities. By any stretch of the imagination that is beginning to dismantle in front of my eyes and, I imagine, with the Minister's previous knowledge of general practitioners and having advocated for them, he must see that as well. This must be addressed. I recognise the financial emergency measures in the public interest legislation cuts are hitting hard and that we expect everyone to carry their fair share, but we do not expect the people to carry the burden of the difficulties.

If we have a downgrading and the closure of GP services in rural Ireland, people will suffer. Unfortunately, what will happen is that we will end up with people being referred back into the acute hospital setting, despite that we are all trying to reverse that trend. The Minister must examine that in a detailed manner to ensure we have a young cohort of GPs coming into practice, that we have a sustainable primary care service and that we do not end up with the type of service whereby there is nothing in rural Ireland, areas deprived in a socioeconomic sense will have fewer GPs and GP services will become the preserve of those who can afford it again - all this despite the Minister talking of rolling out free GP care for everyone. We must examine that in the round.

The Minister has made proposals for those aged five years and younger. We all welcome the fact that the Minister is trying to make health care accessible. However, in making health care accessible to one cohort, he is denying another cohort. This is an area that we must consider. We have fundamental disagreements on this. Anyway, I wish to put on the record again that the Minister has stated there has been no change in the eligibility for medical cards granted on a discretionary basis. I fundamentally disagree with the Minister and Mr. O'Brien on this matter. There is a large cohort of people, who, previously, had discretionary medical cards and which have since been removed. There is another group of people who have the same illnesses, needs, diseases and requirements as those who previously had discretionary medical cards but they cannot access them now. They include children with Down's syndrome and people with profound physical and intellectual disabilities, including motor neurone disease and many other cases. The idea that the Minister takes from those who need it to give to those to whom the Minister wants to give is not a coherent policy. While we have limited resources, the policy must be based on need as opposed to the way the Minister is going.

The Minister referred to the fair deal and the positive ageing strategy of 2013. I have concerns about whether a large cohort of older people, who are in the nursing home support scheme and who have medical cards, are receiving other types of treatment, including physiotherapy, speech and language therapy and many other secondary benefits, to which they are entitled under the medical card scheme. I do not believe they can access the services to which they are entitled. I am not pointing the finger at nursing homes. I simply do not believe the services are available. I suggest, in the context of carrying out audits on nursing homes and places where people with intellectual and physical disabilities stay, that the Health Information and Quality Authority should also carry out an audit not only on the physical infrastructure and the services immediately required but on the obligations on the State to provide the services as well.

Deputy Caoimhghín Ó Caoláin: I will confine my remarks and questions to the three issues I raised in advance of the quarterly meeting. I wish to get off on a good and positive note. I wish to record my absolute welcome for the provision of the €3.2 million for the bilateral cochlear implant programme. I raised the matter again this Tuesday past and I welcome the reply provided among the replies received only yesterday. However, I am especially thankful to Ms Laverne McGuinness, who gave more information on Tuesday than was even in the writ-

ten reply we got yesterday. I urge the Department to take that on board. It is not a criticism because we are simply trying to do our job and information is altogether important. What Ms McGuinness put on the record at the committee on Tuesday should have been and could have been in the written reply to the quarterly question. Mr. Tony O'Brien indicated a range of areas that were not included in the current year because of the difficulties and challenges. In the light of all that and because information is important, I emphasise how welcome it was that this start has been made. My only ancillary question is to ask the Minister to use the opportunity now to confirm that this will be a programme year on year for the future and that there will be continued funding for the bilateral cochlear implant programme for 2015 and every year thereafter to meet the needs of young people with hearing challenges.

The second issue is symphysiotomy. My understanding all along has been that what the victims of symphysiotomy sought and continue to seek primarily is truth and justice. I do not believe the indicators suggest this is where we are going to arrive. I am concerned about the terms of reference for Judge Yvonne Murphy. I am concerned that the Minister repeatedly refers to the women having choice and that they can take their case to the courts if they so wish. Some can, but the reason I have campaigned on this issue for years, in conjunction with colleagues across all political opinion in these Houses is because I know that a significant number of those victims cannot do so because of the statute bar situation. It is a fact of life. I am deeply disappointed given all the work we have invested in it, and I use the term "we" absolutely. I happen to have been the chair convener but there are colleagues on the committee who serve in both Houses of the Oireachtas and who have invested significant effort not only since 2011 but in previous Dáileanna. I call on the Minister to consider the position. Last April, we passed Second Stage of the Statute of Limitations (Amendment) Bill 2013. It has not been facilitated to come to committee. Despite all assurances that there is great concern and a wish to bring closure for the women concerned, we must face up to the fact that women have a right and a choice to make. Some may accept the type of formula the Minister will present but I know, from listening to many articulate and committed women who have suffered grievously, that they want the option of being able to present their case through the courts.

I appeal to the Minister again to revisit the matter in the context of all that he is considering and not to set it aside. I understand that at a meeting last August with the representative groups for victims of symphysiotomy, the Minister indicated several points. For the record, I wish to establish if these points represent the position and I call on the Minister put his position on the record now. I am advised that the Minister told the representative voices of survivors, a group which would have included survivors among their number, that any compensation or restitution, call it as we will, would fall far short of the range specified by one of the groups of survivors of symphysiotomy and that the Minister was in no way considering anything in the ballpark they were arguing for. Furthermore, I understand that any restitution or compensation would be paid in instalments. We should be mindful of the fact that the survivors of this terrible and brutal procedure are a rather aged cohort of women. Finally, I understand that the women would be denied public funding for legal representation in circumstances where they would wish to have it.

They are victims of a health service of its time. We, and the Minister most especially, are guardians of that health service today and we have inherited much. I acknowledge that we have inherited this situation but that does not in any way mean that we do not have a responsibility to face up to and address it and to employ all the compassion necessary in doing so.

I know several of the women and their families, many in the north east, some in my con-

stituency. They are not people of means. Even at this late stage in their life the prospect of providing for independent legal representation is a big problem for them. That could corral people into accepting a situation that falls far short of their due. Will the Minister elaborate on those points and advise us exactly of the situation? I welcome the fact that he has included the women over 40 in dealing with the Neary scandal. We need the same compassion to address this issue. I believe the Statute of Limitations (Amendment) Bill deserves to be progressed through the Houses in order to afford the women that choice.

My last point concerns the National Ambulance Service. I raised this during our private session. The committee has agreed to address this more fully during its work programme in the early part of this year. The reply that I received presents carefully constructed sentences and statistics which almost suggest that there are improvements in the service. There may be improvements but there is a regular series of real tragedies where the ambulance service does not respond within the required timeframe and consequently in many cases lives are lost. I am told that not all emergency vehicles have satellite navigation systems, that they are directed to the call-out point by the central service in Dublin. It has been suggested to me that the satellite navigation systems are not being rolled out because of the possible postal code change and a reluctance to expend moneys in the interim. A pittance is required in real terms when one considers that lives are involved and tragic outcomes need to be avoided. Why do all vehicles not have satellite navigation systems? Will the Minister ensure that they are installed? I know of instances in which ambulances have been going around and around but could not locate the address for the call-out. That is terrible on our small island.

Deputy Seamus Healy: I welcome the Minister and his officials, and Mr. O'Brien and the officials from the HSE. In particular, I welcome the Minister's emphasis on the Public Health (Standardised Packaging of Tobacco) Bill. This is a fundamental issue for public health and for the health service. The committee has set aside several weeks from next Thursday until 13 February to deal with submissions on this. I look forward to the Bill's speedy progress through the Oireachtas.

On Tuesday, I asked the Minister for clarification on the appointment of the boards of the hospital groups. I understood him to say that the appointments were imminent. While he refers to the groups in his opening statement, he does not refer to the appointment of the board members, apart from the chairperson and chief executive officer. Is that imminent and, if so, how soon will it happen?

There are particular pressures on the health service in certain locations. The national service plan acknowledges that and it sets aside €30 million for additional capacity in areas within the acute services which are experiencing increased demand, such as emergency departments, inpatient day care and outpatient department, OPD, services. Some hospitals appear consistently to have trolleys in emergency departments. One of these is South Tipperary General Hospital. It is a very modern, progressive hospital where staff and management work together as a team, and with regional HSE staff, attempting to solve this problem. As the service plan acknowledges, there are particular pressures in some areas and this is one. The budget for that hospital has been reduced by approximately one quarter over the past few years. It has lost a considerable number of staff. Remaining staff have made a huge effort, working above and beyond the call of duty, and additional activity and throughput has been gained. Will some of the €30 million that has been set aside be designated for South Tipperary General Hospital to relieve the pressure on its emergency department?

On Tuesday, I also asked Mr. O'Brien about the €56.5 million and €7.5 million for general

hospital savings and reconfiguration of services. He explained that this referred to back office services and general day to day expenditure. He also suggested that a review is forthcoming this year regarding reconfiguration of services generally. Will he clarify and expand on that statement?

Do we have the figures for agency costs? I am told that the agency cost of a non-consultant hospital doctor, NCHD, can be a multiple of the cost of a directly employed NCHD. That has serious implications for budgets within hospitals. It also has implications for the recruitment of non-consultant hospital doctors. There is €1.3 million in the plan to deal with a sustainable approach to recruitment of NCHDs. What are the agency costs and what is earmarked to receive the €1.3 million? My view and that of the public in general that there has been no change in the policy on access to discretionary medical cards is completely at variance with both the views of the Minister and of Mr. O'Brien. That is a situation which neither I nor the public accepts. It is quite obvious to me and to many Members on both sides of the House that there has been a significant change in policy in this area. We see it every day in our clinics. I had a call before I came to the meeting this morning about the very issue.

Chairman: I call Deputy Ciara Conway who will be leaving to attend another committee.

Deputy Ciara Conway: I thank the Ministers, Mr. O'Brien and his staff for their attendance. I have some supplementary questions to those I submitted about the establishment and progress of the hospital groups. The response to my questions provided details about the appointment of chairpersons and the ongoing recruitment of the chief executive officers. My predominant concern is about the hospital group for the south west and what it will mean for Waterford Regional Hospital. I refer to the difficulties associated with the recruitment of non-consultant hospital doctors and the difficulty in retaining them. I am also concerned that consultant posts are not being filled in a timely manner. I ask what is the national situation. The IMO indicates it is concerned that it is becoming more difficult to attract consultants particularly in the perceived high-risk areas of maternity services, for example. There seems to be a great number of vacant consultant posts in Waterford Regional Hospital. The model of care to which we aspire is a consultant-led model but some specialties in the hospital have no permanent consultant. At one time, the ophthalmology department under Dr. Condon at Waterford Regional Hospital was one of the leading departments in the country. Currently, the hospital has no permanent consultant in that specialty. This is a concern.

I am pleased to note that an additional seven posts will be given to the Waterford Regional Hospital team. We were told that the hospital grouping proposal would mean that consultants would deliver the service as close as possible to the patients concerned. However, in the past six months, outreach maternity services have ceased as have ophthalmology outreach services. I understand these services are to be reinstated in January and this is welcome. However, this is in direct contrast to what we were told would result from the establishment of hospital groups.

I have spoken at the committee meetings on many occasions about retrieving moneys from private health insurance companies. I note that the chief financial officer, Mr. O'Byrne, has taken a personal interest in this matter and he has a team which is focusing on improving the submission of claims. However, €150 million is outstanding from private health insurance companies. This amount would fund the National Ambulance Service five times over. A total of €98 million is awaiting payment from insurance companies with €52 million pending. That is a considerable sum in light of the service plan and the difficulties associated with its provision which we discussed just 48 hours ago. This is revenue owing to the HSE and I ask what more can be done to ensure it is collected. We must ensure that money is reclaimed. In cases

where insurance companies do not pay out, the bills are the cause of great distress for the patients. I presume Mr. O'Byrne is attending the meeting of the Committee of Public Accounts. He spoke about health insurance companies requiring photographs of patients on beds to be submitted with claims. Has this practice been addressed? Can we ensure that money owed to the public purse is paid in a timely manner?

Chairman: I call on the Minister to reply before I call on further speakers.

Deputy James Reilly: I will invite various speakers from the HSE and the Department to answer some of the specific questions about which they are more knowledgeable. I will address Deputy Kelleher's questions first. He is concerned about a downgrading of services as a consequence of hospital grouping. On the contrary, the hospital groups will have local knowledge and autonomy which will enable them to decide where the services are best placed in an individual area for the people whom they serve. He is quite correct and I do not wish to be confrontational. The plan for the mid-west region was a good plan at the time but it was not executed properly. With respect, the previous Government removed the services from Nenagh and Ennis before the supporting services were in place in Dooradoyle. We have been at pains to avoid that and to ensure simultaneous exchange of services so that the replacement services are in place simultaneously and the capacity is in place to deal with the consequences of the removal of services.

I will give an example of the current situation; no one has raised this example but I am happy to refer to Navan. There are accident and emergency departments within a short radius in Cavan, Drogheda and down the motorway in James Connolly Memorial Hospital. I have made it very clear there will be no change to that accident and emergency department until the capacity exists in the other accident and emergency departments to take the additional workload. That remains the position. Deputy Kelleher referred to issues relating to the maternity hospitals. The KPMG report indicated that maternity hospitals should be co-located with adult hospitals in the interests of the safety of pregnant mothers. That is also my view and we are pursuing that policy. A maternity hospital will be co-located with the children's hospital. Holes Street hospital will be relocated to St. Vincent's hospital. The Rotunda hospital will be relocated as will the maternity hospital in Limerick and maternity hospitals elsewhere. There will be a need to review the overall number of maternity hospitals and the services they provide. Deputy Kelleher asked who will monitor these trusts to ensure they are held to account. The Minister for Health and the Department will be answerable to the Oireachtas. More work is required on the question of what is to replace what I regard as a democratic deficit that currently exists with the removal of the health boards. I was concerned about this issue long before I was involved in politics because I could see the value of politicians being able to hold the system to account at local level.

Deputy Kelleher and other speakers referred to Tobacco Free Ireland. I take the opportunity to thank everyone for their support. My personal, political and professional views are well known. We know this is a killer product which kills one in two persons who use it regularly. This is an astonishing bald fact which we cannot ignore. We cannot resile from this fight which we must take to the tobacco companies. We must protect our children from ever taking up this habit. As I have pointed out previously, once one is addicted, one is unable to exercise choice. I commend and congratulate the courage of Mr. Gerry Collins and the current television advertisement.

On the issue of obesity, I see Mr. Chris Macey of the Irish Heart Foundation, is in the Gallery today. He has spoken about the impact of obesity in terms of diabetes, cardiovascular dis-

ease, strokes, heart attacks and so on. Obesity shortens people's lives. Again, we have a duty to put in place systems to protect children in this regard. One example of this is the Healthy Ireland initiatives which we have introduced right across Government. The Department of Health cannot do this on its own. As I mentioned the other day, we are the first Government to appoint a civil servant at principal officer level to oversee this issue and ensure there is co-ordination between the Department of Health, the Department of Education and Skills and the Department of Children and Youth Affairs. It is an issue that will require continuous innovation and new initiatives to address it.

In terms of primary care, people are very fond of saying that a particular service is in crisis. In this instance, we are told that GPs are leaving the country in their droves. The reality is that there was always a certain number of doctors leaving the country. In fact, I suspect that more left in the past than are doing so now, because they could not avail of a GMS contract. We are the first Government to address that restriction by ensuring that any suitably qualified physician can take on medical card patients, rather than having to wait five years as was the case previously. Since that initiative was implemented, 246 new GPs were brought in under the scheme. Indeed, the overall number of general practitioners has increased in recent years. As at December 2012, there were 2,600 in active practice, full and part-time, and some 300 working as locums. Of these, 2,353 were contracted to provide services under the GMS scheme. This compares with a figure of 2,098 on 31 December 2008, some 2,136 in 2009, and 2,258 in 2010. In other words, there has been a steady rise in numbers over that period. We do not have the up-to-date figures for 2013 but, as I said, an extra 246 doctors have come into the scheme under the new regulations. In addition, and in fairness to the previous Government, the number of GP training places was increased in 2010, an initiative we support.

There is no question of a financial collapse in general practice. I am aware that some practices are in difficulty because they invested heavily in new premises. They were right to do so and are deserving of support. Nobody wants to see those practices fail and we will do everything we can to support them through new models of practice and a new GP contract which rewards those new practice models. We must bear in mind, however, the OECD report published some years ago which showed that Irish GPs were the best paid of all the countries that returned figures. Notwithstanding the reductions in remuneration under the various financial emergency measures in the public interest, I am given to understand that a forthcoming updated report will show there has been no substantial change in terms of the relative position of Irish GPs when it comes to remuneration.

Chairman: From what we hear from GP advocates every day on the radio, one would think the world was going to fall down on general practice.

Deputy James Reilly: With respect, that is the job of those advocating for GPs.

Deputy Billy Kelleher: I am sure the Minister is of the view that the Irish Medical Organisation would never be given to exaggeration in these matters.

Deputy James Reilly: I did not quite catch that comment, but I got a sense of it.

At the end of November, 1,983,572 people in this country were in possession of either a medical card or a GP visit card. In fact, the numbers in receipt of both have risen by 500,000 in recent years. In other words, more people than ever have access to GP care under the GMS scheme. I am engaged in discussions with the Minister of State, Deputy White, regarding a new GP contract not just in respect of patients aged under six years of age, but in the context of the

overall spread of free GP care at the point of delivery. Nobody is pretending that this type of provision will not be costly, but it is a question of ascertaining how we can best achieve value for money. In many cases, patients' needs can best be met by their GPs, and the local practice is usually the most convenient location and closest to home for patients.

As it stands, we have doctors doing work that nurses could be doing, nurses doing work that health care assistants could be doing, and consultants doing work that allied health care professionals could be doing. I have referred on numerous occasions to the screening that is being done by physiotherapists of referrals to orthopaedic surgeons, which has resulted in 50% of patients not needing to be referred because they can be dealt with by the physiotherapist. In the area of mental health, for example, GPs whose patients require counselling but cannot afford to avail of it privately are obliged to refer those patients to a psychiatric clinic. The psychiatrist's time is being taken up to refer such patients to the counselling service in the public sector. That is utter madness. These types of practices need to change, and that is what we intend to do. I see a much greater role for nurse practitioners and a much larger number of same working in a new model of general practice, where chronic illness prevention and care will be a major feature and where nurses can screen the patient to see whether they need to consult the doctor. If we keep doing things the way they have always been done, we will keep getting the same results. Changing that is a major part of our planned reform of the system.

There has been a great deal of concern in regard to the provision of medical cards. The reality is that no medical condition ever entitled a person to a medical card; provision was always by reason of financial hardship. Clearly, many illnesses and conditions create financial hardship for citizens. There is no question about that. However, instead of looking to the medical card, which has strict rules attached to it, effective change requires legislation and is a policy issue on which I have not thus far received a directive from Government. Nobody in this room wants to see any person experiencing hardship or those with life-long conditions being further disadvantaged. I have asked the Health Service Executive to put together a small review group to examine how we can best meet the needs of these people. It is about finding a different approach and examining what supports are required.

In regard to nursing home treatment and medical cards, I do not want to be adversarial but the issue of nursing home care and the additional care given under that system was always problematic in the past. It is an issue we are examining. For example, we are in discussions with the HSE regarding methodologies for getting allied health care professionals out into the field. We have fine young men and women who, having studied very hard to achieve 555 points in their leaving certificate, go on to spend four years studying physiotherapy in Trinity College and elsewhere. These young people are very well qualified but do not have sufficient experience to go out on their own into the community. Some of them end up working in McDonald's or leaving the country. We are considering an initiative whereby these graduates could avail of an intern year that would give them the work experience to be able to go out into the communities where they are so badly needed. As a GP of 30 years' experience, I would be very keen to have a physiotherapist attached to my practice. In some cases, for instance, it might not be necessary to send a patient for an X-ray because the physiotherapist can deal with the problem. When the facility is there, people will use it.

I thank Deputy Ó Caoláin for his support for the cochlear implant fund. It is very much our intention that no child should turn seven years of age without having received the bilateral implants he or she requires. After that age, the opportunity is lost for these children. We are having to play catch-up in this area in the same way as we did with the cervical cancer vaccine.

Our plan is to ensure that no child loses out and none is prevented from achieving normal hearing where that is possible.

In respect of the Deputy's concern regarding the Statute of Limitations as it relates to those women who underwent symphysiotomies, the Attorney General's advice is very clear that to make a change in this instance would have all types of ramifications and unforeseen and foreseen consequences. As such, she is completely opposed to what the Deputy has outlined. In the case of many of the women who have suffered so much as a consequence of this procedure, the person who carried out the operation is deceased. Some of the women do not even know the name of the doctor who performed the procedure on them. They have no access to medical notes because those notes are gone. Many will incur huge cost and endure enormous delay by taking their case to court. If we change the Statute of Limitations, the insurers will state that we have changed the game and that they have no further culpability. I wish to place on record the fact that we are not letting the insurance companies off the hook on this matter. They have an obligation in this area and the State will play its part too.

There are some specifics to which the Deputy referred as occurring at the meeting. The Minister of State, Deputy Kathleen Lynch, was present at that meeting with me. I do not have the contemporaneous notes from that period but I do know that I did not determine what would be the scale of awards.

Deputy Kathleen Lynch: We did not discuss it.

Deputy James Reilly: I did not talk about staged payments at all. There is no question that anybody would be denied legal representation. What I did say, however, was that I wanted to ensure that any funds we could procure in order to compensate for the pain, hardship, hurt and distress caused would go to those who suffered and not to members of the legal profession. That is one matter about which I am very clear.

The next point I wish to make is that it would be very wrong of any member of this committee or others to mislead people into believing that the awards they might obtain would be at the very top end of what was obtained by a woman who has indicated, in very clear terms, that she had an open-and-shut case but who was obliged to go through several years of proceedings and who nearly lost her house. The woman in question stated that during the final appeal she woke up one night in a cold sweat and realised that she could lose her house. She had an open-and-shut case but there were several legal points which could have derailed matters. The matter was eventually settled by the Supreme Court not after one, four or nine years but rather after 11. I do not want many more of the people who suffered as a consequence of what occurred pass away before we get to rectify the position for them. That is why I am taking the most expeditious approach possible. Judge Murphy is an individual of considerable repute who has form in this area and who was also involved in dealing with matters relating to childhood abuse. She is very skilled, knowledgeable and full of compassion. With the agreement of the women concerned and their representatives, she will do her best to come an arrangement that will help bring about some sense of closure for them.

A great deal of concern has been expressed about a number of recent incidents involving the national ambulance service. I am also concerned about this matter. HIQA was due to carry out a review of the ambulance service in the second quarter of the year. I have spoken to both the chairman and the CEO of the authority and they have agreed to expedite matters carry out the review as a matter of urgency in order that all relevant matters might be investigated. I appreciate the concerns of Deputy Ó Caoláin, who inquired about the use of Sat Nav. The HSE

does not operate Sat Nav devices because they are not sufficiently safe and do not contain maps for Irish townlands. The HSE ambulance services operates GeoDirectory mapping combined with digital automatic vehicle location, which allows control to direct a vehicle to the scene of an incident. The HSE can probably elaborate on that matter for the Deputy. We must accept, however, that much and all though we strive for perfection, it is something which eludes us. Things sometimes can happen, the wrong information can be transmitted and vehicles can be directed to the wrong location.

I am very concerned about instances outlined to me of four ambulances parked outside accident and emergency departments, especially on days when TrolleyGAR and Trolley Watch indicated that there was no particular issue with regard to trolleys. We all serve the public best by insisting on transparency. When there is transparency, it is then possible to have accountability and, with that, we may get some fairness. I am very happy for HIQA to carry out a very thorough review of the situations in question and of the entire service and to indicate where the problems exist. We will address those problems because the safety of citizens must be paramount.

Deputy Healy referred to the boards of the hospital groups and appointments thereto. Those appointments are in train at present. I wish to make my position clear in respect of this matter. The Tallaght report threw up a great deal of material, some of which is being dealt with in a neighbouring committee room in the context of other issue. I will make one comment on that matter and I assure the Chair that I will not cut across the matters with which the Committee of Public Accounts is dealing. On foot of the Tallaght report, it was determined that we needed a uniform approach to appointments to the boards of hospitals and that such appointments should be based on competency and should not be made on the basis of on with whom one went to school. The relevant competencies would be legal, human resources, HR, financial, managerial, etc. That is what we are doing. We have a grid in place in respect of appointments to boards and we can look at this in respect of any individual and assess which boxes they tick. I agree with Sir Keith Pearson who made the point that no member of staff should be on a hospital board because that is counterproductive. Staff can be members of the wider board of governors but they should not be on the board which supports the management and the executive.

In the context of the issue to which the Tallaght report gave rise in the context of a second stream of payments being made to senior executives in hospitals. There is only one instance of which I am aware where the same individual is the CEO of both the public and private hospitals. I am of the view that this is a conflict of interests and that it is unsustainable. Knowledge of that situation by no means confers acceptance of it. That goes for many other things that have been happening and of which we may have had some knowledge. Those things to which I refer are now being addressed by means of a cogent and coherent mechanism which has regard to due process. I am sure Mr. Tony O'Brien will not want to say too much on that matter because it is being dealt with by the Committee of Public Accounts.

Mr. Ian Carter can address the problem with people on trolleys in hospitals in south Tipperary in a comprehensive matter. It is important to state, however, that overall trolley counts are down this year on last year. That is the case - believe it or not - even though there was a spike during the week. There will be pressure in the coming weeks but such pressure always arises in the first six to eight weeks of the year.

I fully agree with Deputy Healy in respect of the costs relating to agency doctors. This is a matter of serious concern for me, as is that which relates to the cost of agency nurses. That is why we introduced the concept of the "nurse bank", a matter in respect of which Mr. Tony

O'Brien can comment further. We promised to obtain figures in respect of the overall cost for the Deputy but I do not know if it has been possible to do so. Mr. Tony O'Brien appears to be nodding to indicate that the relevant information has been procured.

The issue that arises relates to the recruitment and retention of non-consultant hospital doctors, NCHDs. This is also a matter of grave concern to me. Some time ago I informed the committee of my belief that it is both wrong and morally questionable for us to recruit doctors from the Third World, particularly when we train our own doctors here. I accept, however, that the latter can sometimes leave the country when they have completed their training. We undertook to discover why we cannot recruit or retain NCHDs. I am aware of anecdotal evidence of why the latter is the case. It is because NCHDs do not feel respected, are of the view that they do not have a clear career path and feel they are not treated with the dignity with which they should be treated. This matter is being addressed by Mr. Brian McGrath's group. Mr. McGrath has issued an interim report, which contains timelined recommendations, and will be bringing forward a full report later this year. I hope to address this issue because I am of the view that we have the finest and the best in this country and we want to keep them here. If anybody has any doubt about that, they should realise that when our doctors and nurses go abroad they tend to rise to the top of the very best institutions.

Deputy Conway referred to a consultant-led service. I do not wish to be difficult but we want a consultant-delivered service and that is what we are aiming for. In the past we had a consultant-led service. I have been examining the position with regard to consultant numbers and associated difficulties for the past two days. In that context, Mr. Barry O'Brien obtained an up-to-date report for me and it indicates that 93 new consultants have been appointed and that these are already in place. In addition, a further 71 posts have been approved for filling. If memory serves, approximately one third of those 93 consultants were employed at the new rate. I have discussed this matter with both Mr. Tony O'Brien and Mr. Barry O'Brien. When we introduced the reduction, it was never my intention that somebody who has spent ten years working as a cardiologist in Toronto would be expected to return here and commence work at the starting point on the salary scale. That, clearly, does not make sense. It has to be modified and whatever needs to be done will be done to address that issue. In the main, there is not the great crisis chaos that the Irish Hospital Consultants Association would like to paint. There are many other reasons consultants do not wish to return, one of the main reasons in the past has been the lack of ability to do research - we are very lucky to have Senator Crown here who had led iCore, an Irish Cancer organisation, that does a lot of research in this country through a virtual grouping - but we want to address that through the hospital groups and through involvement of the universities in the hospital groups, etc.

The Deputy was concerned about the maternity hospitals' outreach services being ceased and that they are to start again, and Mr. O'Brien can go into that in greater detail. The claims owned by the private health insurance are obviously a concern for us and in the past we had an issue with consultants failing to sign off. That has not been a problem. That end of it is sorted in the main and Mr. Tom Byrne, as was said, has visited various hospitals and has been sitting in this room while somebody was in the other room signing forms before he got to them. That is not the issue. The issue now is with the insurance companies themselves and delayed payments and we are going to take them to task over that. The Deputy is right in pointing out that this money belongs to the public health system and should be in the public health system, and that it is badly needed by the public health system. I will pass over to the Minister of State, Deputy Kathleen Lynch.

Deputy Kathleen Lynch: I wish to make a brief comment on this matter as people are interested in it. We have put in place a counselling service for people with medical cards, to which GPs have direct access. That service is for people with mild to moderate depression rather than they having to go through the whole system in terms of mental health. That service is working very well. It is significant that a GP has commented on radio about how well the service is working.

I wish to confirm what the Minister has said in regard to symphysiotomy. I appreciate that sometimes circumstances and occasions can overwhelm people and they get the wrong message but at no stage, and we have no vested interest in saying this, was a sum of money ever discussed. It was pointed out clearly what would be necessary to have a successful outcome in the courts. I do not believe at the two meetings that were held on this that any women raised the issue that this would be her preferred option, even though if someone wants to go to the courts, as the Deputy will know, there is nothing anyone can do about that; clearly, that is the person's choice. Neither was there any mention of legal representation not being available. It was never raised as an issue and it most definitely was not indicated from either of the two of us.

Chairman: I call Mr. O'Brien.

Mr. Tony O'Brien: As I mentioned the other day, across our two appearances this week, I have taken the opportunity to field all the members of the directorate across the two sessions. I will give notice to Mr. Pat Healy, Mr. Ian Carter and Ms Laverne McGuinness that I will ask them to respond to some of the group responses to this set of questions and others, no doubt, in respect of the next set of questions. I will take the issues in the order in which they were raised but group the responses across all the questions asked.

Chairman: Some seven other members have also indicated their intention to speak.

Mr. Tony O'Brien: I will be relatively brief.

Chairman: That is okay.

Mr. Tony O'Brien: On the hospitals issue, and Mr. Ian Carter will also respond on this, in regard to hospital consultant recruitment, as the Minister said, the changes have had an impact to some extent on the bringing back of consultants who were in established or senior posts elsewhere and, as the Minister indicated, he intends to do something to support us in that. There has not been an overall generalised problem in regard to the recruitment of consultants. Competitions have been successfully concluded but it has always been the case that between a vacancy arising and a replacement being in post, there can be a significant delay. That is because of the recruitment process, the vetting process and the need for a colleague who is coming into our service to free himself or herself up, often with an extended notice period from elsewhere. There can be intervals of a year or more and sometimes that impacts on the capacity of a team of consultants in any given location to provide outreach services and sometimes they have to pull back in order to maintain the overall quality of service. While I am not speaking to the specific instances that the Deputy has raised it is not an unusual feature that from time to time they have to do that. Mr. Ian Carter may be able to comment further on that.

On the issue of billings, one of the key objectives we set for 2013 was to get to a position where, by volume and value, between 70% and 80% of claims throughout the public hospital system would be through claims sure system. As outlined in the answer, we have got to about 76% by the end of 2013. We have also significantly reduced the volume of claims that are pend-

ing submission. Unfortunately that seems to be matched by a corollary increase in the number of claims being pending for payment. While it is crucial for all of us that private health insurers satisfy themselves as to the validity of claims that are pending submission, because that follows through on to the overall cost of private health cover, which is a significant concern, it none the less remains the case that the vast majority of claims will ultimately be paid. We are currently engaged through Mr. Tom Byrne in a process with those insurance companies to come to a different way of paying. There should be no reason, given that all these claims are ultimately paid, that we do not have a majority of the payments made within 30 days. They will always owe us a sufficient amount but if individual claims are found not to be valid, they can be dealt with in the round as we would with any large training entity. It is also of concern that if the effect of the new legislation that I referenced earlier, which came into effect on 1 January, follows through, we will have an increased dependency. We are expecting €40 million more from private health insurance this year. If we continue to see long delays in payment and long pending times, that will have an increased adverse impact. Private health insurers are not subject to the prompt payment legislation, to which a public body is subject. Clearly, by negotiation and perhaps with ministerial support, as required, we need to bring them forward to a different way of doing business with us because it has an adverse impact on the overall performance of a health system.

Before I pass on to Mr. Ian Carter who will deal with issues related to the European working time directive and the use of the pressures fund, I wish to respond to Deputy Healy who asked me about the broader reconfiguration issue. It is important to stress that one of the recommendations from the HIQA report into the care provided to maternity patients in Galway last year was a recommendation for a strategic review of maternity services. One of the possible outcomes of that could be to examine the number of locations and the size of those locations. The minister has already referenced the Tallaght review which had a specific recommendation about the number of emergency departments - 24-7 - in the greater Dublin area, which by international standards is excessive and probably has an adverse impact on optimal quality and certainly could have an impact on costs. When we talk about reconfiguration, we mean that there will be changes in the way that some services are provided but they will be done following appropriate reviews and with reference to international evidence. It is not the case that by the end of this year or next year one would expect everything to remain as it is. That is not sustainable both from a quality and a cost point of view. I will pass over to Mr. Ian Carter to comment on the specific issues that relate to his area.

Mr. Ian Carter: I will start with Waterford hospital. There are a total of 20 posts currently being advanced of which seven are new consultant posts and of those five are starting. It has proved difficult to recruit consultants to three posts. I note from discussion on this that the construct of the post is causing one of the issues. An exercise is being carried out to see how that posting in Waterford hospital can be linked possibly with CUH to see if it can be made a more attractive post. We are examining that.

In terms of south Tipperary hospital, plans are currently being developed to see what can be done to reduce the congestion in the emergency department. They are threefold. Some beds are currently closed in the hospital and it ensuring that it can properly staff those funded beds. There is an issue relating to the staffing levels and configuration in the emergency department and one of the other key initiatives as we move forward is moving from our solid hospital centring approach to try to improve the community services that prevent admission and facilitate far quicker and more timely management of patients back out to the communities. Those plans as they relate to the hospital should lock on board in the next two to three months.

On the reconfiguration issue, as has been said, the groups are only just starting to come alive with the CEOs to them, hopefully, being recruited later this month. The reconfiguration plans will take some time to generate but the key issue is that they are not going to be somehow a secret. They will be subject to validation but the logical grouping to come up with those reconfiguration plans is the local hospitals working as a cohesive network.

In terms of the European working time directive, EWTD, I suppose that needs to be seen as a journey rather than a specific funding initiative. At the moment the hospitals have been working for the majority of this year on how services can be reconfigured with a higher reliance on consultants and slightly more sensible rosters to ensure there is an overall reduction of the working hours with no service diminution. Within that framework we are just completing the first phase of the exercise. It is a joint exercise with the Irish Medical Organisation, IMO, which is looking at the first milestone to moving to EWTD, that is, the removal of the requirement for non-consultant hospital doctors, NCHDs, to work for longer than 24 hours. We are just completing that exercise to see where we are. We have identified some level of funding, as would have been seen from the service plan. That is for a mixture of investment, as it will translate to a region-by-region basis or a hospital-by-hospital basis in terms of additional NCHDs, consultants and nursing staff.

Mr. Tony O'Brien: In regard to the issues of discretionary medical cards and the fair deal, on which I will ask Mr. Healy to comment, as we made clear in this committee, and at the Committee of Public Accounts previously, there is only one type of medical card. It confers one set of eligibility. The discretionary medical cards granted on discretionary grounds build upon the primary entitlement. Entitlement is not based on medical condition but on financial hardship and in the case of discretionary medical cards we take into account, with input from medical assessors, the costs that arise from a medical condition. The overall financial means of a family is still the fundamental building block. The only changes that have occurred, as per budget 2012, are that certain allowances in relation to weekly travel to work and the cost of home improvement grants became disallowed. The second change which occurred in recent years is that whereas decisions related to discretion were essentially all local decisions effectively, à la the former health board structure, with centralisation a consistent single set of rules apply. Those things combined can have the effect, together with the family circumstances, of meaning that while people's medical circumstances have not changed their entitlement to a discretionary medical card may have.

We are also conscious that the medical card is sometimes more valuable as a passport to other services than it is in terms of its primary design purpose which is access to GP care and medication. As the Minister referenced, we are looking to see – in particular with regard to those with long-term needs in the 0 to 18 category – what we might do to address those other things which were accessed through the passport rather than the direct purposes of a medical card. I will ask Mr. Healy to address that as well as aspects relating to the fair deal.

Mr. Pat Healy: To reassure Deputy Kelleher, in particular, and other members, the availability of community services, in particular early intervention and respite for people with a disability are not simply means tested. The system is based on assessed need. It is important that we reassure the public and service users. We will take the opportunity as we roll out the 0 to 18 programme this year, and using the €4 million in additional development as part of that, to communicate with people to make sure they are aware of the situation and that there is access. At times one can have waiting lists but it is not an income issue that is the cause of the problem but whether the services are available. As we roll out the 0 to 18 programme we will deliver

a more integrated assessment and intervention service that will address some of the concerns people have in that regard.

Mr. Tony O'Brien: I will ask Ms McGuinness to share the detail of agency costs. It is important to stress that the use of agency-type personnel or flexible employment is an inherent feature of any health care system. In view of the statistical process control variations and demand, it is necessary to be able to flex up and flex down. As the Minister referenced, we do, as a result of budget 2014, have a procedure in place to effectively take back some of the costs that are currently resulting from using classic agency employment approaches in both VAT and agency margin. We will operate, as it were, in-house nurse bank arrangements. This does require a small piece of legislation under the 2004 Act to empower health authorities to set up subsidiary undertakings to take the place of agency services. That will have an important impact both on the costs I have mentioned but also on our ability to leverage the provisions of the Haddington Road agreement. Ms McGuinness has the detail on agency expenditure for the first 11 months of 2013.

Ms Laverne McGuinness: In regard to agency costs, the medical and dental spend up until the end of November was €54.186 million. The cost of agency nursing costs was €81.392 million. We do not have the figures for December but I have forecasts which I can provide to the committee if they are considered useful. The forecast on medical and dental agency costs is €59.112. The forecast for agency nursing is €88.791 million.

Mr. Tony O'Brien: Thank you, Chairman.

Deputy Seamus Healy: Is there an individual figure per NCHD?

Ms Laverne McGuinness: I do not have the level of detail on NCHDs. We would be able to provide a breakdown for particular agency recruitment costs at a location level and area level. I could also give the breakdown for each region. They are the figures I have with me. I do not have a lower level of detail beyond that but we could provide it.

Mr. Tony O'Brien: It cannot be provided today but it will be provided in follow-up information.

Deputy Caoimhghín Ó Caoláin: I hoped Mr. O'Brien might address the national ambulance service. Sat-nav is phraseology I understand because I have it myself. Are there other systems? Would it not be better if the system was in the vehicle fleet and under the control of the personnel in the ambulance?

Mr. Tony O'Brien: The information given by the Minister on geocoding is the same information that we will provide. At present there is not the technology for that to be in the individual vehicle. If we were to install sat-navs, safety issues would arise. From experience I know that the house of a relative of mine who does not live too far from Deputy Ó Caoláin cannot be found on a sat-nav and one would be likely to be taken to the wrong place altogether so the geocoding approach is better for now. When we have full postcoding and sat-navs that reflect that, it might change the situation but the reason of cost that has been suggested to the Deputy is not the correct one. The cost of putting in sat-navs is negligible but the risk associated with doing so would be greater, according to the risk assessment that has been made, than using the present geocoding approach through the control centre.

Senator Colm Burke: I thank the witnesses for their presentation. I wish to focus on Questions Nos. 3 and 5. Question 5 related to NCHDs. I based my question on the figures made

available to me at the time. The agency cost for NCHDs was approximately €50 million. I am open to correction but I note that in the reply the hours contracted out to agencies is equivalent to 175 whole-time equivalents. If one divides 175 into €50 million it works out at €280,500 per whole-time equivalent. Perhaps we could get clarification on the real cost of agency staff because I base my calculation on the reply I received which is based on the cost of agency provision of junior doctors of €50 million.

I am also concerned about the reply to my second question. I raised the issue consistently since June 2011. It relates to the fact that more than 2,000 junior doctors are still on six-month contracts. I accept what the Minister said about the interim report but I am a little disappointed that the final report will not be available until June which means there will be very little real change until January 2015. We have a huge drain of junior doctors out of the country and that is one of the issues that must be tackled. The reply I received today said it is not anticipated that the number of NCHDs holding six-month contracts would reduce in the short-term. I am concerned with the reply in terms of when exactly we will have a reduction in the number of people being offered six-month contracts and moving to at least two-year or three-year contracts. That is my first question.

My second question is on question No. 3, which relates to the €812 million paid to section 39 organisations. I note and welcome that the reply states that a letter was sent to section 39 organisations on 10 December, which is a number of days after I had submitted my question, and I am delighted that section 39 organisations will now be required to make disclosure to the Health Service Executive as regards the pay to senior management. It is disappointing that we are paying out €812 million to section 39 organisations yet we do not have the information on the current pay scales of people in senior management in many of these organisations, and there is substantial funding. I understand that over 131 organisations are receiving between €1 million and €10 million. I specifically asked my question on the level of pay. The HSE is now saying that for 2014 it has to make that information available. I ask that this information be made available to this committee because when I asked a question about section 38 organisations on 17 October, the information was not given to me but it was made available to the media within seven to ten days and it is disappointing that it was not made available to this committee first. I ask that when the information on section 39 organisations becomes available it is made available to this committee at the outset rather than being released in the public domain without the members of this committee being made aware of it beforehand.

Senator Jillian van Turnhout: The witnesses are very welcome. I fully endorse everything the Minister said about a tobacco-free Ireland and the Healthy Ireland initiative. I welcome the update from the Minister of State, Deputy Lynch, on mental health but regarding the child and adolescent mental health services, social workers have repeatedly told me about their difficulty of engaging and I am fearful that because they will now be in separate bodies under the new agency we may exacerbate that problem in some way. I would like to see a protocol in place at the earliest opportunity to ensure that does not happen. A situation that arises frequently is that once the child goes into care, child and adolescent mental health services, CAMHS, back off and say the child can now get private mental health services. We need to consider having a joined-up system because that is unacceptable. We must ensure that engagement is taking place. We have seen too many reports. I highlight that issue for the Minister, which I will follow up.

My question No. 9 on nurse prescribers came up during the end of life care hearings in this committee. The reply refers to the Department supporting that in principle and putting in place

governance and accountability structures but the reality is that those structures are already in place. Nurse prescribers carry out regular audits of the medication they prescribe. They only prescribe from a list of medications approved by the general practitioner who has mentored the prescriber. There is a collaborative practice agreement in place, which was developed collectively, and when I read the answer I felt it reflected the policy versus practice dichotomy we often face in health care. The policy is in place. Could whoever is responsible be nudged to put that into practice?

The reply to question No. 10 on cardiac services is disappointing. It gives the impression that the services being supplied are adequate. The fact is that the number of patients has significantly increased but I believe that is down to the dedication of the staff and not a reflection of the shape of the services. It is likely that the staff would see the response I have been given here as using their dedication against them and it might increase their frustration and undermine their morale. We have to be very careful about that because they have given above and beyond.

The survey that listed a number of significant service deficits does not overcome the inadequacies. It is like having a builder make a virtue of the fact that one's house has two walls but not address the fact that the house is falling down. That is how I felt when I read the answer. We must ensure that we record appropriately. We must record that a service has access to a discipline, even if that access is as low as an hour per month. We must be careful about overstating the case. When I read the answer I felt it did not reflect the reality. It refers to staff vacancies and to maternity and sick leave but the reality is that there has been a constant diminution in staffing levels since 2005 despite the priority for this life-saving service.

Question No. 11 is on the neuro-rehabilitation strategy. It is not my first time to address that issue. It was due to be rolled out from 2011 to 2012. We are now half way through its lifetime and the implementation plan is still not finalised. How long will it take to finalise the implementation plan and is there any intention to speed up this painfully slow process, which will have a huge impact on people's lives?

Deputy Dan Neville: I welcome the representatives of the HSE, the Department and the Ministers. ReachOut will terminate at the end of this year. In terms of my experiences establishing ReachOut, it took three years of consultations and meetings of the expert group before it came to a decision. Some 90% of the recommendations were included in the National Task Force on Suicide, which reported in 2008. During that three years, the answer to every question asked in the Dáil about suicide was that the Minister was awaiting the report of the expert report. There were no questions responded to or improvements made over a three year period because they were waiting for a report. I am not saying that will happen but that issue might be addressed. It was extremely frustrating during that period because nobody was telling us anything that was going on other than that the expert report was awaited.

Regarding question No. 6, the Minister informed us that of the 891 new staff to be recruited to the community mental health services etc. in 2012 and 2013, 514 have already been recruited but 30% have not been recruited, therefore, €30 million of the budget of €70 million for that period has not been spent. In fact, it is in excess of €30 million because there was recruitment during 2013. Where is the €30 million that was not spent because the recruitment did not take place? We know the Minister and the Government made a specific decision to allocate moneys. Obviously, they felt that was necessary because of the historical neglect and the likelihood that would continue in regard to development of the mental health service. Is there an incentive in terms of using moneys not spent elsewhere within the health service?

Regarding medical cards, and I appreciate what Mr. Healy has said, I want to dwell briefly on the administration of the medical card system in which considerable problems remain. I will mention a few of them that have been raised with me by general practitioners. Renewal forms are sent out between two to six weeks before expiry date but it takes six weeks or more to process them. Can GPs extend a medical card for a period of three months if a decision is not made on a medical card? Also, application forms are being lost repeatedly. Most of us in our clinics have come across people who say they sent in the application in October or December and they still have not got the card.

Furthermore, patients are not being removed from lists despite timely issuing of death certificates. I had a situation where a death certificate was submitted last March and the doctor was still being paid up to recently for that individual. Also, cards are being cancelled without patients or doctors being informed prior to the cancellation. A patient turns up the surgery only to discover out of the blue that he or she does not have a medical card even though it has not expired. These are some of the administrative difficulties that still are inherent in the system.

Deputy Peter Fitzpatrick: The aim is to have universal health insurance available to the entire population by early 2016. What is the plan to progress this in the next few years to ensure this does happen? As for the primary care services, I believe 34 primary care centres are progressing at present, while a further 12 have been approved. How does the Minister find the task of getting qualified personnel to work in these centres? He should indicate what progress is being made in this regard. In respect of the €40 million in additional funding for disability services, I note that €7 million has been allocated to provide for an estimated 1,200 additional places for school leavers, as well as people in training and emergency residential placements. What is the plan for the future in this regard? How can members track that this is being implemented? Moreover, how can the €3 million being allocated to provide emergency placing for people with disabilities whose family circumstances have changed, as well as the €4 million for children with disabilities, including autism, be tracked and followed up? I believe the €30 million provided to help to address the waiting lists will increase access to emergency departments, inpatient treatment, day care and outpatient department, OPD, services. At present, the waiting time for adults is eight months, for new eye patients it is 12 months and children wait for as long as 20 weeks. Is this funding to maintain or improve these levels of service?

Over Christmas in particular, a lot of old people have no one to look after them. What plans are in place to look after them? An issue that I am encountering more often in my clinics is that many elderly people are being abandoned in hospitals. Their families no longer wish to take the responsibility of looking after these elderly people. Is money being put aside to look for such people? They are being discharged from hospitals, are being sent home and so on but they have no one to whom to go home and they are not fit to do so. Another issue that has received my attention is that of voluntary health insurance. Premiums for many elderly people have been increased. Older people tend to wish to opt for the top policy because they are more inclined to get sick and many such policies are increasing by between €400 and €500 per annum. As they simply cannot afford it, can anything be done to help such people to pay their premiums?

I will conclude with a question regarding the national ambulance services as in recent weeks, all one has heard on news reports has been references to delays in ambulance response time. I have been informed that in 2013, €25 million was allocated, which was a capital investment for a national control centre, as well as 25 new intermediate car vehicles. There still appears to be a problem. Can these delays be examined and can one ensure this does not happen again? It is all down to communications, which will be extremely important in the future.

Deputy James Reilly: I will begin by responding to Senator Colm Burke. He notes the full report will not be ready until June and is somewhat disappointed. I must respectfully say to him that this is the first time this has been done. It has been a running sore for 30-odd years. There has been an initial report in order that some changes can take place but to do the full job on this, particularly in respect of creating the clear career path, we must engage with quite a number of groups, including the colleges and universities. I do not accept that it should take 12 years to become a consultant and in other jurisdictions, it takes six years. I do not suggest that at six years, one will have the same experience as someone who has been a consultant for ten years, clearly not, but people need to be able to live their lives with some view of the future. I have asked that consideration be given to two and three-year contracts. This is a matter that will be addressed in the report as well, namely, the entire issue of retention and I believe a good report will be forthcoming from Professor Brian MacCraith. He is a good individual, who has an interest in this area and who is the president of DCU, one of the most progressive universities in the country. I attended a conferring ceremony there recently and noted that one of its alumni now is a worldwide assistant chief executive officer of Microsoft. Good people are produced from that university and he is a highly progressive individual. He perceives the need, as does everyone present, to give people a proper shot at life. If one is obliged to change job every six months, how can one have a marriage or a relationship? How can one even get a mortgage or a car loan, if one cannot show that one will have a steady income? All these issues must be addressed. It is complex and will take time but I believe it will be worth the time spent. There was one other issue that related to page 11, to which I will revert. The Senator noted the reply “it is not anticipated that the number of NCHDs holding six-month contracts would reduce in the short term”. As I stated, I do not accept that either. I accept that it will change in the short term, I want it to do so and like the Senator, I would be concerned if this were to remain the case.

On the section 39 payments, I will allow the representatives of the HSE deal with it because there are technical issues in that regard. However, this all arose from the Tallaght hospital report from HIQA, which has uncovered quite a lot of irregularities in the system. In the very first public utterance I made on this issue, I made it clear that it would be open to people to come and make business cases for those situations which pertain. However, they must all be approved by the Departments of Health and Public Expenditure and Reform. That is the key and I reiterate we need transparency across the entire system. I will let the HSE deal with that issue.

Senator van Turnhout mentioned child and adolescent mental health services, CAMHS, and I will allow the Minister of State, Deputy Kathleen Lynch, to deal with that matter. In respect of cardiac rehabilitation and neuro-rehabilitation, we are highly fortunate to have in attendance the clinical director, Dr. Áine Carroll, and she can address that. The Senator also spoke about nurse prescribers. While I will allow the HSE to talk about that too, personally I am highly supportive of this and of a greatly expanded role for nurses, particularly in general practice but right across the system. I am pleased that with the roll-out of the colon cancer screening, advanced nurse practitioners will be carrying out the endoscopies, not consultants. We need to think outside the box in respect of how we use the staff we have.

Senator Jillian van Turnhout: In the nursing homes, where that policy is in place.

Deputy James Reilly: Absolutely and there is that whole issue around nursing homes where historically, nursing home owners did not want people dying in the nursing homes, there-by giving them a bad reputation. We are trying to move away from that culture and explain to people that this is their home and most people want to die at their home. They do not wish to spend the last 12 hours of their lives sitting on a trolley in an emergency department. While

there also will be upskilling for general practitioners, GPs, in this regard, it will mainly be for nursing home staff in order that they are comfortable in this space. Our chief nursing officer is present and can address those issues in a much more comprehensive fashion.

Deputy Neville mentioned ReachOut and mental health staff. I will defer to the Minister of State, Deputy Kathleen Lynch, on those issues. As to whether the GP can extend the medical card for three months my information is he or she can. While that is from memory, I will have this confirmed by the HSE in a moment. On the last point mentioned by the Deputy regarding patients not being removed from the list, despite the death certificate being issued, that is not playing the game. The GPs were given an opportunity to put on their list a newborn child when he or she first presented to the surgery, rather than waiting for the HSE to do it over a period. In return for this, however, they were to remove from their list people who had passed away or had left the practice. Consequently, it is a bit facetious for a general practitioner to be trying to present to Deputy Neville the idea they issued a death certificate and therefore the HSE should know.

Deputy Dan Neville: The doctor informed the HSE.

Deputy James Reilly: Births, marriages and deaths, or hatches, matches and dispatches, as they are referred to, are in a different section. Consequently, it is up to the GPs, who must play ball in this regard. The Deputy should not get me wrong, as in the main they are. I believe this is working well and this is the reason much of the work on the issue of probity etc. already has been done on this. This is the reason the idea that €113 million could be saved from that process left me highly unconvinced and is the reason I requested and secured agreement from the Departments of the Taoiseach and Public Expenditure and Reform to carry out the validation process, which proved us to be correct.

Deputy Fitzpatrick raised a number of issues. The plans for universal health insurance are on course. The White Paper will be published, there will be an opportunity for everyone to be consulted and for a constructive conversation to take place across this for all stakeholders, including the public. The Deputy mentioned that 34 primary care centres have been progressed. They have actually been completed and 12 more are in the pipeline, as well as others that might enter the pipeline if we can get more interest from GPs to develop them themselves. Whether we develop them or they develop them, whether they are done through direct build or through lease, there is no point in putting a brick in the ground if the GPs are not signed up. That is why, of the 35, only so many went ahead. One does not get GP interest. The last thing we want to do is build a primary care centre and have the GPs sitting outside asking how much they will be paid to be included because that is what would happen.

On staffing, I am not aware that there is any issue about staffing once the agreements have been reached, but Mr. O'Brien can go into that. The Deputy mentioned mental health issues, which I will let the Minister of State, Deputy Kathleen Lynch, deal with.

On the €30 million intervention fund, Mr. Ian Carter who is here might give the committee a flavour of how that might be spent. It is used to support innovation to improve the patient experience, both in emergency departments, inpatient and outpatient waiting times.

The issues around the care of the elderly are issues that are common to both myself and the Minister of State, Deputy Kathleen Lynch, in terms of the acute sector having facilities in place to allow the frail elderly commence rehabilitation immediately they are fit to do so. Often what happens is somebody goes into hospital with pneumonia, ends up with the medical problems re-

solved after 48 or 72 hours, but is clearly not well enough to go home and needs physiotherapy and occupational therapy. Sometimes such a person does not get this in the hospital and is left lie in the bed so that he or she becomes unable to go home ever, and that is what we are trying to address through the frail elderly programme. Dr. Áine Carroll who is present can talk through many of the clinical care programmes. There has been astonishing progress made on stroke, which I mentioned already and which Dr. Carroll can go into in more detail, and in congestive heart failure which has been raised by members as well.

On private health insurance, PHI, the cost of insurance has gone up and I am most concerned about that. As I have stated before and will say again, I do not accept that this 9% medical inflation should be taken as a given when the rest of the country was in deflation. It is utterly unacceptable. We are still paying for procedures that used take two hours at the same rate when now they only take 20 minutes. There is a host of work to be done here - it will be done - in terms of clinical audit, audit and benchmarking what we are paying and why we are paying what we are paying. Clinical audit is critically important. One needs a similar professional to challenge the professional concerned as to why tests are done or why treatments are carried out because there has been much anecdotal evidence of patients having procedures carried out that were not strictly necessary.

The Deputy referred to the national ambulance service. We dealt with that earlier through HIQA, which will be addressing that urgently. I will refer to the Minister of State, Deputy Kathleen Lynch.

Deputy Kathleen Lynch: I congratulate Deputy Fitzpatrick for asking questions. There were a good many but, nevertheless, they all were questions.

I will start with the child and adolescent mental health services, CAMHS, Senator van Turnhout raised. I will ask Mr. Stephen Mulvany to come in on mental health. In terms of CAMHS, and the service available to children, it is not the same all over the country. It is not uniform. That is something we need to do.

Also, we are dissatisfied with whether it is up to age of 16 or 18 in law. Of course, one is a child until one is 18 years of age and, therefore, one would expect all the statutory services to comply with that legal definition. We are working on that as well.

We need to look at a transition aspect in terms of those who conclude at 18 years and must transition into the adult service. It is not right that someone at 18 years of age falls off the cliff and goes into the adult service even though in some instances in some areas the adult service can be better than the child and adolescent service. It is something we are looking at seriously.

We have a difficulty in terms of recruitment. It has come up in other areas as well, that one simply does not have persons with the expertise we are looking for available when one needs them. I will let Mr. Mulvany deal with that. It is a matter of trying to put in place a system that is uniform throughout the country. Whether one is in Donegal or Dingle, access should be the same and the service should be the same. Hopefully, we will have better outcomes as well. We are working on that.

I would agree entirely with Deputy Neville. When it comes to mental health, we must defer to him. Deputy Neville was talking about mental health when it was neither profitable nor fashionable. I always defer to him on these matters.

ReachOut took a long time to put together, as did, to a great extent, A Vision for Change. We

are conscious of the fact that it is coming to the end of its life and that, maybe, we need to put a structure in place not to take a look at what is beyond A Vision for Change and what is beyond ReachOut, and whether ReachOut is working. Are we doing the right things? I will ask Mr. Mulvany to refer to that.

In terms of the recruitment, there have been stops and starts, but we are well on track. As I stated earlier, those who are already working in the system are as important as the new staff we will recruit. We need to ensure that they can work as a team, which does not always come naturally. We have set some funding aside to ensure that teams work in a productive fashion.

In response to Deputy Fitzpatrick, I will ask Mr. Pat Healy to deal with the additional funding for disabilities and the €4 million on the nought to 18s, which we see as a crucial element in terms of disability. We do not want those at the 18 years of age stage coming out of the childhood services and falling off the cliff. I am not certain that one can call it a crisis if one knows it is coming. We want to ensure that such does not happen.

We have separated out funding from the fair deal scheme to look at exactly the issues in regard to older persons of which the Deputy spoke. I am not certain that anyone sitting around this room wants to end his or her days in a nursing home, no matter how pleasant or kind staff are. Some people do not have a choice in that regard where it is the only option available. If all of the research tells us that each of us would prefer to die not only in our home but, if not, in our community, then we are looking at how we will manage that better, and this is the first year that we have taken steps in that direction. What we are doing is what we have talked about for so long. We are now, I suppose, financially, and with the finances, physically, moving in the direction we want to be.

Mr. Tony O'Brien: Mr. Stephen Mulvany will respond on the variety of mental health issues.

Mr. Stephen Mulvany: Senator van Turnhout asked about the protocol on the new agency. A new protocol either just has been or is about to be signed between the director general and the chief executive of the new agency referring to how it will interact with mental health but also the other divisions in the HSE.

In terms of CAMHS and children going into care, stepping back and saying one can now go private is not something which would ring true to me. It is something I have not heard.

Senator Jillian van Turnhout: I will get back to Mr. Mulvany.

Mr. Stephen Mulvany: A child in care is just as much an appropriate service user for the CAMHS as any other child.

In terms of Deputy Neville, as he stated, the ReachOut strategy finishes this year. This is its last year. In the HSE service plan, there is a clear action for us this year to set out a new strategic framework to replace ReachOut. The intent is to have that complete this year and we do not intend to have a period when there will not be a strategy for suicide prevention.

In terms of funding around posts, it is a feature of Government accounting that the funding for a post is given for a full year even though the post will only be recruited at some point in the year. The alternative would be to have to go back twice to the Department of Finance to seek funding for posts and that would not be recommended. What happens to any funding is it is either used for the purpose for which it is intended or for the general health service by agreement

or it is returned to the Exchequer. We did not return any funding to the Exchequer, therefore, that resource would have supported the mental health service and the wider overall health service. This year, in the service plan, we have been more explicit than in any year about the need to phase certain developments and the need to use time-related savings from that to support the overall service and deliver the maximum amount of current and new service, including, for example, the cochlear implants which were mentioned earlier. I think that covers all the points.

Mr. Tony O'Brien: Both the memorandum of understanding and the protocol between the HSE and the new child and family services agency was signed this week. There may be additions to that as we go on, but the primary documents have been signed.

If I may, I will ask Mr. Ian Carter to refer to the issue of cardiac rehabilitation.

Mr. Ian Carter: On the issue of cardiac rehabilitation, I suppose the response was not designed to be unrealistic but there are two matters to report to be exact. One, there has been an increased demand and there has been increased productivity, but also it is identifying some degree of fragmentation of the services. Some fragmentation of the services is being identified. Therefore, we will be working this year with the hospital to try to better structure the service so it will not have the disconnects. That work will be commencing directly.

With regard to NCHD overtime hours and agency hours, rather than going into detail now, as agreed, we will supply the committee with all the information in a short period.

With regard to what is being termed “innovation funding”, the aim for 2014 is for that funding to apply to both scheduled and unscheduled care. This is to try to maintain the scheduled care access in relation to the unscheduled access to try to maintain the performance improvement we have seen in the past two or three years. It will be structured on both a hospital-specific site and a hospital community-specific site.

Deputy James Reilly: Perhaps Mr. Carter might expand on the intervention fund. He asked about the €30 million.

Mr. Ian Carter: The application of that €30 million will be across the country on a hospital-specific basis or a hospital and community basis designed both to improve emergency waiting times and maintain the improvements secured this year and last year in regard to scheduled care in terms of inpatient and outpatient activity.

Mr. Pat Healy: Regarding the services for the elderly, a number of questions were raised. I confirm for members that the nursing home support scheme will provide 22,000 places this year. There will be over €939 million continuing in that resource. At the same time, we have used €23 million from that fund to develop new options in 2014. Many of them will address the issues that Deputy Fitzpatrick talked about. For instance, €10 million will be used to develop intensive home care packages. That will be targeted at people with dementia in addition to others whose only option at present is to enter long-stay care. We will be targeting cases of the kind exemplified by those who are currently in hospital for a long time and we will be trying to ensure they get better options, not just long-stay care. We will also be developing new opportunities on short-stay provision, transitional care, rehabilitation and such initiatives. We will be trying to combine this with home care packages in a more integrated way that has not been achieved in the past. Thus, our first step will be to ensure that the public providers, in addition to the private and home care providers, start working in a more collaborative way. Yesterday, we met Nursing Home Ireland. Over the next year, we will be having more productive

engagement with it and the home care providers to ensure that we combine in delivering more integrated services. Some 56,000 people have been receiving annually home help and home care packages. This level of provision is being maintained in 2014. It represents a significant resource of over €315 million.

As the Minister of State, Deputy Kathleen Lynch, stated, there are developments amounting to €14 million benefiting the disability service plan this year. Some €10 million of this is targeted at initiatives to meet the needs of approximately 1,200 young people who are either leaving school or exiting rehabilitation training places. As the Minister of State said, our intention is to put in place this year a much more focused programme. This is already under way to ensure that all families, including the children and young people involved, will be advised of the places they will receive by June of this year. Thus, the challenging issues that arose over the summer months in the past year and preceding years will not arise. Out of the resource, we will address a number of emergency places that arise during the course of the year. We will be working with the service providers in that regard.

The other key initiative, which I referred to earlier, is the €4 million that will be used to roll out a more comprehensive, integrated programme for those aged between zero and 18. The detail of this will be included in the divisional plan that will be published later in the month. The intention is to build on very good work done already in some of the local health offices with local implementation groups and to expand across the 25 local groups to ensure all of them are progressing in an integrated way in rolling out the model of care for this year. That covers the services.

Mr. Tony O'Brien: Ms Laverne McGuinness will deal with Deputy Fitzpatrick's question on the National Ambulance Service.

Ms Laverne McGuinness: As the Minister has indicated, the HIQA review will be carried out earlier. With regard to the level of investment, the €25 million was put in place to improve response times in the ambulance service. There are a number of components to this, one of which is a national control centre. There is to be a control centre, over two sites, that will be able to monitor every single ambulance so the ambulance nearest the scene can be dispatched. The system will be able to determine where other ambulances are available. That will be in place by 2015. As the Deputy will know, a number of centres have already moved to the single site in Townsend Street, which will be monitored in future from Tallaght. The centre in Navan has moved there. Those in Tralee and Cork moved in 2013, and others are to go on stream this year.

Let me refer to the other important piece of infrastructure that is being put in place. It was mentioned by Deputy Ó Caoláin in relation to ICT infrastructure and the geomapping and directory system. All radio controls are now being upgraded to digital instead of analogue. There was an investment of €7 million in ICT infrastructure, and this is important.

The other significant investment was to put in place intermediate care vehicles. Twenty-five of those new vehicles were put in place in the second half of last year. Rather than using an ambulance to transport patients from one hospital to another for inter-hospital transfers, we will be using the intermediate care vehicles with a view to freeing up ambulances so they can get to a scene quicker and on time.

The improvements are not as we want them to be. We set a target response time in 2013 of 70%. We have delivered on that and we have set a target this year of 80%. In some regions,

we have been hitting a figure of 78%. Therefore, we have been moving beyond the targets in those particular areas.

It is important to note that while we are trying to improve the response times, there are approximately 334,000 calls to be answered every year. I refer in particular to the high-category calls, which we call the delta and echo calls. In these blue light categories, we are responding to an extra 1,000 calls per month. This, in turn, can affect response times.

One of the key areas to be addressed is the turnaround time of the emergency departments. It is a question of how quickly an ambulance gets back from the emergency department. We have set a target of 20 minutes. That is not always achieved, so that is being addressed as part of an action plan that is currently in place.

Deputy Kathleen Lynch: Our new chief nursing officer, Dr. Siobhán O'Halloran, and I attended a conference on end-of-life services recently. We were told that very few people out of nursing homes now die in accident and emergency departments. There is a new system in place to ensure that people can remain in what is tantamount to their homes. Figures were produced to prove that very few people among the cohort in question now die in accident and emergency units or hospitals. Where end-of-life services are concerned-----

Deputy James Reilly: Dr. O'Halloran will address the nurse prescribing issue.

Dr. Siobhán O'Halloran: In response to what the Minister of State said, the end-of-life service work is being progressed through the All-Ireland Institute for Hospice and Palliative Care. It is a joint initiative between North and South.

With regard to nurse prescribing, there is a legal and regulatory framework in place. It has been in place since 2007. We currently have 650 nurse prescribers and 425 in training. There is no doubt that the introduction of nurse prescribing in the nursing home sector can yield the same benefits as in the acute sector, where it is more prevalent. It can also yield additional benefits in terms of continuity between the acute and nursing home sectors. There is an issue at the moment with nurses accessing primary-care prescription pads for the purpose of reimbursement of medical card patients that we need to resolve. In resolving that issue, we also need to ensure that the governance of that issue is robust. In this regard, the Department, through engagement with the HSE, will progress the matter and any other matters that may be slowing down the expansion of this in the nursing home sector.

Dr. Áine Carroll: I thank Senator van Turnhout once again for her continued interest in the area of neurological rehabilitation. Since the last time I appeared before the committee, a draft implementation plan has been introduced and I understand that a meeting in the coming weeks will finalise that document. Since I spoke here before, from a rehabilitation medicine programme point of view, five consultant posts were advertised and by the end of January four of those consultants will be in post, which represents a 70% increase in consultant numbers, which is a very welcome development. Significant work is under way in the development of three regional units which is very welcome. Those are key areas contained in the strategy document.

A key priority for the directorate as a whole is the development of a specific integrated programme looking at chronic disease prevention and management. It is important to look at prevention and management together as a whole rather than looking specifically at treatment. That is another welcome development for 2014.

Mr. Tony O'Brien: The protocol now for medical card renewals is that the renewal or

review process should commence three months out and not one month out. In addition one month's notice is required of a decision to withdraw a medical card.

Chairman: That is not happening now.

Mr. Tony O'Brien: That is now happening.

Chairman: I can assure Mr. O'Brien that is not the case.

Mr. Tony O'Brien: I will certainly go back and check. That is the decision we have made.

Chairman: I can assure Mr. O'Brien that is not the case. I know of people who have gone into the pharmacy and been told their medical card is not valid. That is not made up.

Mr. Tony O'Brien: Is the Chairman talking about currently or in the recent past?

Chairman: Before Christmas.

Mr. Tony O'Brien: Certainly the protocol now arising from the communications review referred to in this committee in November is that there should be three months' notice of the review and then a period of notice of any decision to withdraw. I will certainly take away what the Chairman is saying and have it examined.

On the issue of those, now thankfully rare, instances where a person may remain on a register after having been deceased, this is not a significant issue for us at this stage since a protocol is in place for the recovery of any over payment. Given that we always owe GPs more than they owe us, it is not an issue of significant concern to us. We have access to the death events publication service and once an event is formally registered, the primary care reimbursement service will correct any overpayment that may have been made on an agreed basis. In addition, since the end of 2012 a protocol has been agreed with the IMO that enables general practitioners themselves to renew an otherwise expired medical card if there are circumstances that lead them to believe that should happen. This gives rise to a further opportunity for any engagement regarding the renewal of that medical card. So they have that ability.

Deputy Dan Neville: Does that cover pharmacies?

Mr. Tony O'Brien: Pharmacists cannot do it, but it will cover the pharmacist element. It is a medical card not a GP-visit card.

Chairman: In the case of a card under appeal, is that medical card still valid?

Mr. Tony O'Brien: Yes, it is.

On the issue-----

Deputy Seamus Healy: Can the HSE provide confirmation in writing on the ability of GPs to extend the card? I am certainly not aware of any GP who tells me he knows about this.

Chairman: They may be playing politics in some cases.

Deputy Seamus Healy: Regardless of whether they are, I have not come across them and I deal with them on a regular basis, as does the Cathaoirleach. It would be helpful to get written confirmation from the HSE that that is in place.

Mr. Tony O'Brien: I am happy to repeat the previous confirmation that was contained in

my last opening statement - not of this year, but of last year. However, if the Deputy would like a separate letter I am very happy to do that.

I wish to address the issue of section 38 and section 39 organisations. The section 38 review arose from the Tallaght HIQA inquiry. It went to the HSE board as it then was in July. For the avoidance of any doubt about public pay policy, a process was commenced including the Department of Health and the Department of Public Expenditure and Reform, which resulted in a restatement on an unambiguous basis of public pay policy at the end of September. That resulted in communications to the section 38 organisations from the national director of HR confirming that policy and the bringing to conclusion of the audit process against that policy. That policy also made clear that while section 39 employees are not public servants and are not bound in the same way, there is a requirement for them to have “due regard to public pay policy”. The letter that issued in November was in that context.

Regarding section 39 organisations’ disclosure, that was written into the 2013 service arrangement or agreement and consequently they have all had an obligation under that agreement to make those disclosures. We are currently evaluating the completeness and accuracy of those disclosures. When we are in a position to do so we will be happy to share the data to ensure the committee is made aware of those data.

Regarding the provision of the section 38 report to another committee - the Committee of Public Accounts-----

Chairman: It might be chasing ambulances too. I apologise; I could not resist.

Mr. Tony O’Brien: The Chairman might say so; I could not possibly comment.

Chairman: Exactly.

Mr. Tony O’Brien: The Chairman has completely knocked me off my train of thought.

Chairman: Sorry.

Mr. Tony O’Brien: Given the conclusion of the policy process I referenced, the Department, which had been subjected to numerous freedom of information requests, felt there were no longer any grounds on which the audit report, which was in its possession because the HSE had provided it, should not be released under freedom of information. It notified us accordingly that the decision maker had reached that view in compliance with the Freedom of Information Act and accordingly proposed to release it on the Friday of that week. We were appearing at the Committee of Public Accounts on the Thursday of that week - I cannot remember the exact date. On foot of an undertaking I had given the Committee of Public Accounts in November 2012, I immediately provided a copy to the Committee of Public Accounts. There was absolutely no sleight intended to this committee by virtue of its provision there, although obviously there was nothing to preclude me from providing it to this committee. I regret any offence that may have been caused; it was entirely unintentional.

Chairman: I ask Mr. O’Brien to give us an update as to where we stand on the meetings with the section 38 organisations in terms of the compliance procedure.

Mr. Tony O’Brien: We have met the chairs and at least one other board member of every section 38 organisation during December. We met them differentially whether were acute-type service providers or more disability-type service providers because they are slightly different

in their characteristics and the nature of their governance structures. Where we have identified specific issues outstanding from the audit or our interaction with them, we are having one-to-one meetings. Members will be aware of the outcome of our one-to-one meeting with the CRC. Shortly the Committee of Public Accounts will be aware of the outcome of our one-to-one meeting with St. Vincent's University Hospital. There are others which have not yet reached that point.

We have also instituted a new compliance statement that will be required as part of the audit process. This has been arrived at following consultation with the Comptroller and Auditor General, who is not the auditor for most of these bodies. We will be requiring their boards to actively certify the extent to which they are compliant with a range of good-governance practices, including compliance with public pay policy. That will be part of the annual process and will be embedded within it. As members are aware, we have formally taken control of the Central Remedial Clinic following the decision of its board to resign in the context of our communication to it that given what we now knew, there was no basis for us to continue to provide it with public funding. Consequently, it has exited and we have put in place an interim administrator. We will be making arrangements, working with a voluntary body, Boardmatch Ireland, to put in place a board on a competency basis. It is not a State body so it is not a matter for ministerial appointment. We expect to complete that within a period of months. We currently have an interim administrator in there through whom we are carrying out a forensic audit of all matters pertaining to the governance of that service. I must put on record my admiration for the staff of the Central Remedial Clinic, CRC, who I visited last week, for the tremendous efforts they have made to maintain vital services at a time of considerable stress for them, the patients and the parents of patients during the course of public disclosure of matters of which they had no knowledge themselves. I met with some parents and clients who very much value the work of the staff of the CRC and whose integrity should not be brought into question as a result of these disclosures. We very much hope through this process to rehabilitate the good name of the CRC, as well as the Santa Bear appeal and the clinic's other appeals that have been widely supported over the years.

Regarding Deputy Fitzpatrick's questions on interventions, yesterday I visited the Louth-Meath hospital group which this year, with specific supports, has made significant achievements in its performance in inpatient-outpatient service provision, elective surgery and trolley waiting time reductions. It also achieved a 92% rating from HIQA on hand hygiene standards during a recent audit. All of these developments represent a significant turnaround at this hospital group, led by Margaret Swords, general manager, and Dr. Dominic O'Brannagain, medical director.

Chairman: We all concur with Mr. O'Brien's remarks that it is incumbent on all of us to help in the rehabilitation of the tarnished images of some of the section 38 organisations and whose staff do tremendous work which we all very much appreciate.

Deputy Regina Doherty: I welcome the publication of the Health Identifiers Bill 2013 and today's announcement of an e-health strategy for Ireland. Will Mr. O'Brien provide the committee with more detail of the scope and objectives of this strategy, as well as the timelines for kicking and dragging our health system's use of technology into the 21st century?

I also welcome the recent announcement of the establishment of a review group to examine the 0 to 18 year old category of people with lifelong conditions, so as to establish how we can best serve their medical needs through devices or access to services they might lose by losing their medical card. This is particularly welcome given the media attention on children with Down's syndrome who have lost their medical cards over the past several weeks.

Bringing forward the HIQA investigation into ambulance response times is an acknowledgment that we have an issue in this area, be it a public perception or real one. What will be the scope of the investigation? When will it start and finish? How quickly will we respond to its recommendations? If there are particular hotspots where the accepted call-out time for 70% of ECHO calls is not achieved, will factors around these be fed into the scope?

The public deal announced by Mr. Tony O'Brien solving a particular issue at St. Vincent's Hospital is due to the fact that the gentleman in question will be completely paid out of private funds. This fixes the issue arising for section 39 bodies. The Minister said this morning, however, that he found it wholly unacceptable that one person should be the chief executive officer of both hospitals as it causes a conflict of interest. Will the Minister reconcile this with the HSE's announcement that fixed that situation several days ago?

Senator John Crown: I again welcome my colleagues. With respect to my previous question on accountancy numbers which was very technical, I am very happy with the written answer provided and do not require any further clarification on the matter.

I would welcome a little discussion on the graduate nursing scheme, with which I am slightly troubled. It appears to be implicit in the philosophy behind the scheme that there was some type of deficit or lack of experience among the nurses coming into the system. This was to be remedied by these candidate nurses coming into the graduate scheme through an intermediate job where they will get additional education. When was this first flagged as a problem, as it is certainly not one that was obvious to me? If the logic of the scheme is that it is remedying an experience deficit, then surely the logic of the scheme extends to the point that when they achieve the experience, they stay in the system in full jobs as fully experienced and trained nurses. If, however, they rotate out of the jobs, as will happen, to be replaced by additional graduate scheme nurses, then we will just have a continuously rotating pool of people coming in without experience. If we are trying to address an experience deficit, it seems to me there is a failure of logic in that approach.

There is another interpretation which can be put on this. By having a continuous pool of graduate nurses coming in on a different payscale, who are doing the same work that fully trained and experienced nurses were doing before, we are recalibrating the lower market salary scale for nurses. In fact, this is attempting, by fiat, to distort the normal market for nurses coming into post.

In addition, there is a real corollary to this. If these posts are different from the full posts which occur following completion of the graduate scheme, then they should have a substantial educational component. In talking to and canvassing the opinions of nurses in the scheme to date, there is a perception that this is not the case as yet. Will the Minister clarify for me what the exact extent of the scheme was and what are the plans to firm up the educational arrangements?

Is Mr. O'Brien happy that the board structures of many of our hospitals which provide a service in the public sector, particularly our voluntary hospitals, are elected and comprised in an appropriate fashion? Alternatively, are they self-perpetuating oligarchs which act to represent the interests, partly, of the institution but, partly, of other interests who no longer run the institutions? The latter is my perception. Will there be any attempt to get a match between the actual accountability of the board structures of our public hospitals and those who actually pay for them?

Deputy Catherine Byrne: I thank the delegations for their presentations. To whom or to what agency will the hospital groups be accountable when they are established? The Minister has stated he hopes planning permission for the national children's hospital will have been secured by December 2014. How long will this delay the completion of the project? When will the GP-visit card for the under-fives card be rolled out?

The national screening service is expecting 140,000 women to attend for breast screens this year. The mobile clinic serving Drimnagh and Crumlin will be withdrawn at the end of this month for two years. The staff of this unit told me they have no funding. Crumlin, Drimnagh, Inchicore, Ballyfermot and south-west inner city Dublin are the most challenging health areas in Dublin city and they are serviced by this unit. Women in these areas have been told to attend clinics in Tallaght and Clondalkin, which will be a significant inconvenience to them. We should be targeting those areas where people will not normally want to attend these clinics. Will this be reviewed?

On Monday last, my brother was taken seriously ill at my local primary care centre and he needed to be brought to hospital by ambulance. When he arrived there, he was in a distressed state but the staff were wonderful with him. I was told about five minutes later that it would be an hour before the ambulance could take him to the local hospital, which is St. James's Hospital. I was asked by the doctor who was his GP at the time whether I would mind taking him in the car to St. James's Hospital, which I did. This took on average a couple of minutes but they were very important minutes because he was very stressed, in a lot of pain with his chest and had a number of other issues that needed to be dealt with. From the time I entered the accident and emergency department, he was dealt with straightaway and taken into resuscitation and, thank God, he is still in hospital and doing well.

The reason I am raising it is because of the delay of an hour. The doctor has suspicions that he could have had a heart attack or really bad respiratory problems. Waiting in the accident and emergency department, I witnessed three ambulances that were stationary out in the area. I happen to know somebody in the medical team who arrived in one of them who said it was a constant reminder that each time they entered the accident and emergency department in St. James's Hospital, they could be anything from 30 to 40 minutes waiting to receive a trolley back. I am raising this because on that day, I can only say that the work I saw doctors, nurses and aides do was unreal. I have never seen anything like it. There were 72 patients in cubicles, ten on trolleys in the corridor and another 62 waiting in the accident and emergency department. Over 100 people were in that accident and emergency department. Is there any other way? We are talking about a turnaround time of 20 minutes. I heard what Ms McGuinness said. A number of other people have raised issues. Only that I witnessed it, I would not have believed that anybody with chest pains would be asked to wait an hour for an ambulance to come. I was lucky that we lived so close to the hospital. The doctor said that but for the fact that we lived so close to the hospital, she would not have allowed him to be taken from the primary care centre. What delays ambulances departing from the bays is the fact that they are unable to retrieve their trolleys. That is a fact, not a myth or a story. I witnessed it myself. Perhaps somebody might be able to address that.

Deputy Robert Troy: I thank the Chairman and will try to be very brief. I want to ask some supplementary questions. In respect of question No. 23 and the money follows the patient model, how will this work in terms of non-elective and emergency activity? It will be more difficult to predict what is emergency and non-elective. How will that element of funding be adjudicated on and costed? Will the Minister confirm that the money will actually follow the

patient? I raised this issue on a number of occasions. In the past two to three years, the Midland Regional Hospital Mullingar has received a reduction in its annual budget despite the fact that its activity has increased.

In respect of question No. 38 about dermatology services in the midlands, I note that plans are being developed for the provision of this service in the region. When will those plans be published? Can the Minister indicate whether he would be willing to consider re-establishing a full-time consultant position within the Midland Regional Hospital Mullingar because there was a full-time consultant for this service from 2007 to the end of 2010? This service is now being shared with St. James's Hospital. At the end of last year, urgent cases are taking eight to nine weeks to be seen. There were 1,052 routine cases at the end of December 2013 and a waiting list of two years and four months in the Midland Regional Hospital Mullingar. Patients from this area are being asked to visit a consultant in St. James's Hospital who comes down to Mullingar two days a week. Will the Minister explore the possibility of re-instating that consultant on a full-time basis in the Midland Regional Hospital Mullingar?

In respect of question No. 22 and funding for maternity hospitals, I do not expect the Minister to have this information today but perhaps he could furnish me with the ratio of maternity staff to patients for the Midland Regional Hospital Mullingar? According to my information, it is not comparable to similar maternity hospitals. Again, the Minister talks about carrying out a plan and strategy. When will he furnish the project plan for this strategy and can he indicate a clear timeframe? He talks about review and evaluation of current services. Will there be a review of the viability of some maternity hospitals or units? If so, what criteria will be used?

In respect of discretionary medical cards, I am sorry I missed some of the meeting. I acknowledge there is a reduction in the targeted savings but there still appears to be a targeted approach to decline medical cards to achieve savings. I, and I am sure other members, deal with a variety of constituents and they have to fight so hard to obtain a discretionary medical card which they had up to now. Their circumstances have not changed and in some instances have deteriorated and they still find it extraordinarily difficult to get their medical card so I would welcome the Minister's opinion on that.

Senator Colm Burke: In respect of the figure of over €50 million for agency costs and general doctors and the ratio of 175 whole-time equivalents, is my calculation of €280,000 correct? Could I get some clarification on that? If the information is not available today, could the Minister come back to me on it?

Deputy James Reilly: I will let Mr. O'Brien answer that.

Mr. Tony O'Brien: In respect of Senator Burke's question, we have already undertaken to come back with detailed costings in respect of Deputy Healy's question which will answer the Senator's question.

Deputy James Reilly: Fair play to Deputy Troy for getting as many questions in as he could. I can come back to Deputy Regina Doherty about scope and objectives regarding e-health and give her a very detailed answer. This is a hugely important initiative and we have nearly finished our ICT strategy, which will be ready in the next few weeks. It is critically important for the reform of the health service. I was astonished to hear the other day that there are 1,700 different IT systems within the health service. They do not all rate the pay but they are all different little systems that have grown up for different purposes. We must address that and are doing so. We will have a very cogent and coherent plan for that. It is important to say

that there has been a history of near trepidation and fear of anything to do with IT ever since the PPARS fiasco but this is a nettle we must grasp. I am very pleased to say that very good people in the HSE and the Department are working on this. The new chief information officer will be critically important in this regard.

In respect of HIQA, it is not an investigation but a review. It was a standard review to be done in the second quarter but I want it done now with immediate effect insofar as that can be achieved. Obviously, it must make some preparations to do it. It should not take a long period of time. It will be comprehensive and will certainly focus on the areas that have been highlighted here such as the issues in Letterkenny, the issues mentioned by Deputy Catherine Byrne in St. James's Hospital and issues that have arisen in Drogheda and the north east. It will be right across the system to see why we have had problems. As I said earlier, it is certainly not acceptable that an ambulance should be held for an hour outside an emergency department. If nothing else, they should give them a spare trolley and let them go. The patient in need lying at the side of the road must be looked after and looked after quickly.

I will let Mr. Carter address the area addressed by Deputy Catherine Byrne in a more comprehensive fashion. Sticking with Deputy Regina Doherty, Mr. O'Brien can clarify the issue of the top ups but my position is that I am talking about best practice in terms of the management of a public hospital and any perceived or real conflicts of interest that might exist through being CEO of both a public and a private hospital and what that might mean. What Mr. O'Brien was alluding to was compliance with public sector pay but I can let him talk further about that.

In respect of Senator Crown's question, the graduate nursing scheme will continue. I was very much involved with and supportive of this scheme. It offers job opportunities outside the employment control framework imposed by the Government and it gives nurses a chance to stay here while developing their skills. A range of areas, such as wellness screening and prescribing, as well as procedures like intravenous cannula insertion and catheterisation, would be invaluable not only in a community setting, whether a nursing home or general practice, but also in hospitals. While we cannot guarantee people jobs when their two-year term has been completed, if they are employed it will be at the full rate. In my view they will be highly sought after and, as general practice expands to cope with an increasing workload, much of the work will be carried out by practice nurses. I would like to see every GP employing at least two practice nurses to deal with the amount of work coming their way. I ask the chief nursing officer to address that issue in more comprehensive detail.

In regard to the current constitution of voluntary hospital boards, the comments from the director general preceded what we found in Tallaght and we have been addressing anything that has happened since then with the new competence based regime. The director general can address that issue more comprehensively. In regard to who is responsible, the trusts will be answerable to the HSE in the interregnum until the new health commissioning agency is established. At all times they are ultimately answerable to the Department of Health, the Minister for Health and the Oireachtas.

I do not have details on the mobile clinic in Crumlin and will refer the issue to the HSE. The roll-out in respect of children under the age of six years will take place in the middle of the year. A number of contractual issues have to be resolved and it will be necessary to consult stakeholders. Legislation is also required.

I apologise to the committee for indicating in my opening statement that planning permission for the new children's hospital will be dealt with by the end of this year. It will actually be

spring of next year. That will not delay construction, however. We have appointed a children's hospital board which is working well. One of the key issues is to ensure that the mindset of the board, management and those who will staff the hospital regard it as a virtual hospital even before it is completed so that all the problems we encountered over 17 years in Tallaght and when Beaumont Hospital was set up will not arise in this instance. Even though there was a close relationship between Beaumont and the former Richmond Hospital, as a local GP I can attest that it was a long time before the hospital got its act together. We want to make sure the problems are addressed long before construction is completed in late 2018.

Deputy Troy asked about the money follows the patient model in respect of emergency departments. It was never intended that the money follows the patient model would apply to an emergency department because it would be too complex to achieve. Emergency services will be funded centrally. He referred to Mullingar in particular, which is a great hospital, and asked about the dermatology plan for the midlands. I will revert to the Deputy on that. We can examine the question of reinstatement and see what it throws up. I agree with him that it would be a useful exercise to investigate the funding and staff ratios of maternity hospitals, including Mullingar in particular, and I will revert to him on that. We continuously review what happens in our hospitals, particularly our maternity hospitals, and are actively considering the question of co-locating maternity and adult hospitals.

Members' questions on medical cards were addressed earlier. I acknowledge the concerns that have been expressed about the ability of those with lifelong conditions to access services. We will be putting in place a small review group within the HSE to investigate how we can best address the needs of such individuals. As Mr. Healy addressed that issue in some detail, Deputy Troy will forgive me if I do not rehearse his comments.

Dr. Siobhán O'Halloran: The nursing degree programme introduced in 2001 set the baseline for registration as a nurse. All of our nurses and midwives now undergo a four-year degree programme, on completion of which they are eligible to register with An Bord Altranais. Once they register with the board they are nurses. They can practice within the full scope of practice of a nurse and are held accountable to the full code of conduct. There is no difference between any nurse who registers in Ireland in terms of what he or she can practice or for what he or she can be held accountable.

The graduate nurse programme was introduced as a separate employment initiative. In stringent times, it was designed to give opportunities to up to 1,000 nurses and midwives to gain experience. It includes two additional elements, namely, the capacity for nurses undertaking this programme to get a variety of clinical experience to add to their portfolio and access to three modules of an educational programme approved by An Bord Altranais. It is entirely separate from the programme for registration and it does not in any way undermine the programme. It can also be offset against higher and future educational qualification, such as at masters level. Where substantive vacancies arise the HSE may choose to recruit to fill a vacancy and in such instances graduate nurses may apply in the same way as any other nurse. There are currently 358 graduates on the programme, with a further 305 in process. Overall, there are 1,049 applicants for the programme.

Senator John Crown: Can we have an assurance that there is no question of existing full-time, full-pay jobs being replaced by cheaper graduate nursing positions? We spoke about the employment guidelines but both the departmental guidelines and the graduate nursing scheme come from the Government. This could be construed as an attempt to lower the bar of competition for the pay and conditions of nurses.

Deputy James Reilly: It is not the intention that such would be the case. I do not know if I am in a position to give the Senator a cast iron guarantee that it could never happen but it was not designed for that purpose. It was designed for a number of reasons, as outlined by the chief nursing officer. It was a means of getting around the employment control framework so that additional staff could be made available. Along with the nursing bank, it also removed the need to depend on agency staff. In that regard, it is not intended that the jobs be seen as replacing full-time, full-pay jobs. That is not the case.

Mr. Tony O'Brien: As the places under the graduate nurse programme and the allied health professional internship programme are outside the employment control framework, there is no reason or incentive for us to offset one against the other. Not only is there no plan but there is no reason for us to pursue one.

In regard to the discussion on St. Vincent's University Hospital, I am conscious of the Chair's directions on Standing Orders and I am doubly conscious that currently my nominee and Corkonian cousin, Mr. Barry O'Brien, is before the Committee of Public Accounts to discuss the issues arising.

Chairman: Furthermore, the relevant individuals are not present for this discussion.

Mr. Tony O'Brien: However, I will say for completeness that there was no deal. I have met with representatives of the board of St. Vincent's on three occasions between just before Christmas and as recently as Tuesday, and I have made clear what elements are required for us to be able to regard them as being compliant. As of the last time I was appraised of the matter, they had not been in a position to confirm this. Perhaps they have now done so before the Committee of Public Accounts. For this reason, I want to be careful in what I say. In regard to a specific question on the matter, we would not regard good governance being in place if a single individual was the chief executive of both the public and the private hospitals. If those roles are to be separated, it is important that the chief executive of the public hospital and the general manager of the second public hospital report to a public interest committee of that board rather than to the group board directly. Obviously, they would have a relationship with the group board, as in any situation.

Senator Crown asked about general governance issues. It is clear that there are some anachronistic governance arrangements. I will explain how we have sought to deal with them. We are requiring all boards of directors to commit to adherence to a new governance protocol by the end of this month. The protocol will be embedded in the audit process of each institution. It will include a clear statement that the functions of the board of a publicly funded health care provider are to act in the best interests of the users of its services, its staff and, more generally, the body it oversees; to ensure appropriate clinical and professional governance arrangements are in place; to lead and direct the organisation's activities; to provide strategic guidance; to monitor the activities and effectiveness of the CEO and the management team; to ensure effective systems are in place for identifying and managing risk; and to ensure the adequacy of internal financial controls, particularly in the interests of accounting accurately to the State as the primary funder of its activities.

We are also requiring that the membership of the board should reflect diversity in terms of gender, skills and areas of competency and that the size of the board should be large enough to take account of its full range of duties but small enough to perform those duties effectively. We are saying that unless otherwise set out in statute, the membership term of each board member or director should not generally exceed three years and the number of terms should be limited.

We are also saying that the rotation of board members should occur on a phased basis from now to ensure there is both change and continuity. We have reserved the right to appoint a named individual to work with the board and the directors in resolving any unidentified governance or performance issues, and indeed to appoint a public interest director should the need arise.

With due respect to the many fine individuals who serve voluntarily and without pay on the boards of various section 38 and section 39 bodies, the vast majority of whom are not the subject of the current issues of concern, it is clear that the issue of compliance with public pay policy has become somewhat totemic. There is now a focus on the general compliance of these boards with good governance in terms of their structure, their rotation and some of their decision-making processes. We want to work with each of the boards to bring them to a different place that is informed by a contemporary approach to good corporate governance. It is absolutely at the forefront of our efforts that this process should serve the interests of those whom these institutions are designed to serve, as opposed to the interests of those who may own them now or may have owned them in the past. The straight answer to the Senator's question about whether I am satisfied that all of those things are now universally in place is "No".

Senator John Crown: I thank Mr. O'Brien. That is very helpful. Who will pick the boards?

Mr. Tony O'Brien: In the cases of genuinely private institutions, the people who own the founding shares in the articles of association will go through a process. We will encourage all of them to introduce an independent dimension. In the case of the Central Remedial Clinic, for example, the HSE, as the entity with responsibility for re-establishing the board, is working with Boardmatch Ireland as part of an external, independent and competency-based approach. We will offer support to encourage all of these boards to use that type of process for the reinvigoration of the boards. Each corporate entity will have a process laid down under company law that governs how board members are formally appointed. That is of less concern to me than the process by which they are selected.

Chairman: Does that mean the HSE will have no formal role in that regard?

Mr. Tony O'Brien: We will have no formal role, but we are asserting a role through these arrangements.

Chairman: Okay.

Mr. Tony O'Brien: We do not have the information that was sought with regard to Drimnagh, but we will come back to the Deputy on the matter.

Chairman: I thank Mr. O'Brien. Before we finish, I would like to welcome the appointment of Dr. Siobhán O'Halloran to her new position. I congratulate her on her appointment and wish her well. I thank her for being with us this morning. She is very welcome.

I thank the Minister, Deputy Reilly; the Minister of State, Deputy Kathleen Lynch; the officials from the Department of Health; and Mr. O'Brien and his colleagues from the HSE. I thank them for interacting with us this morning. I thank the members of the committee for their attendance. I thank Mr. Paul Howard of the Department of Health and Mr. Ray Mitchell of the HSE for co-ordinating this session. The next quarterly meeting will take place on 3 April next. The select committee will meet next Tuesday to deal with the Estimate for the Department of Children and Youth Affairs. This committee will meet next Thursday.

UPDATE ON HEALTH ISSUES: MINISTER FOR HEALTH AND HSE

The joint committee adjourned at 1.15 p.m. until 9.30 a.m. on Thursday, 23 January 2014.