DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Déardaoin, 23 Deireadh Fómhair 2014

Thursday, 23 October 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 Clare Daly,	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 9.40 a.m.

Mental Health Services: Mental Health Reform

Chairman: I remind members, witnesses and those in the Visitors Gallery to please ensure their mobile telephones are switched off for the duration of our meeting as they interfere with the broadcasting of proceedings even when in silent mode. They also interfere with members of staff.

This morning's meeting is divided into two sessions. The first is a meeting with representatives of Mental Health Reform from which I welcome Dr. Shari McDaid, director, and Ms Kate Mitchell, policy and research advisor. As members know, Senator John Gilroy is the committee's rapporteur in the area of mental health and will present a report in due course. We look forward to a very good discussion today on the priorities for the mental health service in Ireland. Mental health issues have a huge and profound impact on people's lives in all parts of society. We look forward to hearing from Mental Health Reform, which promotes and prioritises mental health services. I thank Dr. McDaid and Ms Mitchell for attending the meeting on behalf of a very powerful advocacy agency which campaigns for improved mental health services.

I remind witnesses regarding privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by the committee to cease giving evidence in relation to a particular matter but continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, you should not criticise or make charges against any persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of a long-standing parliamentary practice and ruling of the Chair to the effect that members should not comment on, criticise or make charges against a person outside the House, or any official by name in such a way as to make him or her identifiable.

As we will have two parts to our meeting, is it agreed that we will conclude this section by 11.15 a.m. at the latest? Agreed.

I invite Dr. McDaid to make her opening remarks.

Dr. Shari McDaid: I thank the Chairman and committee members for inviting the representatives of Mental Health Reform to appear before the committee. Some of the issues we will discuss were contained in our pre-budget submission which was circulated to the committee.

Mental Health Reform is the national coalition of 48 NGOs interested in working towards improved mental health services and implementation of the Government's mental health policy, A Vision for Change. There is no doubt that in recent years there have been positive developments. However, the reality is that despite the appointment of 727 staff in the past three years, at the end of July there were just 63 more staff in the mental health services than there had been at the end of 2012, and still almost 1,000 fewer than in 2009, showing that the huge losses the mental health services incurred in the early part of the recession have yet to be made up, never mind increasing the staffing the levels that were envisaged to provide the holistic service set out in A Vision for Change. The scale of the challenge before us is clearer when one considers

that full implementation of the policy would entail having 12,482 staff and as of July we had fewer than 9,000. It is in this context that I would like to outline our perspective on the recent progress made on the policy.

In our view, recent years have brought some significant positive developments. For the first time in the modern era, the national public health service has a leader at the head of the mental health services who sits at the senior management table, with a national director for mental health and a distinctive mental health division within the HSE. The Government had ring-fenced funding amounting to €90 million to develop specialist community-based mental health services and for suicide prevention between 2012 and 2014, and a further €35 million has been allocated for 2015. We certainly appreciate the additional investment. However, it is important to understand that much of this funding has gone to replace staff leaving the service, so that the net increase in funding up to the end of 2013 was quite marginal.

As in prior years, we are concerned that the HSE has delayed recruitment of staff under this year's allocation so that the funding of €20 million allocated under budget 2014 is not likely to be spent this year. On a positive note, the proportion of non-medical staff, including social workers, occupational therapists and psychologists, within the mental health services has more than doubled since 2009. This is very positive as it reflects the strong desire expressed by people who use mental health services to have access to a less medicalised service and access to more complementary or non-medical supports.

The HSE's recent decision to mainstream its culture-change project, Advancing Recovery in Ireland, on a national basis provides a basis for driving the culture change needed within mental health services towards a recovery-orientated service that works in partnership with service users and family members. The appointment of someone with personal experience of using mental health services as a member of the national management team for the mental health division is also a very welcome symbol of how service users need to be at the centre of planning.

However, Mental Health Reform is very concerned about the continued gaps and very real strains in the mental health supports available for people across the country. We still do not have in all parts of the country the model of 24/7 crisis intervention within the specialist mental health services that was set out in the policy. Not all services are providing home treatment and there are very few crisis houses to provide alternatives to inpatient beds. This is unacceptable in a context where we still have upwards of 500 people each year taking their own life, the majority of whom will have had some contact with a health professional during the previous year.

The waiting list for child and adolescent mental health services is still too high. In July 2,757 children and adolescents were waiting to be seen by CAMHS. Although this was a 2% decrease on a year earlier, it still means that quite a large number of children are waiting to be seen. There are also too many children and adolescents being admitted into adult wards. The most recent information from the HSE shows that for this year out of 158 admissions up to the end of June, 53, which is more than a third, were to adult units. This is despite the fact that under the Mental Health Commission's code of practice, no child under age 18 should be admitted to an adult ward, save in exceptional circumstances.

We are also concerned about the large increase in the numbers of homeless people being admitted to inpatient units. The information for 2013 is that 245 people of no fixed abode were admitted to inpatient units, an increase of 40% on 2012. We are concerned therefore that the wider housing crisis is having a very real impact on people with mental health difficulties.

We continue to be concerned about staffing shortfalls, as mentioned earlier. In order to fully implement the policy, the HSE would need 12,482 staff. As of the end of July of this year, there were fewer than 9,000 posts and the services were short 231 doctors and 567 nursing posts. More than 1,000 nurses have been lost to the service since 2009. The combination of the moratorium along with the wider difficulties of the levels of remuneration for people taking up positions as nurses and doctors are clearly impacting negatively on the ability of the HSE to recruit and retain staff for mental health teams.

We are also concerned that mental health services in primary care are not able to cope with demand. We have been told by the HSE that there are waiting lists for the new counselling in primary care service. This is a service which is intended to be available free to medical card holders by referral through their GPs. It was only initiated nationally in July 2013 and as of the end of August 211 people were waiting between three and six months for an appointment and 70 people had waited more than six months. Clearly, timely access to a counselling service is vital to give GPs confidence in referral and also to make it an effective early intervention.

Despite recent positive developments, there are still huge challenges to bringing about the type of primary care and specialist mental health services set out in A Vision for Change. These challenges reflect the continued vulnerability of mental health services within the overall health system and the need to have sustained political will in order to redress decades of neglect.

Deputy Billy Kelleher: I thank Dr. McDaid for her presentation. She has outlined it as it is. There are clearly grave challenges in terms of funding. We must accept that governments need to work within certain parameters. For many years mental health was described as the Cinderella of health services. There was clearly insufficient commitment in any programme for government to ensure there was enough funding. When we saw the cutbacks even though there was ring-fencing of funding it was only ring-fencing in name and did not really translate into guaranteed committed funding year-on-year. Obviously we have seen the exodus of health professionals over recent years creating further problems. That is the backdrop to where we are in terms of trying to provide mental health services in our communities throughout the country.

Dr. McDaid referred to child and adolescent mental health services. Many adolescents are still being admitted to adult units even though we all know it is wrong from a clinical point of view as well as from the point of view of an individual's rights and entitlements. Have we made much progress in that area? I know there are ongoing developments. Have we gone much further down that road to ensure that we do not have adolescents attending adult psychiatric units, for example, and being admitted to adult psychiatric services? Some general practitioners have expressed concern to me - as I am sure they have to others - about the new counselling and primary care service. The view appears to be that if we do not address this particular problem quickly the result will be people again being admitted through the emergency departments of our hospitals. Is that something about which the witnesses would be concerned?

It was stated that we have sufficient social workers. There is one area where I believe there may be a break in the chain, namely, secondary school career guidance counsellors. There has been a huge reduction in recent years in the number of guidance counsellors in our schools. Is Mental Health Reform aware of any difficulties in this area? People often say that vulnerable people should be seen by a general practitioner. A vulnerable child whose general practitioner is the family general practitioner may not wish to speak to him or her. Are there other avenues open to vulnerable students, who previously would have spoken to their career guidance counsellor and so on, who may have been camouflaging their difficulties for some time and may not want the family to know about them. In the witnesses' experience, are there any difficulties in

this regard?

Deputy Caoimhghín Ó Caoláin: I join in welcoming Dr. McDaid and Ms Mitchell to this meeting. I wish Ms Mitchell every success in her new role. Wearing my hat as Sinn Féin spokesperson on health, mental health is of huge concern to me. I am the Sinn Féin representative on the all-party group on mental health. I commend the representatives of each of the parties and Independent voices represented here for their input in this area over the past number of years. Without the help of Mental Health Reform and Lara Kelly we would not have been as proficient as we have been in drawing attention to some of the critical areas that need to be addressed.

That said, the Mental Health Reform presentation made this morning is alarming and distressing. Despite all our best efforts at highlighting the importance of properly resourcing our mental health services, in excess of 2,700 children are awaiting access to child and adolescent mental health services. While there has been a 2% decrease on the data for the last year, this is not good enough. When presented with such stark relief it is very alarming. We will have an opportunity during the second part of this meeting to address some of these points with the Minister of State with responsibility in this area, Deputy Kathleen Lynch, the Minister for Health, Deputy Varadkar and representatives of the HSE. I would encourage colleagues to reflect on some of the information shared with us by Mental Health Reform.

On homelessness, it was stated that 245 homeless people were admitted to inpatient units last year. Data for this year are not yet available. However, 245 is a significant increase on the data for 2012. This information indicates a connection that needs to be recognised and addressed and not only through mental health services. Homelessness in all of its dimensions needs to be properly addressed.

On staffing levels in the mental health services, the position that should apply under implementation of A Vision for Change is being missed when there are fewer than 9,000 people providing a service for almost 12,500 people. I know from personal experience, having met and conversed with the services in my own area, that the people involved are giving heroic service in terms of front line provision, in particular the community mental health teams. Their role in all of this must be acknowledged and commended.

Roll-out of the new counselling and primary care service across the country is unequal. There are huge gaps in access to and the availability of counselling supports in terms of mental health needs. Having highlighted some of the most salient points made by the witnesses, I would like now to put some questions to them. The Minister for Public Expenditure and Reform, Deputy Howlin, referred in his budget address to the Dáil immediately following the address by the Minister for Finance, Deputy Noonan, to new staff recruitment and in this regard mentioned psychologists and counsellors for the mental health services area. There was no detail of this in the subsequent contribution of the Minister for Health, Deputy Varadkar.

Chairman: The Deputy must conclude.

Deputy Caoimhghín Ó Caoláin: Does Mental Health Reform have any indication of that likely recruitment and how quickly it might come to pass? The allocation for this area in 2015 is €35 million. It has been highlighted today that the lesser sum provided in the current year will not be fully employed. We had a commitment from the Minister of State that the shortfall for this year of €15 million would be provided in addition to the €35 million allocation for next year but that has not happened. Perhaps the witnesses would set out the likely negative conse-

quences of that failure to adhere to the commitment that was contained in the programme for Government in 2011.

The witnesses might also elaborate on the Mental Health Commission's needs in terms of fulfilling its functions as set out in its pre-budget submission. Reference was also made in the agency's pre-budget submission to the need for extension of free primary care to all who require long term mental health treatment. As part of Sinn Féin's effort in its preparation of an alternative budget, I attempted to have that costed by the Departments of Health, Finance or Public Expenditure and Reform but they were not able to do so as they have no information in relation to the current number of people who require mental health services, never mind projections in this regard into the future. There are major problems in this area.

Senator Jillian van Turnhout: I, too, welcome Dr. McDaid and Ms Mitchell. It is helpful to us as Oireachtas Members when organisations come together. I have a few questions arising out of today's presentation. While I can speculate the answers to those questions I am interested in hearing the responses of the witnesses. It is difficult for us to know how we are performing given that the last review of the monitoring group of A Vision for Change was in 2011 and published in 2012. The Minister has said that there will be no more reporting and that other mechanisms will be put in place. However, there is no other mechanism which allows us or the State to assess its progress. Progress is not reported in any other way, other than, perhaps, the CAMHS reports. We are still getting the annual CAMHS reports, which is a tribute to those concerned although I do not like what I am reading. However, it at least shows us where we need to focus attention. I am very concerned about the absence of a reporting mechanism.

I am concerned about children being placed in adult psychiatric wards. I very much support the witnesses' position that no child under 18 should be admitted to a ward of this kind, except in exceptional circumstances.

Several years ago it was agreed that no child should be in an adult ward. I do not know why this is occurring and tried to establish why the practice persists. Anecdotal evidence gleaned by me shows that some units are determining themselves that they will deal only with certain cases or conditions, such as eating disorders. There is no national co-ordination. Thus, when a place is being sought for a child, services are deciding locally the cases they will deal with and not deal with. I refer to children in need. It is unacceptable that we cannot deal with the more difficult, complex cases. Surely it is for these that we have a health system in place. Surely it is when the issue is complex that a child should be put into a ward. It is not a treatment but part of a process. When this part of the process is required, the appropriate beds need to be in place.

On the issue of CAMHS, which I mentioned, I was interested to see that the Royal College of Surgeons in Ireland has expressed concern that we have the highest rate of mental illness in Europe among those under 25. We need to be cognisant of that when dealing with children and young people.

I am concerned about the waiting lists and will certainly be bringing this up with the Minister at our subsequent meeting. I am concerned also about the experience of teachers and social workers. When referring cases, they are not getting the responses they wish for. In fact, social workers have told me that when they refer a case of a child in care to CAMHS, they are basically told, "They are in your care now; they are out of the community and you should look after them". For me, the very reason for having CAMHS was to address this. It is for this reason I felt CAMHS should be moved into the Child and Family Agency. Do the delegates believe that would be beneficial? Is it a position they support?

I am concerned about the triage process for determining priority because it has a masking effect. Children are often medicated and other options are given such that, by the time a child is seen, we do not always know the position. The age in question is such an important one developmentally. Saying three months or one year has an effect on a child's educational and social development, in addition to other critical aspects. We know it is during the teenage years that children are most likely to present for the first time. That we are not dealing with the issue causes stigmatisation later in life.

Having read about this matter in preparation for this meeting and our next, I noted two issues, one of which is awareness-raising and the other of which is the action taken. Over recent years in particular, NGOs have increased the level of awareness-raising. I question, therefore, why the State needs to focus on this area. Perhaps it should be supporting the NGOs in focusing on awareness-raising and focus itself on delivering the mental health services for people in need of them. We are raising awareness but the service is not available when requested. We ask people to talk and present, yet the service is not in place for them. Therefore, I have a huge question about this. While it is nice for the State to engage in awareness-raising with the NGOs, it should ensure the services are in place.

Dr. Shari McDaid: I will respond to the questions one by one.

Deputy Kelleher started off by talking about funding and the fact that there has been investment. The challenge has been that, despite allocations of funding at budget time, the issues with retaining staff in the service and the slow process of recruiting new staff have meant the numbers have just not increased; that is the bottom line. It is a case of a boat with a hole in it wherein one keeps trying to throw the water out. The services are leaking staff all the time. This is the case because there are attractive retirement packages. The age profile of the nurses in the mental health services is such that a generic provision meant to lower the overall number of health service staff has affected mental health services much more heavily than others. This has not been dealt with. We are now at a point where, for the first time since 2006 and the publication of A Vision for Change, we are facing severe difficulties in providing enough nurses to staff acute wards and provide community services so people do not end up in acute wards. I refer to services such as day hospitals open seven days a week. These have to be staffed by nurses. If we do not have enough nurses, we cannot provide the crisis support required to prevent people from ending up in hospital. Right now, we are really in danger of moving seriously backwards with the agenda in A Vision for Change because of the difficulties with staffing.

Interestingly, the difficulty employing consultants is part of the reason CAMHS is not doing as well as it should be. It has had severe difficulties in recruiting specialist consultants to fill teams and man inpatient wards.

With regard to the admission to wards of children and adolescents, we have actually gone backwards this year. This is of severe concern. Steps were taken to increase the number of beds. There was a maximum increase of approximately 56 beds earlier this year. This then decreased by ten over the summer, resulting in fewer than had been anticipated. In the context of A Vision for Change, there should be 80 beds. This was based on a smaller population so we really need more now. We are in danger of moving backwards rather than forwards.

With regard to the counselling in primary care service, it was asked whether difficulties in meeting demand mean people end up in hospital. That is a possibility although the service is really geared towards people with mild-to-moderate mental health difficulties, not those in a severe crisis. The intention is that, by catching people early, they will not end up needing

specialist mental health services and potentially more severe treatment down the line. It is so important that general practitioners have a place to refer patients to because we hear time and again that people have felt over the years that all they are offered on going to their general practitioner is medication. They do not necessarily want medication alone; they want other types of supports. The service needs to be built up much more and we need to consider creative solutions. If we do not have dozens of psychologists available, we need to consider creative solutions drawing on the expertise of NGOs and other types of providers so as to meet the need.

The reality in Ireland is that there are very strict referral criteria for child and mental health services. Basically, a general practitioner must make a referral. There are some sound clinical reasons for that. This is understandable but, in recent work we did examining procedures, we learned there is more flexibility in other jurisdictions, including the United Kingdom and Australia. Therefore, we believe there is scope for more flexibility, as in allowing concerned teachers and social workers to have easier access.

The Jigsaw services comprise a positive development. I refer to open community centres that young people can go to. They are more youth-friendly than other services. They are not medical or general practitioner surgeries but centres to which people can go to talk to somebody if they are concerned about their mental health. Those seem to be working well and there is investment in rolling them out more widely this year.

I thank Deputy Ó Caoláin for his kind words about mental health reform. We work hard to essentially draw together the concerns, issues and good practice around the country. We will keep trying to do that. I will speak to the homelessness issue and the relationship between the housing crisis and what might be happening in mental health services. One of the concerns drawn to our attention this year in particular is the difficulty in being able to discharge people from acute wards because of a lack of housing availability. It is shocking that despite a major push towards community-based mental health services, we might have people ending up in an institutionalised setting in an acute ward longer than they need to be there because there is no appropriate housing option in the community. That concern arises because of the housing crisis.

We were asked if we had any information on where the 2015 allocation will go but we do not. It is correct that this was not specified by the Minister of State, Deputy Kathleen Lynch, in the joint announcement about funding. We expect there should be some information about that in the HSE's national service plan or the mental health division's operational plan. There is still a major shortfall to be made up. We were asked about the negative consequences of the €15 million shortfall and I can allude again to staffing shortfalls. We are not in a position that we have so many staff in mental health services that we cannot think of what to do with more; we are in the opposite position, as services are under strain. Even with multidisciplinary staff, although it is positive that the proportion has doubled, the numbers of staff are still well below needs according to A Vision for Change. There is plenty of scope for further investment.

There was a question about the Mental Health Commission, which has been impacted by the moratorium to the extent that it was having difficulty filling some of its inspection and other senior management posts, meaning it has been difficult for it to fulfil its functions, particularly in having multidisciplinary input into its inspections. We want to know that the Mental Health Commission can fulfil its remit, as it is the main means of accountability for how well mental health services are fulfilling legal obligations.

I thank Senator van Turnhout for her kind words about our organisations. She expressed concern about the absence of an independent reporting mechanism. I agree that we are in a

position without regular annual reporting, which is against the recommendations of A Vision for Change, either internally by the HSE or externally by an independent body. That puts us in a very difficult position. No voluntary organisation has access to the information that might be obtained by having an official mechanism for reporting. I agree that there is a need for a robust but efficient reporting mechanism, which should not be overly onerous on services but which should give the required information. I did not allude to a difficulty in my statement but it is mentioned in successive pre-budget submissions. We asked for an information system for mental health services over previous years and were told initiatives were under way to improve the position. There has been a modest improvement this year, with some activity data for the adult mental health services that we have not had before but it falls far short of what is provided for the child and adolescent section.

We are very disappointed the development of an information system is not progressing at a better pace as we simply do not know the level of need for mental health services. It is very significant that we have not had a national survey on the psychological well-being of the population since 2007. Right through the recession we have not had a data source on the national levels of need. It is very welcome that the Royal College of Surgeons in Ireland has produced data on child and adolescent need which is pointing to the higher levels in Ireland, and we can only suspect what may be the higher levels for adults as well, given the economic strain that people have been under. Both of those elements are very important.

Why are children still being admitted to adult wards? We have spoken about the reduction in the number of beds and there is also a need for good training for staff. The HSE's restriction on training has had a very direct impact on the adequacy of the inpatient child and adolescent mental health services. Staff who do not feel equipped to respond to children with very complex needs or behaviour will resist children being admitted to wards. We need to shift towards investing in training for staff so they can respond appropriately. Interestingly, that extends to services where we need training in how to work with adults with difficult behaviour as well so we can have less use of seclusion and restraint.

We were asked if non-governmental organisations, NGOs, should see more investment in order to provide awareness training. There is a need for a combination of public sector investment and work with NGOs. A partnership approach is probably correct and I would like to see much deeper investment in community development initiatives for mental health and well-being. Sustained community development work will bring about a shift so that fewer people will develop mental health difficulties at an early stage.

Chairman: As six other people wish to contribute, I ask members and others to be brief as we must conclude by 11.15 a.m.

Senator Colm Burke: I thank Dr. McDaid for the comprehensive presentation. In fairness, it outlines the positives and where there is a need for action. With regard to staff shortages, the witness indicates that over 12,000 people are required. Will she indicate where is the shortfall between the 9,000 people and the 12,482 people? Per head of population, is the 12,482 figure comparable with what is available in the UK? The witness spoke about the shortage of doctors, with a shortfall of 200, and there is also a shortfall of 500 nurses. Is this a result of action not being taken by the HSE to recruit or is it because people are not available? The number of doctors mentioned is quite high, so does that take in both consultants and junior doctors? Is there a major problem in the area? How can the issue be tackled?

There is the issue of homelessness, and the witness has pointed out the lack of services for

homeless people. What could be done immediately to address the problem? I am referring particularly to something that could be done over the next two to three months, especially as we are approaching Christmas. The issue is highlighted at that stage more than any other time of the year. What do the witnesses believe could be done to deal with the issue in order to fast-track some action?

Deputy Catherine Byrne: I thank the witnesses for the presentation. I have one or two questions, one of which Senator Burke alluded to, about the shortfall in staff numbers outlined in A Vision for Change. It was said that up to July there was a shortfall of approximately 3,000 staff. I am concerned about the 567 nursing posts that have not been filled. I accept dealing with people with mental health issues requires highly skilled professionals. The work is very intense. Are agency nurses employed in the mental health sector?

It was said that 212 people are waiting for between three months and six months and another 70 are waiting for more than six months. Is there a breakdown of their specific geographic location? I read that 34% of children are still being admitted to adult psychiatric services in hospitals. I echo the comments of other speakers that it is absolutely scandalous. We must examine the situation as a matter of urgency. It was said that some of the 500 people who took their lives had contact in the past year with health professionals. Is there a percentage available? Is it 20% or closer to 80% and where does one get such figures?

I fully agree with what was said about homelessness. People seek housing on a regular basis. Depression and anxiety about where to go in the evening are among the main problems that arise. Many people end up sitting in accident and emergency departments and they develop many other problems there in addition to the reason for which they are admitted. Alcohol abuse is one of the main problems I encounter among the people I deal with who experience homelessness. In my area there are two houses where homeless people can go in order to drink. Not all areas in Dublin have such a facility as they seem to be concentrated in certain parts of the city. That is a real problem because I meet people who regularly come from other parts of the city to the inner city in order to be facilitated in wet hostels. Some homeless people would not have to go to accident and emergency departments if they could be facilitated elsewhere. I accept that is a broader issue but the situation must be examined.

I have had some dealings with community-based mental health services as part of primary care services through relatives of people who suffer from their nerves. All of them have said the service in the community is excellent and that people are well looked after. It is a huge comfort to families that their relatives can be seen in the community rather than them having to travel. It is good for communities to know that people suffer from mental health issues and that people should not be stigmatised as being affected with some kind of plague. Most families in this country have someone who suffers from depression, anxiety or other mental health illness and we should not hide the fact in a closet and pretend it does not exist because it does. One of the things that has helped families to cope with the mental health illness of a family member is the availability of a community-based service.

Senator John Crown: I welcome the witnesses and thank them for their good work. Reference was made to the shortfall in the number of psychiatrists. Even if the shortfall were addressed, where would we fit in an international league table of psychiatrists per head of population? For most specialties in medicine we are way off the bottom of the charts. I am sorry to catch the witnesses on the hop and I understand if the information is not to hand. What is our ratio of psychiatrists per head of population compared to the United Kingdom, which tends to be second worst in the world among OECD countries for most specialties, and in comparison

to an average figure for continental Europe?

This is a specific and technical question. Does Dr. McDaid have any sense of the provision of liaison psychiatry services? I do not know where this fits in the planning for psychiatry services. A great deal of the demand for mental health services comes via other doctors and other illnesses. People develop complications that require psychological care, which I find is often very hard to access.

Could Dr. McDaid also give me a sense of the average waiting time for treatment? I refer to somebody who has a routine psychiatry request from a GP for an outpatient appointment that is not felt to be life threatening; if, for example, somebody has an addiction issue or personal issues which are not felt to put the person in the way of self harm. Approximately how long does a person wait to get seen?

Deputy Mary Mitchell O'Connor: My query relates to the question asked by Senator Crown about waiting times. I am aware of a lady who tried to take her life. When she contacted the hospital where she was to see a psychiatrist, she was told it would take eight weeks. Her family was obviously very upset. In spite of that, the doctors in the hospital were able to ring her and tell her to come in as they had a bed for her. I do not understand how a long timespan would be given and then the doctors could change their minds within 24 hours.

Reference was made to a national coalition of 48 NGOs in the context of Mental Health Reform. Following a previous presentation I inquired how many groups were involved in suicide prevention and I did not get an answer. I was told that between 350 and 500 groups were in existence. Could the witnesses comment on those groups and what they are doing, given that we have been told there are 48 groups in the national coalition?

Twice this week I have been contacted by school principals who are extremely worried about adolescent children in their care. They want to know where they can go and whom they can get to see. It is not that the children need to be admitted to hospital but they need help. I am aware that when one rings the local support services, one gets an answering machine but one never gets a call-back. Nobody seems to answer the phone. Why is that the case? The support group is based in the locality but it does not respond to people.

Senator Marc MacSharry: I thank Dr. McDaid for her presentation. I apologise for being late. I have read it in the meantime. Could she provide a view on out-of-hours social worker access? Actions speak louder than words.

The National Office for Suicide Prevention advertised recently for ten suicide prevention officers nationally. Our assessment is that 40 are required, at least one per county and significantly more for larger counties such as Dublin, Galway and more populous areas. Has the organisation done an analysis on the cost of mental health versus the funds allocated to it, including indirect costs such as the impact on affected families in terms of reduced output and what may be termed "presenteeism"?

Deputy Peter Fitzpatrick: I thank Dr. McDaid for her excellent presentation. My problem is that coming last, most of the questions have already been asked. Suicide is my main concern. Every family in this country has some experience of suicide. I am concerned about whether the money is going to the right place. As Deputy Mitchell O'Connor outlined, there are so many agencies around the country but I wonder whether the money is going to the right agencies. A total of €90 million has been spent on mental health in the past three years. In fairness to the

primary care centres, they are doing a fantastic job. Most of the money has gone towards the replacement of staff. I refer to social workers, psychiatrists and occupational therapists. They are very important people in combatting mental health issues. The Government is taking mental health very seriously and has ring-fenced €35 million for next year.

Two weeks ago in my area of Dundalk the son of a family who contacted me was knocked down by a car and there is nothing they could do about it. If people are suffering from mental health problems and are thinking about taking their own lives, I am sure there must be some early indications. This is something we can prevent. Is the money going to the right places? Is it following the patients? The money allocated is considerable. Some €90 million has been allocated in three years, €35 million is to be allocated for 2015 and I hope that the Government allocates more. Are we doing enough to help prevent suicide?

Deputy Sandra McLellan: I welcome the delegates and thank them for their presentation. When one sees it all presented in this way it is very shocking. I want to make one point regarding the shortage of doctors and particularly nurses. I find this hard to understand that there is such a shortage of nurses when nurses are emigrating to find work. I know nurses who could not get employment here. I find it difficult to get my head around that.

I have only one question to put to the delegates. In terms of A Vision for Change, is the situation getting better, standing still or is it getting worse? When people come to my clinic, as they would call to other members' clinics, I find I am getting stressed trying to access services on their behalf. I can only imagine what that does to the people who suffer from mental illnesses.

Dr. Shari McDaid: I will respond in the order in which questions were asked. Senator Colm Burke asked where the staff shortages are but I do not have exact figures with me. He asked me a number of questions around figures and I would be happy to forward them to him after the meeting as I do not have all those figures with me. The staffing numbers, to which we refer when we mention a shortfall are the numbers that were developed by the expert group. In all of the international information on good practice that is available, there are not necessarily figures indicting that X number of doctors, social workers or occupational therapists are needed because it depends very much on the population, its needs, specific make-up in terms of, say, disadvantage and its age profile. We have a particularly young population and we might need more child and adolescent mental health services than other jurisdictions. It is not easy to do a straight like-for-like comparison in terms of this is what is provided elsewhere and this is what we should have. What we have is what the expert group came up with. This is the expert group appointed in 2014 to develop the mental health policy. It gave its considered and consensus views on what the staffing levels should be, and that is what we are working off now.

The percentage of the health budget that goes to mental health services in Ireland is still only about half of the percentage of the health budget that goes to mental health services in the UK. We must recognise that we are coming from a very long legacy of decline in spending on mental health services. In the 1980s, 13% of the health budget was spent on mental health and it is now down to 6% or 6.5%. I would have to check the most recent budget and once we have the HSE service plan for next year we will have a clear indication of where it is at for 2015. We still have a long way to go and for all the reasons I outlined earlier it has been very difficult to get an increase in spending because of the difficulties in recruiting and retaining staff.

Deputy Colm Burke wanted to know whether the difficulties in recruiting the staff arises from action not being taken by the HSE or from it not being able to recruit. It is a combination of both. On the one hand, the HSE has been very slow in deciding where it wants to spend

the money. We know it is only as of September of this year that it was able to say that this is exactly where it wants to spend the 2014 allocation. We hope it will be in a much better position to know where it wants to spend the funding for 2015 but that is the third successive year the funding has been delayed, in part because the Health Service Executive has been slow to determine where to spend it. On the other hand, we have to take account of whether the recruitment package is attractive enough to get people into the service. That is a wider issue across the health service.

Deputy McLellan asked the reason we would have a shortfall of nurses but psychiatric or mental health nursing is a specialist discipline. We need people who are particularly trained in mental health nursing and, generally speaking, it has been difficult to recruit nurses.

Deputy Catherine Byrne wanted to know if there are any private agency nurses involved. My understanding is that to make up deficits agency nurses are used, but I do not know the extent of that at this time. I do not have a breakdown of that. We would have to go to the HSE to get a breakdown of the where we are at in terms of the waiting lists in the counselling and primary care service but if that would be helpful, we would be happy to seek that information. The Deputy wanted information on the fact that the majority of people who take their own life will have seen a health professional. I would have to double check that. I believe it comes from research carried out by the National Suicide Research Foundation but I will confirm that because I would like to be sure of the information I am providing.

I would agree with the Deputy that as we have travelled around the country, and we hold four public meetings every year to make sure we are hearing what is happening to individuals trying to access services and their family members, we have heard of good services being provided and the difference a good service makes. Where an individual has good access to a mental health nurse in terms of having their telephone number and being able to ring them whenever they are concerned, or where the mental health nurse gives a family member their telephone number directly so that they can access that kind of follow-on support after discharge from hospital, that is very valuable and appreciated and can work very effectively to keep well and out of hospital. I agree with the Deputy on that.

Senator Crown asked for some specific information, which I would be happy to provide at a later date. The numbers in A Vision for Change were set out by the experts involved in developing the policy, therefore, that is the basis upon which we are saying that there is a shortfall of psychiatrists. However, there is scope for looking at those numbers again with regard to Ireland's population to see if they need to be improved upon. The Senator asked about routine procedures referral by general practitioners into mental health services and the waiting period in that regard; I hope I am correct that this is what he asked. To clarify, if someone goes to a GP with an addiction they will not be referred to mental health services because there is a separation of services in Ireland between mental health and addiction services. That is a difficulty in that many people with mental health difficulties also have addiction issues that need to be addressed. That is something that needs to be examined.

In the adult mental health services I believe the target being worked towards in terms of people being seen is 12 weeks. That can be seen on the HSE's published information on its performance monitoring reports. It is working towards a target of 12 weeks, which is the reason it seems to take a long time to get access. However, this is the first time we have had a target and we need to consider now whether that target will be adequate. When a GP refers someone into a specialist mental health service he or she generally has significant concerns about that individual because only people with severe mental health difficulties are referred to the mental

health services. On the other hand, we need to provide more support to GPs in order that they feel more capable of responding and providing mental health support to individuals, both those at risk of developing a more severe mental health difficulty and those with mild to moderate difficulties. We are looking to some of the clinical care programmes being developed in the HSE to improve the supports to be provided to GPs. For instance, there are plans for an early intervention in a psychosis clinical programme within the HSE. A key function of that programme is to improve the consultancy support for GPs in order that where they are concerned that someone might be developing psychosis, they are quicker to refer the person to the mental health services but are also more able to provide a range of supports. The early intervention psychosis programme has been discussed for a couple of years and it needs to be implemented.

I think I have answered the question from Deputy Mitchell O'Connor about the waiting list for adult services. With regard to the number of suicide prevention organisations that have arisen in response to suicide in local communities, there is a difficulty with the co-ordination of those activities. We are looking to the new suicide prevention - what I hope will be a mental well-being framework as well - to address better co-ordination of the local initiatives on suicide prevention. It is widely recognised that while people initiate local programmes out of very sincere desire to improve the situation, there will be a better impact overall if those supports are co-ordinated throughout the country. We need to see in the new suicide prevention framework what specific actions will be taken by the National Office for Suicide Prevention to improve the co-ordination of those initiatives.

On the question of why support groups might not be available, co-ordination would help with that. With the launch of the Little Things campaign - I am wearing a Little Things badge today - the Samaritans have a phone number which is 116123 for people to call which has been provided to the Samaritans by the National Office for Suicide Prevention. This is a way of getting the message out to the public that there is a centralised highly skilled service available for individuals who are feeling like they are in danger of harming themselves. This initiative will be helpful.

In reply to Senator MacSharry about out-of-hours social worker access, the mental health policy sets out that every community mental health team should have a 24-7 intervention arrangement. It does not specify what that arrangement should look like. We consider it should be a combination of the seven day a week day hospital with telephone access to acute wards with good family education in order that families will know how to respond to a person in crisis, as well as home treatment in order that families are supported by intensive home treatment where a family member is going through a crisis period. Those are some of the components we would expect to see in a 24-7 service.

With regard to the ten suicide prevention officers being recruited, I do not have the exact number of existing suicide prevention officers but these ten would be additional-----

Senator Marc MacSharry: There are ten officers. We thought there was a need for 40.

Dr. Shari McDaid: On the question of the cost of mental health versus the funds allocated, mental health costs the economy about 2.5% of GDP every year. The funds specifically allocated to mental health are approximately €700 million. A significant disparity exists. I refer to an initiative undertaken in the UK which we have not considered as yet in this country where it has been decided that mental health needs to be given parity of esteem with physical health in allocating the budget. That issue has not even been broached in this country but in the UK they have grasped the nettle and decided that the only way to address the decades of underspending

on mental health is by having a concerted effort to have parity of esteem on spending.

Deputy Fitzpatrick asked whether the funding for suicide prevention is going to the right agencies. My reply to Deputy Mitchell O'Connor links in with that question in the sense that we need better co-ordination of the funding on suicide prevention and we need it to be going to evidence-based interventions on suicide prevention. We need to see that change coming out of the new suicide prevention framework.

Deputy McLellan asked about the strategy, A Vision for Change, and whether we are getting better, getting worse or standing still. I am very hesitant to call it in that way because we have a very disparate system where parts of the system are moving forward and parts of the system are falling backwards. Those parts of the system that are moving forward are still scattered and are still in some ways the exception rather than the rule. The number of services which provide home treatment are still in the minority. I refer to the number of services adopting a recovery orientated progressive approach and which are reaching out and pushing social inclusion for people with mental health difficulties, but these services are in the minority. While those services are to be commended on how they are driving things forward, it needs to be much more consistent throughout the country. We also need to remember that there are particular disadvantaged communities which have received very little attention to date in A Vision for Change. When I say disadvantaged I mean people with intellectual disability for whom the services have not been given attention since A Vision for Change was published in 2006. I am talking about people from ethnic minority groups and I include the Traveller community for whom the services recommended in A Vision for Change have not been given attention. I refer to people with eating disorders where the eating disorder service has not yet seen any significant developments since the publication of A Vision for Change. My overall assessment is that I commend those areas where it is doing better because in every place where it is doing better there are individuals who are getting a good quality service and it is making a real difference to their lives. I would not rest easy, however, until everyone in the country has that level of service.

Chairman: I thank Dr. McDaid and Ms Mitchell for their attendance. I thank the members for their participation.

Sitting suspended at 10.48 a.m. and resumed at 11.30 a.m.

Business of Joint Committee

Chairman: I remind Members, witnesses and people in the Visitors Gallery that mobile phones must be switched off because they interfere with the broadcasting of proceedings and with the work of members of staff, which is unfair to them.

I formally thank and pay tribute to our outgoing clerk, Mr. Paul Kelly, who is leaving us to go to a different section of the Houses of the Oireachtas. He has been a very watchful, careful and excellent clerk and has with dealt with many sensitive issues in private and public sessions. To me, as Chairman of the committee, he has been a source of strength and has become a very good friend. I thank him most sincerely for his stewardship of the committee.

I welcome to our family of the Committee on Health and Children, which is what we are to be fair, Mr. Ronan Murphy who is joining us from the Local Government Management Agency. He is very welcome and I wish him a happy tenure with us. He will find we are an eclectic

bunch of people. He will also find we have a very good work ethic and a strong sense of what is right as a committee, both in private and in public. I welcome him to the committee and thank Mr. Paul Kelly most sincerely.

Deputy Caoimhghín Ó Caoláin: I add to the words expressed by the Chairman. Paul has been very diligent in his work and responsibilities. He has been hugely personable and supportive to me and to all the members, without exception. That is my knowledge of it and I thank him sincerely. I wish him all the very best in his future career in this institution.

I wish Mr. Ronan Murphy well. I also welcome the new Secretary General of the Department who is not a stranger to this room. I wish Mr. Breslin every success in his new role and responsibilities.

Senator Jillian van Turnhout: I, too, thank Paul for helping me to learn the ropes, especially at the beginning, and for telling me what we can and cannot do.

Chairman: He gave the Senator bad habits.

Senator Jillian van Turnhout: I thank him very much. This committee has dealt with some very significant and very sensitive issues and his guidance has been very useful. I thank him for that.

I welcome Mr. Murphy and hope he finds us a good team. We tend to work quite well and across party on the issues. Health and rights of children are our priority on which we work well.

I also welcome Mr. Breslin with a slightly saddened heart because he will be missed from the Department of Children and Youth Affairs. I congratulate him and it is excellent to see him take up this new position.

Deputy Catherine Byrne: On behalf of us all in the Fine Gael group, I thank Paul for all his help. He has been very helpful to me on a number of occasions and I always found he was only a phone call away. Above all I thank him for the work he did during the debates on the Protection of Life during Pregnancy Bill, and everything we asked for he provided. Finally, I always loved his coloured ties.

Senator Colm Burke: I thank Paul for all the work he has done. Organising all the witnesses for the public hearings was not an easy task. He did the work very efficiently. The public hearings were very balanced as the views of everyone directly or indirectly involved were presented. I thank Paul and all the staff, but particularly Paul, for their contribution. I wish him well in his new role.

I welcome Mr. Murphy and look forward to working with him. I also welcome Mr. Breslin and wish him every success in his new appointment. I am sure there are many challenges in the area of health and I have no doubt he has the experience and expertise to deal with them over the next few years.

Deputy Peter Fitzpatrick: I wish Paul the best going forward. He was a fantastic help to me in the compilation of my report when I was rapporteur on obesity for the committee. He will be a big loss and I wish him the best of luck. Mr. Breslin is in for a tough time over the next couple of years and I wish him the best of luck going forward.

Deputy Sandra McLellan: I concur with all the sentiments expressed by my fellow Deputies and Senators and wish Paul the very best. This is a great committee because, as Senator

van Turnhout has said, we put the care of people first rather than our political parties. We have worked very well as a committee. Paul has played a huge part in that work and he has been helpful to us in every way, being only a phone call away. I wish him all the best.

I welcome Mr. Murphy who has big shoes to fill. I also welcome Mr. Breslin and wish him the best in his new role.

Chairman: We will talk to Paul after the meeting.

Quarterly Update on Health Issues: Discussion

Chairman: The main business of the meeting is the quarterly meeting with the Minister for Health, the Department of Health and the HSE. I welcome to their first quarterly meeting the Minister for Health, Deputy Leo Varadkar, and Mr. Jim Breslin, the new Secretary General at the Department of Health. I also welcome the officials of the HSE who are led by their director general, Mr. Tony O'Brien.

I advise the witnesses that they are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. Only evidence connected with the subject matter of these proceedings is to be given and witnesses are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that members should not comment on, criticise or make charges against a person outside the House or an official by name or in such a way as to make him or her identifiable.

I again thank the Minister, the HSE and all his team for being here. I acknowledge that the Minister of State at the Department of Health, Deputy Kathleen Lynch, is also in attendance for the first time as the Minister responsible for primary care. She has always been a good friend to this committee and I welcome her.

Deputy Kathleen Lynch: I thank the Chairman.

Chairman: I call the Minister for Health to make his opening remarks.

Minister for Health (Deputy Leo Varadkar): I thank the committee for the invitation to attend and I look forward to robust quarterly meetings with the committee. I am also joined by Minister of State, Deputy Kathleen Lynch, and officials from my Department, including Mr. Jim Breslin, the Secretary General, and Mr. Fergal Goodman, the newly appointed assistant secretary with responsibility for primary care. Mr. Tony O'Brien, the director general of the HSE is also present along with his colleagues from the executive.

I updated the committee last week on how we were dealing with the threat of Ebola. The risk to Ireland is considered very low but we are maintaining high levels of preparedness. We continue to plan and prepare at a national level while engaging at an EU and international level to contribute to and participate in the planning and preparedness process.

Before I continue with my prepared script, I will share one reflection. As someone who has

been in the job for about three months, what has been very interesting to me is to compare the health service in which I used to work seven or eight years ago with the one of which I am, at least nominally, now in charge. The focus in health tends always to be on the things that are going wrong, whether it is the number of people on trolleys or waiting lists, gaps in services or difficulties with eligibility. I expect, for obvious reasons, that this committee meeting today will focus on those things that are going wrong. That is fair enough. I point out, however, a few things that are going right and things that have really improved in the health service since I wore a white coat and stethoscope.

To mention a few of them, there are the national clinical programmes led by Dr. Áine Carroll, who is present, and the improvements are phenomenal in areas such as stroke and acute coronary syndrome. People get treatment for their heart attacks or strokes very quickly. There is also the stroke programme. A person's life is saved every day who would have died when I was a doctor, not because I was a doctor but because health care was different in those days. In addition, every day a person who would have become disabled does not become disabled because of our stroke programme. That is just one example of such programmes.

We have HIQA inspections. While they can be very annoying for staff who can find them unfair, I have no doubt that standards have been raised because we inspect and investigate things now that would not have been investigated in the past. We need to realise, when we hear about HIQA inspections in the news and when HIQA highlights bad things, that is in some ways a reflection on an improving health service. Such issues would have gone uninspected and unreported ten or 15 years ago and would not have been acted upon.

We have greater access to health care free at the point of use than ever before. Two million people have medical cards or a doctor visit card. That is more than was ever the case.

In respect of hospital acquired infections, MRSA rates are falling and have been at their lowest rate for quite a number of years. That is reflected in the fact that we do not talk about MRSA very much any more whereas we used to when it was an enormous problem years ago. It still is a problem but not to the extent it was.

We have more day surgery than ever before. We have reduced the length of stay. People who go to hospital are spending less time in hospital. To give the committee one example of that, people who go to hospital with chronic obstructive pulmonary disease, COPD, which in the old days was bronchitis or emphysema, used to spend on average nine days in the hospital. They now spend about seven and a half days in hospital because they can be discharged to the community and have nurses visit them initially after discharge and check on their care.

Notwithstanding the marked deterioration that has occurred in recent months, waiting times and trolley numbers are still better than they were in 2011, when the Government changed.

We have the air ambulance, which is a huge improvement, especially for the west and the midlands, in getting people to hospital quickly. That did not exist in the past.

We have a very good story to tell on transplants. Ireland is moving up the league table in terms of transplants done. Today, Ireland will perform its 100th lung transplant in the Mater hospital. I want to recognise the CEO of the hospital, Professor Mary Day, and also the director of organ donation there, Professor Jim Egan, for the work they do. In a country with very high levels of cystic fibrosis, in particular, having a lung transplant programme is very important. Similarly, when it comes to renal disease and kidneys, we are one of the few countries in the

world that has more people who have had a kidney transplant than are on dialysis. That is a remarkable achievement.

Also, and it is the final good thing I am going to talk about before I talk about all the bad things, we are seeing real improvements in patient transfer, for example, in getting patients from a smaller or regional hospital to a national centre. When I was a junior doctor, if I had to transfer a patient from Navan to Dublin, for example, I would go in the ambulance. I would be a rather junior doctor, not very experienced, but I would be going with the patient, probably for several hours, to get the patient from Navan to the Mater or wherever they were going, and then I would go back in the ambulance or by taxi. Not only did that mean the patient had a relatively junior doctor travelling with him or her, it also meant the hospital was down a doctor for half the day. That was quite a dangerous thing, particularly on a Saturday, Sunday or bank holiday. The hospital could be run by one or two doctors for the best part of a day. With neonates and paediatrics, that is no longer the case. Last week, a new paediatric transfer service was put into place. If a child is being transferred from a regional hospital to one of the two national centres, there is now a dedicated team whose main job is to go in the ambulance, pick up the child, provide them with the care they need from the moment they get into the ambulance, and take that child to the national centre. At no point is any hospital denuded of its core staff because a patient needs to be transferred.

Dare I say it, those are ten examples of how the health service has improved since the days when I worked in it.

It is just over 100 days since I was appointed Minister for Health. On my appointment, I said my first priority was a realistic budget and I believe we achieved that with our budget allocation in 2015, which has an increase in the Exchequer allocation of more than €300 million when compared with the 2014 allocation and more than €500 million when compared with the ceiling that had been planned for 2015. Alongside the increase in this allocation, we have also identified one-off additional income measures of €330 million and savings of a further €130 million in procurement, medicine and agency staff. Combined, this means the HSE has in excess of €750 million more to fund services than it did when it was preparing its 2014 service plan, roughly this time last year.

The cycle of cuts in health care has come to an end. As I said on the night of the budget, we have secured a welcome but modest increase in the total financial resources available to the HSE, which is for the first time in seven years.

Chairman: I apologise to the Minister. For the benefit of Senators, there is a vote in the Seanad.

Deputy Leo Varadkar: The 2015 budget is challenging, but its targets are achievable. We are entering a two-year process in which we aim to stabilise the budget and allow for existing service levels to continue, along with some enhancements in targeted areas.

Members of the committee will know, as much as I do, that despite the additional spending power, next year is still going to be a real challenge. There are major cost pressures. We have a rising population and within that we have an increasing number of older people, particularly very elderly people. Our achievements in developing new medicines and treatments also come with higher bills attached. Our progress in diagnosing and screening for cancers and chronic diseases means more people require those treatments. We know our responsibilities in addressing these needs but we must also recognise the additional resource demands that are going to

come with that.

Management of health spending within available resources will require an exceptional management focus with strict adherence by all services and budget holders to their allocations. It is important we are clear that where we identify further savings or efficiencies, we will now have the capacity and scope to reinvest those savings back into the health service rather than giving them up to service a debt or reduce a deficit. That is a key message I want front-line staff and managers to understand. From now on, savings made in our health services go back into health services; they do not go to pay down debt or to reduce a deficit. If we can exceed our savings targets, that is more money for services. It will not go back to the central Exchequer.

The progress we have made as a country in dealing with the legacy of the global financial crisis has empowered us to take more control of our resources in the health service. This does not just apply to financial resources. We will also have more autonomy with regard to staffing and human resources, following the announcement of the Minister for Public Expenditure and Reform, Deputy Howlin on the public sector recruitment embargo. With greater autonomy and capacity to reuse our savings for services comes a greater responsibility for cost containment and cost avoidance.

As a country, we took very tough decisions in our health services, just as we did in education and a range of other things. Tough decisions still have to be made in terms of managing resources, addressing performance and ensuring accountability, but the difference now is that those decisions will yield benefits we can use to improve our health services. For this reason, we are focusing on an improved accountability framework in 2015 in order that our hard-earned flexibility will not go to waste and people and patients will benefit from our economic progress. We are also continuing the reform programme because improving structures through, for example, hospital groups, helps staff in the health services to do a better job. Better structures empower people who can then deliver better care. Reform is not just an end in itself but a valuable tool which helps us do more with the additional resources we now have.

Our budget is patient centred. We have frozen hospital and prescription charges for next year and no adjustments will be made to the drugs payment scheme threshold or eligibility for medical cards. With the patient in mind, we will deliver on GP care for those under six and those aged over 70 once we come to an agreement with the Irish Medical Organisation. Once this is achieved, for the first time in our history more than half the population will have access to GP services without fees. I see this as the first step to universal health care, which is seen as the norm and a right throughout the western world but, for some reason, is still controversial in this country.

We have also allocated specific funding to deal with delayed discharges because these involve citizens, mainly elderly people who have earned the right to be treated with dignity and respect, and because it improves health outcomes when discharges from hospital are timely. We have also set aside further money for mental health, approximately €35 million in 2015, and we will extend BreastCheck to women aged 65 to 69 years.

As part of the two-year process starting in 2015, the spending ceiling for 2016 will increase by a further €174 million. This does not mean we are awash with cash, but it does make the funding situation in the health service more manageable, knowing that budgets will increase each year. I should also mention we have a capital allocation of €382 million. Members of the committee know we intend to progress five important capital programmes. These are the new children's hospital on the St. James's Hospital campus site; the new mental health campus at

Portrane, for which a planning permission application has been lodged; the national maternity hospital, which will move from Holles Street to St. Vincent's; the development of primary care centres, of which we are opening one a month at present; and additional community nursing homes for our rising population.

We also plan to invest in information communications technology, where existing systems and the level of integration are not appropriate to a health service of our scale and complexity. Better facilities and better IT systems benefit patients and their families. They help improve health outcomes and they help our staff do a better job. They are not just an investment in computers and software but an investment in our staff, our people and our shared future.

The next step in the process is for the HSE to develop a service plan which will set out the volume and type of health services to be provided in 2015 within the agreed allocation. With the return of the Vote to the Department for 2015, working closely with our colleagues in the HSE, the Department will be able to better monitor budgets and spending. This is part of the improved accountability framework I mentioned earlier. Once the service planning process has been concluded, the HSE will publish it and we will immediately set to work on ensuring it is fully implemented from January next year.

In his opening statement, Mr. Tony O'Brien will address some specific issues about which the committee may wish to hear.

Chairman: I thank the Minister. I acknowledge Mr. Fergal Goodman on his appointment. Before I call Mr. Tony O'Brien, director general of the Health Service Executive, I congratulate Mr. Barry O'Brien on his new appointment and thank him for his courtesy to the committee and the Oireachtas. I wish him well. In his opening remarks I ask Mr. Tony O'Brien to refer to the HSE report on Positive Action. Will the report come before the committee? I believe it should. What are Mr. O'Brien's plans for it?

Mr. Tony O'Brien: I thank the Chairman for his remarks on Mr. Barry O'Brien, who will be sadly missed at the HSE. I will certainly pass on the Chairman's remarks, which I know Mr. O'Brien will appreciate. He is going to UCC so he will be near to where the Chairman has other interests.

I am joined by Ms Laverne McGuinness, Dr. Aine Carroll, Dr. Tony O'Connell, Mr. John Hennessy and Mr. Pat Healy.

The committee requested information and replies on a number of issues prior to the meeting and committee members have received responses, so I will confine my remarks to some of the key areas.

The latest performance assurance report for August is about to be published. It will show hospital emergency departments continued to be very busy during the month. The cumulative increase in the number of emergency or unscheduled admissions in 2014 compared with same period last year is just over 5,000, or 1.9%. As a result of increased emergency admissions, elective admissions for the same period have reduced by 3,700, or 5%, and this has had a knock-on effect on the number of people on waiting lists. The capacity of acute hospitals to respond to increased demand is reduced due to the number of patients who are medically fit for discharge and who are awaiting alternative arrangements. The Minister touched on this issue. At the end of August, 704 people awaited alternative care arrangements. Acute hospitals and the older persons service are working collaboratively to address this issue.

The number of home help hours provided to the end of August was 6.8 million, and home care packages are 20% above expected levels. At the end of August, 82% of adults, or 39,743 people, were waiting less than eight months for a scheduled procedure and 18%, or 8,692 people, were waiting more than eight months. Outpatient attendances are 25.1% ahead of the expected target with 2.14 million attendances recorded for the first eight months of the year. The National Ambulance Service recorded an increase in emergency calls of approximately 1,000 calls each month. Notwithstanding this, improvement in response times continue to be made, with ECHO calls reaching the target of 75.3% and DELTA response to calls improving from 64% to 67%. A total of 94% of specialist palliative care inpatient beds were provided within seven days of referral.

Despite the demographic and other service pressures which drive costs, the Comptroller and Auditor General's 2012 report shows that of the six Government Departments or agencies which generally required a Supplementary Estimate between 2008 and 2012, the health service had the lowest average annual supplementary at 1.3%, compared with a range of 1.7% to 7.1% for the other five, none of which operates in as complex an area as health. Similarly, despite much adverse media and other comment, over the period 2008 to 2013, the HSE received just 0.19%, or €137 million, in Supplementary Estimates related to its core services. In other words, it was 99.8% compliant with the available budget over the period. It received 0.63%, or €452 million in Supplementary Estimates related to medical cards, GMS drugs and demand-led schemes. This indicates it was 99.4% compliant with the available budget over the period despite these primary care reimbursement service areas not being within the sole control of the HSE, by virtue of being demand led. A total of 71% of the total Supplementary Estimates were related to Exchequer or technical items which do not reflect health service financial performance.

Within the overall 2014 projected deficit, the acute hospital section is expected to have a net deficit after application of held funding of €273 million by year end. To put this in context, hospitals had a deficit of approximately €180 million at the end of 2013. It was only possible for us to deal with approximately €100 million of this in setting the budgets for 2014, leaving an ongoing underlying problem of approximately €80 million. Hospital costs have grown by approximately €80 million, or just over 2%, against a €4 billion cost base in 2014. This is at or below the growth in the workload of the hospitals. Bed days used and day cases increased by between 1.8% to 3%. As I mentioned, total emergency admissions increased by 1.9%, with the number of very elderly patients, those aged over 85 years, up 4.5%. Medical agency and clinical non-pay costs, including drugs and medical supplies, have risen the most within this. Hospital pay and non-pay budgets were reduced by €115 million in 2014. Therefore the €80 million incoming problem, plus the €80 million cost growth linked to activity, plus the €115 million in budget cuts this year accounted for the current €275 million projected deficit for 2014. In light of the budget announcements last week, we are working to finalise the service plan for 2015, which we expect to submit to the Minister by mid-November.

Preparedness for Ebola was the subject of a specific meeting last week. As committee members are aware, the overall risk of a case of Ebola being imported into Ireland is low, and while there has been no case of Ebola in Ireland to date, we are preparing for the eventuality that we will have a case at some stage. Our preparation includes Ireland's representation on the European Union health security committee, which was set up to co-ordinate health threats at EU level. Officials from the Department of Health attend and participate at the committee. The HSE emerging viral threats planning and co-ordination, EVT, group is focusing on the co-ordination of operational response plans for the HSE. An operational response subgroup of the main EVT group includes representation from emergency management, the Health Protection

Surveillance Centre, public health, general practice and acute hospitals. The purpose of the subgroup is to ensure co-ordination of operational response plans, whether the patient presents in primary care or acute hospital settings. The HPSC produces up-to-date information on Ebola for the public and health professionals. This information includes extensive guidance for health professionals, hospitals, general practitioners and laboratories. There is also extensive information on travel advice for the public and a range of other information. Personal protective equipment in line with HPSC guidance is in place in hospitals and we have in place procedures for the urgent re-stocking of hospitals where required. We have also distributed PPE to GPs as an additional measure. Specific ambulance protocols are in place for the appropriate inter-hospital transfer of an Ebola patient throughout hospitals. We are linking in with international colleagues daily with respect to new or revised guidelines on PPE and all other matters. It is important to emphasise this is a dynamic process.

We have a national isolation unit located at the Mater hospital in Dublin. It is the national referral centre for high-risk suspected and confirmed cases of viral haemorrhagic fever, such as Ebola, and other serious infectious diseases. The national virus laboratory is fully equipped to diagnose Ebola in the event of a case appearing here. The HSE is briefing staff representative organisations and a wider set of stakeholders on Ebola preparedness. The HPSC continues to monitor the situation closely and, together with our emergency management and response functions, will remain at a heightened level of activity until this crisis is over. The HSE is considering options for how to support the countries and the people most acutely affected by this outbreak.

It is important I should make clear that the HSE has no policy in respect of the manipulation of waiting lists. The HSE would never condone any such action. Had the HSE been aware that any manager urged employees to manipulate waiting lists, if indeed this ever happened, it would be the subject of appropriate disciplinary action. The HSE recently called on the Sunday newspaper in question to release the document or alternatively to furnish us with some of the necessary detail. To date, the HSE has not received any information from the newspaper to validate what it has alleged. We suggest it is neither just nor equitable that the Sunday newspaper failed to contact the HSE prior to publishing the article. Had it done so, it would have allowed us to bring a modicum of balance to an otherwise one-sided article. We consider it unreasonable that the Sunday newspaper chooses not to release some elementary detail of the alleged internal document when requested. If it were to do so, it would allow us to deal with many questions posed to us in an objective manner. Again, we call on the newspaper in question to release the document or, alternatively, to furnish us with some of the necessary detail. If no such document exists, we call on the newspaper to state as much and withdraw the allegations.

We announced recently the appointment of six new hospital group chief executives. These appointments are in addition to the appointment of Ms Eilísh Hardiman, chief executive of the children's hospital group, who has been in post since last November. The establishment of these groups is a fundamental modernisation of our health system in line with best international practice. The six new chief executives will report to Dr. Tony O'Connell, national director, acute hospitals. They are: Ms Mary Day, Ireland east; Mr. Bill Maher, RCSI hospitals group, also known as Dublin north-east; Dr. Susan O'Reilly, Dublin midlands group; Ms Colette Cowan, University of Limerick hospitals; Mr Gerry O'Dwyer, south and south-west hospitals group; and Mr. Maurice Power, on an acting basis, for the west and north-west hospitals group, which has recently re-styled itself as Saolta.

The hospital group chief executives will lead their respective groups through the next phase

of implementation as they develop strategic plans to describe how they will provide safe, high-quality care in a cost-effective manner. The reorganisation of public hospitals into groups is designed to deliver improved outcomes for patients. I acknowledge in particular the willingness and commitment of each of the individuals for taking on these challenges. I thank Dr. Susan O'Reilly in particular for her significant and remarkable contribution to the development of our cancer services. I know she will bring the same determination and commitment to her new role as group chief executive. She will be succeeded by Dr. Jerome Coffey on an interim basis.

We published the Community Healthcare Organisations report recently which sets out how health services outside of acute hospitals will be organised and managed. Community health care services include primary care; social care, which includes services for older persons and persons with a disability; mental health; and health and well-being. More than half of our total spend on operational services in 2014 has been in this sector. The sector is significant and the reform of these structures will facilitate a move towards a more integrated health care system. This will improve services for the public by providing better and easier access to services, services that are close to where people live, more local decision-making and services in which people can have confidence.

The new governance and organisation structures being put in place to enable this type of integrated care will include the establishment of nine community health care organisations, CHOs, which are the best fit to deliver an integrated model of care. They will see the development of 90 primary care networks, averaging a 50,000 population, with each CHO having an average of ten such networks. The reform of social care, mental health and health and well-being services will better serve local communities through this process. Following the publication of the report, an intensive communication and engagement process has been under way, including feedback to all those who contributed to the process. Members will be aware we provided two briefing sessions in this precinct last week. A national steering group will oversee the implementation of the report's recommendations, the first step being the appointment of chief officers, with a view to their taking up responsibility by no later than the beginning of January.

The extensive process undertaken over the past 12 months by the HSE along with our section 38 agency colleagues to reach compliance with Government pay policy is in the final stages of nearing completion. All recommendations made in the HSE internal audit report have been rigorously addressed and are being concluded. A final report on the measures taken to address the issues and recommendations in the internal audit report is being finalised for consideration by me and the leadership team and, as previously advised, it will be made available to the committee, it is hoped by the end of October.

Positive Action is a section 39 agency. It is important to emphasise that section 39 agencies are distinctly different from section 38 agencies as they are not directly bound by the Department of Health consolidation salary scales. While employees of section 39 agencies are not members of a public sector pension scheme in the way section 38 agencies are, those agencies are expected to have due regard to overall Government pay policy in respect of their senior managers. A process to verify and validate the remuneration templates on section 39 agencies commenced this year with a priority focus on the large agencies. Details of the organisations in receipt of €3 million annually were provided to members at a previous meeting. We continue our work with these agencies as part of the service arrangement process to address the issues raised in the review. A new enhanced service arrangement is being finalised and its implementation will ensure a more enhanced process from 2015 onwards.

There has been reportage concerning a finalised internal audit report on Positive Action

which has been provided to me and is awaiting consideration by our management team. I emphasise that Positive Action is a section 39 agency. It is not audited by the Comptroller and Auditor General. In this context I will be perfectly happy, once it has been cleared legally for release, for the HSE to provide it to this committee, as requested. Although Positive Action is no longer in existence, the community it served, those infected with hepatitis C, still have access to other agencies that we continue to fund.

Chairman: The committee members should consider asking Mr. O'Brien to refer the report to us as the relevant line committee that deals with the Department of Health and the HSE. This is the appropriate committee to discuss the report. I will call on the committee to discuss the matter afterwards. Deputy Kelleher has seven minutes.

Deputy Billy Kelleher: I welcome everyone to the meeting. I apologise for missing some of the meeting. I was speaking in the Dáil on water services and I imagine those present were listening to me with interest. I read the Minister's opening address and I was present for Mr. O'Brien's presentation.

The Minister referred to the fact he is now 100 days in office. We wish him well in this regard. This is my first opportunity to do so at a committee meeting with HSE representatives present as well. They are two sides of the one coin, and I do not mean that in a disrespectful manner.

I become concerned when I listen to the official replies to questions on the current provision of health care. While I do not expect Health Service Executive officials to be self-critical or critically analyse their organisation, it is clear that some areas of the health service are severely deficient. The pressure on emergency departments is one example, as is health service employees protesting outside health care facilities because patient safety is being compromised. Front-line staff are professionals and consistently advocate on behalf of patients. They believe patient safety is being compromised in emergency departments. The representatives of the HSE should take into account the views expressed by their employees, rather than lightly dismiss them, as sometimes occurs.

Mr. O'Brien referred to a report in *The Sunday Business Post* which alleged manipulation of waiting lists and denied any memorandum had been issued by the Health Service Executive. Is he satisfied that a full trawl of HSE information technology services has been carried out and all correspondence between area managers and others checked? Is he certain that there is no such memorandum in the HSE's information technology services?

I received a large number of redacted letters from the Cavan area which were written, I presume, by a general practitioner. While they might not have indicated official manipulation, they showed that the Health Service Executive had been referring patients from its outpatient waiting lists to private health care providers. These patients subsequently rejoin the waiting lists. When their names are included in a waiting list for a second time, are they placed at the bottom of the list or at the point at which they were referred initially? It is critically important to establish the position in this regard. If it is the case that such persons rejoin the lists as new patients, it would indicate manipulation of waiting lists. Patients who have been waiting for a long period for an outpatient appointment are referred to a private service provider. While I have no ideological problem with this practice, the issue is whether they subsequently rejoin the waiting list as new patients. If that were to be the case, it would indicate that the figures were being manipulated because the person concerned would have to wait to have the same procedure carried out. What is the official view of this practice, about which I have major concerns?

There is considerable merit in *The Sunday Business Post* story about waiting lists, which are a key political priority. The Health Service Executive has been under severe pressure on this issue. It has been consistently pointed out that the numbers waiting to have procedures carried out as outpatients are increasing. We have been informed time and again, however, that this was not a major concern because 250,000 people attended outpatient clinics each month. There is a crisis in waiting lists. This continues to be a major problem.

A couple of months ago I received a letter from the orthopaedic department of the South Infirmary-Victoria University Hospital informing me that one of my constituents who was on an urgent waiting list would, happily, be given an appointment two and a half years hence. I will circulate the letter to the Minister and Mr. O'Brien to give them an idea of what is happening. The lady in question is crawling around in agony. I do not wish to be alarmist, but I am not the only Deputy who has received letters of this nature. Many others have received similar letters. This is a major problem and rather than dancing along the surface and pretending everything is all right, the HSE must acknowledge it and not only because we have a new Minister. I hope the Minister will assess and address the problems in the health service in a realistic manner because what we had on some previous occasions can best be described as camouflage.

Patients are waiting 15 weeks to have an assessment made under the Fair Deal scheme. Why are assessments taking longer than in previous years? Given that the scheme does not apply retrospectively, I am beginning to take the view that the reason for the delays is to kick payments into the subsequent calendar year. The Health Service Executive is under pressure as a result of the wholly insufficient budget it received last year, as was well documented in the committee's discussions at the time. Why is it more difficult to assess a person now than it was in previous years? Has something changed, other than the fact that there is no money available at the end of the process? The process is being delayed until such time as the expenditure can be moved into the subsequent accounting year.

Representatives of the Mental Health Forum came before us this morning to discuss progress on mental health services, including child and adolescent services and other pressure points. In acknowledging the work being done and advances being made in certain areas, they were highly critical of the level of progress made in some other areas. We must address the underlying difficulties in the mental health service. It appears that a sum of €35 million which has been ring-fenced for mental health services cannot be spent because I have been hearing about it for three years. I have also heard about difficulties in the recruitment of personnel and delays in interview processes. These delays seem to be never ending. I ask the Minister of State, Deputy Kathleen Lynch, to comment.

The Minister boasts that the Government has frozen prescription charges, whereas the programme for Government refers to their abolition. The Government has a long way to go to achieve its objective on prescription charges.

Yesterday I received a telephone call from a councillor in County Roscommon informing me that dental surgery for children in the county had been cancelled. Is that correct? It would be very alarming if it were to be the case. I am referring to cases involving children who require surgery under anaesthetic. The councillor in question was informed that his son would not have surgery.

We have been hearing for three years that addressing the problem of 700 patients staying in acute hospitals unnecessarily is a priority. How does the Minister propose to address this issue and move patients from hospital care into community or home care settings?

Chairman: I call Deputy Caoimhghín Ó Caoláin who has seven minutes in which to contribute.

Deputy Caoimhghín Ó Caoláin: Unlike the Minister and the director general, members' contributions are timed and we must prioritise, given the large number of issues to be raised.

Chairman: For the record, the Minister spoke for six minutes, while Mr. O'Brien spoke for 12.

Deputy Caoimhghín Ó Caoláin: I hope the Chairman has not yet started the clock. I will prioritise a number of areas, focusing initially on maternity policy in the Health Service Executive. In the reply to my question for this quarterly meeting the Minister indicated that the Department and the Health Service Executive were working on a new maternity strategy. The Department commissioned a review of national and international literature on the issue, which has been completed and is informing the development of a maternity services policy paper. The reply indicates that the Minister will establish a high level working group to assist in finalising the strategy. When will the working group be established and when will the strategy be finalised? Is this a priority for the Department? If, as I hope, it is, will he indicate when he expects the strategy to be published?

I also note that, as part of the outworking of this process, interviews and discussions will take place with staff across maternity services units, of which there are 19 in the State. A range of site visits is also planned. Will, as I hope, all obstetric units be visited or will only some of them be visited? If the latter is the case, which units will be visited? Will nurses and midwives in each obstetric setting visited be included in the engagement on the new maternity strategy?

The Minister stated the Health Service Executive continued to implement all recommendations in both the HIQA Galway report and the HSE Galway report. All of the obstetric units were invited to self-assess against the recommendations contained in the HIQA reports. The self-assessment has been completed and the HSE will shortly survey all hospitals to review progress made in responding to the initial self-assessment, which will be evaluated against the recommendations contained in both reports that followed the death of Savita Halappanavar. When will the surveying of all hospital sites get under way? Is there a timeframe for its completion?

As we have heard, the Health Service Executive is continuing to implement all of the recommendations made in the two Galway reports. I submitted a question about the recommendations made in the report on the tragic loss of baby Jamie Flynn who was born in Cavan General Hospital in November 2012. The response I have been given indicates that the Cavan-Monaghan hospital management team is in the process of commissioning a new external review team. How long will it take before this new team is put in place to carry out a second investigation into this tragedy? I have been told that family members are being kept updated. That may well be the case, but I know that they are deeply distressed. I have been given a list of measures being taken at Cavan General Hospital's obstetric unit. It appears that five of them will address potential delays in accessing the theatre for emergency Caesarean sections and that three of them will strengthen clinical governance arrangements for women's and children's services. Given that we had two further tragic outcomes in April this year, surely every identified improvement in systems and practices must be introduced. Surely we do not have to wait for another report to be presented. I seek clarity on the listed eight measures being introduced. Are they reflective of the recommendations contained in the first report which was suppressed as a result of High Court action? Regardless of the decision to suppress the first report, if the

recommendations made in that report stand on merit and are self-evidently needed, I hope they will be implemented without question or delay. A further report should not be needed to ensure these actions are taken. I ask the Minister to expand on the position outlned in the response he has given. Many women who are expecting and others who are planning to have children in the future are very concerned. We have had three tragic outcomes, but we have had no public presentation of a report or recommendations. We simply do not know what, if any, actions have been taken as a result of the recommendations contained in the first report.

I would like to move on to the issue of mental health services. With the Minister of State, Deputy Kathleen Lynch, we met representatives of Mental Health Reform earlier today. I have commended the contribution of that organisation which has highlighted a number of serious deficiencies in mental health services. Even though the programme for Government contains a commitment to "ring fence €35m annually from within the health budget to develop community mental health teams and services as outlined in A Vision for Change", just €20 million was provided this year. As I recall, it was previously indicated that this year's €15 million shortfall would be added to the 2015 funding of €35 million. It has not been indicated or stated anywhere more recently that this will be done for the coming year. I would like the position to be clarified. Is it the case that the additional money promised in the previous commitment will not now be forthcoming? We have been told that the €20 million provided for the current year has not been and, most likely, will not be fully expended before the end of the year in the recruitment of the essential staff needed.

I would like to make a final point about maternity services. I wanted to ask several other questions. The Minister gave me a response yesterday on the midwifery practice of a named, very well known and highly respected midwife. I am not referring to her specific case. I have received four e-mails this morning from some of the 29 women who have yet to have a midwife allocated to them to fill the vacancy created by the removal of cover from their first-choice midwife. The pregnancies of some of these women is advanced and they are extremely concerned. With respect, I do not think the suggestion made in the Minister's letter that the matter is receiving attention is enough. The women concerned need to be advised about the availability of replacement midwives as a matter of extreme urgency. I, therefore, ask the Minister to commit here this morning that this will be done. There should be no further delay in having that need met.

Chairman: For the record, it was agreed by the committee at the beginning of the current Dáil that each member would have seven minutes of speaking time at each quarterly meeting. We can revise the requirements for all meetings at another date if members wish. As Deputy Clare Daly is the only member from the Technical Group in attendance, I will allow her to jump in before Senator Jillian van Turnhout comes back from the vote.

Deputy Clare Daly: I had agreed with Senator Jillian van Turnhout that she could speak before me.

Chairman: I appreciate that.

Deputy Clare Daly: When she comes back, she will want to speak about some of the issues I will be raising. It is difficult to comment sufficiently on everything covered by such a wide-ranging Department. We have to hone it down.

I would like to develop some of the points raised by Deputy Caoimhghín Ó Caoláin. I will concentrate almost exclusively on the issue of maternity care. We have to accept that maternity

care in Ireland is expensive and wasteful. In many instances, it has proved to be damaging to maternal and foetal outcomes. We have seen a number of tragic cases. The approach to research in this area has not been based on evidence and we are at an absolutely critical juncture. Some of these points have been made previously. The country's rate of Caesarean sections is completely out of kilter with the rate in other countries. Eight of the country's 19 maternity hospitals have recorded Caesarean rates of over 30%. There is blanket use of electronic foetal monitoring in all units. The level of Caesarean sections and unnecessary interventions can be attributed to the failure to deliver a nationwide strategy of midwife-led units as the best way forward. The country's maternity practice - the combined model of ante-natal care, in which a woman gains access to a general practitioner and a consultant obstetrician - has not been reviewed for 60 years. The GP aspect of the system alone costs approximately €17 million. If we were to stand this on its head by looking at having the service led by midwives, it would be far better for everybody. All European and international countries came to that conclusion a long time ago and we are really behind the bar on this one. The issue needs to be addressed now.

While we cannot discuss the case of Philomena Canning and nobody is doing so, it has brought the issue centre-stage. Every woman is supposed to have the right to access a home birth facility in a low-risk scenario. The effect of the State's action - the HSE's decision to remove Philomena Canning's indemnity cover, which was made without explaining the matter to her or speaking to the two women involved - has been to leave 29 women without this option. While we cannot discuss it, we can say that what happened next really shows the failure of the HSE in its duty of care to women. As Deputy Caoimhghín Ó Caoláin said, there are 29 clients of Philomena Canning, one of whom was in touch with us this morning. She is 35 weeks pregnant. She was told last week, after five weeks of trying to get answers, that a replacement midwife had not been found for her and that she would, therefore, have to go to a hospital. Another woman had to go to the Coombe Women's Hospital. In four cases women had to privately access the British neighbourhood midwives scheme at a cost of thousands of euro to themselves. Obviously, women who do not have private insurance cover could not envisage taking such action. The HSE was able to expend a huge amount of money on what, in some ways, was an unnecessary legal action. During those court proceedings it was said that Philomena Canning would be allowed to continue under the supervision of another midwife. Now they are saying to the people who have been left out that there are no other midwives to cater for those women. Clearly, therefore, the evidence given in court must have been a little bit suspect, if that is the case and if no services can be provided. We know that no services have been provided because the women have told us.

I would like the Minister to take note of the women's dossier outlining their concerns. They wish to waive their anonymity and would be happy to have their stories told here. I do not have enough time to do so, however, so I wish to give the Minister the dossier. I think he will be crying at the end of it.

Heavily pregnant women had developed a rapport with their midwives, which is the whole benefit of midwifery-led services. It is highly traumatic for them to have their pregnancies interfered with in this way. It is just not good enough, so I would like to see an inquiry into the HSE's handling of this matter. I would like the Minister to tell us why the Nursing and Midwifery Board of Ireland is not involved in this matter. It is the role of that board, rather than that of the HSE. I am not sure why it has not been involved, but the situation is absolutely unacceptable. I echo Deputy Ó Caoláin's point that this matter needs to be dealt with now. Those women are entitled to midwives. If the State is saying they are not available here in Ireland, women should be entitled to access that service from Britain. It should be paid for, because it

is their entitlement. The issue has not been dealt with appropriately since it emerged.

I wish to raise two other linked issues. One is the Protection of Life during Pregnancy Act, the guidelines for which we have seen since the last meeting.

Chairman: I am sorry to interrupt the Deputy, but I wish to advise Senators that there is a vote in the Seanad.

Deputy Clare Daly: The production of those guidelines has caused huge problems for many doctors. As regards the panel of psychiatrists, what steps is the Minister taking to screen some of those people to ensure they will work within the legislation, given that about one third of psychiatrists in the State have signed a petition stating that they do not agree with the Act? They do not agree that there are any circumstances in which a suicidal woman should be given access to an abortion. Clearly, we could not have a situation in which those people would be involved in assessing such women. I wonder what the Minister intends to do about that.

Can he tell us anything more about his knowledge or involvement in the Y case, obviously in the context of information that he cannot divulge? That case demonstrates that women do not have a right to access abortion in Ireland when their lives are in danger, so clearly the legislation is defective.

My last point concerns the practice of symphysiotomy. Given the fact that there is no real, meaningful oversight of clinical practice, there are a lot of discrepancies in the figures, including the number of symphysiotomies that were carried out. The women involved have had difficulty in accessing those records. What inquiries has the Minister made concerning allegations that a symphysiotomy was carried out in St. Luke's Hospital, Kilkenny, as recently as last year? Has that been investigated? It is only an allegation, but it is one that people believe to be true. Given the abhorrent and criminal nature of the practice of symphysiotomy, an investigation is urgently required to ascertain whether this has taken place.

Chairman: I will now call on the Minister and Mr. O'Brien to respond in the appropriate order.

Deputy Leo Varadkar: I will go first, followed by the Minister of State, Deputy Kathleen Lynch, and Mr. Tony O'Brien.

Obviously, a lot of things have been raised here.

Chairman: Just a moment. There is a vote due in the Dáil at 1 o'clock and Mr. O'Brien has to leave us at 2 p.m. I ask members of the committee to acknowledge that in their contributions.

Deputy Leo Varadkar: I will start with Deputy Kelleher's remarks. The situation in emergency departments is variable. We have roughly 50 emergency departments across the State. In some, it is rare for patients to be on trolleys - St. Vincent's hospital is one example of that - while in others it is intermittent, but in certain hospitals it is almost always the case that there are large numbers of patients on trolleys. It is not simply down to bed capacity; a lot of it is down to patient flow and bed management.

Neither the Department of Health nor the HSE dismisses the concerns of staff in these emergency departments. In fact, they are our staff and we take what they have to say seriously. However, I do think we need to challenge the idea that it is always down to staff resources or bed capacity, because it is evidently not. In one hospital, another 20 beds were opened quite

recently and it solved the problem for a few weeks, but then all of a sudden the beds were all full again.

I look at the numbers every day and it is a much more complex phenomenon than people make out. It is remarkable that some hospitals seem to be capable of managing their emergency departments without having patients on trolleys, while others seem to be incapable of it no matter what supports they are given.

As regards the alleged manipulation of waiting lists, it is certainly the case that waiting lists are validated. The HSE does make sure that people are not on two waiting lists for the same procedure, for example, and that people are still in the country. Such things are done to ensure they are validated, and that is entirely appropriate in my view. I have not seen the memo but I do understand that it may have been at regional level or at the level of a local manager. In some ways that is reassuring, because it shows that certainly at national level in my Department and in the HSE there is no policy of manipulating waiting lists. If we could see the memo it would allow us to take action against any manager at regional level who was clearly breaching policy. The policy is that urgent cases are treated first and everyone else in chronological order. I want to make that clear.

Leaving that aside, the Deputy touched on a much more important issue - the fact that people are waiting far too long for procedures and appointments. It is distressing that in a lot of areas - orthopaedics, for example - people are waiting for unacceptably long periods of up to two years. That is something I hope to drill down into and understand better in the next few weeks. While we may have great difficulty meeting the eight-month and 12-month targets, I really hope that next year we can do something to deal with those people who are waiting unbelievable lengths of time for treatment. I think we all agree that that is unacceptable.

On the Fair Deal scheme, there may well be delays in the assessment. The Deputy is fundamentally correct in saying that the real problem with the Fair Deal scheme is that it is budget-capped, which is in the legislation. It is not like medicines that have to be reimbursed or medical cards that happen to be issued if the person is entitled to them. The entitlement to the Fair Deal scheme is budget-capped, and when the budget runs out that is part of the big problem.

Prescription charges were introduced by the Deputy's party when it was in Government. There is no commitment in the programme for Government to abolish prescription charges. I would love to be able to do it, if we could - they bring in hundreds of millions of euro every year - but it is not within the current finances to be able to do that. I certainly have not increased them, however, and do not intend to do so.

The number of delayed discharges at the moment is 700, heading for 800, which is bad. It is bad for the health service because it means that beds that should be used by other patients are not available. It is also bad for the individuals whose discharge is delayed because they are more at risk of falls, infection and medication errors. We have set aside a dedicated fund of €25 million for the early part of next year to try to get a handle on delayed discharges. There are lots of things that could be done, including step-down beds while people are waiting for the Fair Deal scheme, and enhanced home care packages to get them home with a higher level of home care than we have been used to providing. In addition, community intervention teams can get people home and have nurses visit to provide intravenous infusions, while early supported discharge can be used in the case of stroke patients. Many things could be done but we do not yet know how best to employ that €25 million or over what period of time. That is something that the HSE and I will be working on closely in the next couple of weeks.

I will leave mental health questions to the Minister of State, Deputy Kathleen Lynch, a bit later.

When it comes to the national maternity strategy, as a first step the Department is currently finalising a policy paper on maternity services. I have not yet seen the draft of that, however. After that is finalised a working group will be established to review the policy paper and develop a comprehensive national maternity strategy. The working group will be convened before the end of this year. I hope to have some international involvement in that too. With cancer services, for example, we have often brought in international views, and I would like that to be done in this case also.

It is envisaged that the development of the strategy will be subject to wider consultation with stakeholder interests and that the strategy will be completed during 2015. I imagine all 19 units will be visited and I cannot see why they would not be. I expect that to happen and I share the view of others that maternity care is too obstetric-oriented, much more so than it needs to be. I have an open mind on midwife-led units. In Britain, a woman makes a choice early on, in the case of a low-risk pregnancy, to go left into the midwife-led unit or right into the obstetric unit. They tend to be beside each other in case something goes wrong. In any pregnancy, the one thing we do not want to happen is for the woman to bleed heavily after pregnancy and be at home with one midwife. No matter how good, one person cannot deal with a patient who is bleeding and one patient who has just been born. That is my opinion, and international models will be studied before we come to a proper strategy in 2015.

I will leave the questions on the HIQA report to Dr Tony O'Connell. My understanding of the case in Cavan is that the court quashed the recommendations, not just the findings, and that leaves us with a dilemma. Dr. Tony O'Connell knows more about that than I do. I do not want to talk about the midwife in question because an investigation is starting quite soon, if it is not already under way. Court actions have been taken and, while we have parliamentary privilege, we should not abuse it. I do not wish to speak too much about things that are *sub judice*. The investigation is occurring as a result of complaints made by other clinicians, not an unqualified individual with a vendetta against home births. The complaint is from other midwives who have concerns.

Deputy Caoimhghín Ó Caoláin: With respect, Chairman, I want the Minister to answer the question I posed about the 29 women. I did not name the midwife. I asked about the provision of an alternative midwife.

Chairman: In fairness, there are six other members waiting for questions to be answered.

Deputy Leo Varadkar: Mr. Hennessy can give further information on that. It is a matter I inquired into this morning. Some of them were offered an alternative community midwife while others were not and were offered hospital care instead. Community midwives in Ireland are independent contractors and cannot be forced to take on women if they do not want to. Where a community midwife is available and willing to take the patient, that has occurred. It has not been possible in all cases and, as a result, they have been referred to hospital. I am happy to allow Mr. John Hennessy to speak further on that.

I also checked out the Caesarian section rates. People are of the opinion that the rate is too high, and that is a legitimate opinion, but it is not correct to say that our Caesarian section rates are out of kilter with other countries. We are the mid-range for the Western world when it comes to Caesarian section rates.

The abortion guidelines were drawn up not by me but by an expert committee which included psychiatrists. We can never get five doctors in a room to agree on everything, particularly in respect of ethical issues, and the fact that one third of psychiatrists do not agree with the guidelines is not that uncommon. If there were guidelines on cardiac care, we would find one quarter or one third of doctors who do not agree with them. That is the nature of these matters. It was drawn up by a committee that included psychiatrists, and they were particularly involved in that aspect of the guidelines.

I do not want to speak too much about the Ms Y case. One of the most distressing things that happened to her was that her confidentiality was breached. It is not the kind of thing that happens in other countries and it should not have happened. She does not want to relive the experience of what happened to her, and that is why I will decline the offer to tell the Deputy more about what is happening to her or where she is now. She is an individual and should not be treated as a *cause célèbre*.

Deputy Clare Daly: I did not ask anything about where she is.

Chairman: There is one Chairman.

Deputy Clare Daly: The Minister can try to hide behind not answering the question by alleging that I said things did not say.

Chairman: We are not playing to the gallery in the committee.

Deputy Leo Varadkar: If I misunderstood, perhaps the Deputy can clarify the question.

Deputy Clare Daly: How can the Minister infer from my question that I was asking anything about the personal circumstances of the woman? I asked about the Minister's involvement and knowledge of the case, nothing about the woman.

Chairman: The Deputy spoke for eight minutes.

Deputy Clare Daly: I did not get the answers to the questions I raised.

Chairman: If the question has not been answered, I will allow the Deputy to speak at the end of the meeting.

Deputy Clare Daly: Will we not get an answer to the questions about the neighbourhood midwives?

Chairman: With respect, eight members have been waiting since 9.30 this morning as members of the committee. I will invite Deputy Daly to contribute at the end of the meeting if her question has not been answered. That is the custom in this committee. If members' questions have not been answered, we bring them in at the end of the segment.

Deputy Leo Varadkar: As that was a clinical case, I had virtually no involvement with it. As is the case with any patient and doctor, what happens between the patient and the doctor is not something politicians have much involvement with.

With regard to symphisiotomy, I had not heard the allegation. I am interested to have any information on it, but I should clarify that symphisiotomy is not a crime in Ireland and is still performed in some countries. There have been cases in Canada and Massachusetts and in Africa. I doubt it was carried out unless someone refused a Caesarian section or was at the point of

obstructed labour. I find it hard to believe, but I would be interested in hearing any information the Deputy has on it.

Minister of State at the Department of Health (Deputy Kathleen Lynch): With regard to oral health, I assume Deputy Kelleher was asking about children with intellectual disabilities, which is the only group that needs to be sedated for oral health. I do not know about the case to which he refers. Perhaps we will find out about it afterwards and revert to the Deputy. With the development of the new oral health policy, there is less need for full anaesthetic for people with an intellectual disability. Mild sedation can be applied, usually by trained nurses in the local dental surgery. We will inquire about the case, but I am not certain, so I will not say anything more.

With regard to Deputy Ó Caoláin's question about the additional €15 million in the mental health budget, about which Deputy Kelleher also indicated, I did not go looking for the additional €15 million this year. I am normally open and frank about these things. If we did not get the money, who is paying the salaries of more than 1,000 people who are employed with the additional development money? It surprises me that people do not recognise the fact that people are being paid every month. Clearly, the money has to come from somewhere. During the year, we discovered in one of my regular meetings with the executive clinical directors, ECDs - the consultants who lead the service - that the moratorium and cutback on the numbers employed meant the administrative staff had been depleted. Rather than using part of the €35 million received in 2013, we used some of it for administrative staff. I consider that to be as important and crucial to mental health services, so that when people are seen as outpatients or inpatients the proper notification is in front of the treating clinicians. That was not in the original application. I consistently check this point and seek various charts.

At the end of August, approximately 99% of the 416 approved posts for 2012 - that is, 411 - have been filled. Of the 477 approved posts in 2013, 75%, or 352, have been filled and the remainder of the vacant posts are at various stages of recruitment, with some difficulty in identifying outstanding candidates. This is for geographical or qualification reasons which I will explain further later. A total of 85% of people recruited for the combined two-year posts have taken up duty. Approximately €5 million of the €20 million in development funding for the additional 250 posts is targeted to be spent in this quarter of 2014, with €15 million meeting various broader service pressures for this year. This will go to fund the additional 2014 posts in full in 2015. Funding for the National Office of Suicide Prevention has more than doubled, from €4 million in 2011 to €8.8 million in 2014.

Funding is included in the HSE's capital plan to provide for planned infrastructural development of the national forensic mental health service, for instance. The application, as the Minister rightly said in his opening statement, is in place. I am sure there will be some objections, but from what I hear there will be very few. The issue is construction more so than the institution itself. We will have to study this seriously, because within that new building we will put in place a new unit for people with intellectual disability, which we have not had before now.

Deputy Caoimhghín Ó Caoláin: Is the Minister of State speaking about Portrane?

Deputy Kathleen Lynch: Yes. There will also be a new children's unit for forensic stabilisation. We send many children abroad, as the committee knows, and we hope to ensure these people will come back. That is also the intention for the intensive care units that we will build around the country so that people who have mental health difficulties and need that forensic input will not have to be so remote from their families. We will bring them back to their com-

munities.

In doing that we have to ensure we have the right subset for the posts. When I meet the people who lead the service, they say they advertise through the national panel and people apply and get the posts. If, however, a person gets a position that is vacant in Monaghan and the one he or she originally wanted, maybe in Cork, becomes available, that person has the right to move to that post. Therefore, one is constantly trying to backfill the posts. This is even more acute in the forensic service because the person has to go through an intensive training process and if, after doing that, the post he or she originally wanted comes up, the person moves out. We are considering how we can best apply local specialised panels to ensure we get the right people in the right place.

We have a difficulty in respect of psychology, as everyone knows. We are not training enough psychologists and some of those we do train go abroad to get wider expertise, which is good because they will bring it back with them. That is why we are seriously considering the prospect of retraining highly skilled nurses and social workers in the service in cognitive behavioural therapy, CBT, which has very good outcomes for mental health.

I hope the committee members have received the table showing the posts that have been recruited and will be filled this year. There are 196 for this year. This is a response to question No. 34 from Senator Marc MacSharry. The table shows that we are putting people in place for old age psychiatry, which we had not done for the past few years, and for people with intellectual disability, which is also a highly specialised area. It is a question of finding the gaps and determining how to fill them. Up to now we had been paying particular attention to child and adolescent and adult psychiatry.

The strategy A Vision for Change refers to the establishment of 99 multidisciplinary child and adolescent mental health services, CAMHS, teams providing community-hospital liaison and day hospital services. A total of 69 teams are in place: 62 community services, three adolescent day services and three hospital liaison health teams. This is very important for liaising with families.

Deputy Caoimhghín Ó Caoláin: What about the waiting list for CAMHS in July of this year?

Deputy Kathleen Lynch: I will get to that.

Deputy Caoimhghín Ó Caoláin: I can tell the Minister of State about them.

Deputy Kathleen Lynch: I am sure the Deputy can, and maybe he does not need to ask the question.

By the end of August, approximately 140 of the 150 posts approved for CAMHS were filled.

The matter of most concern to me, which I have been working on for the past month or two, is that there are 46 child and adolescent beds nationally: 14 in Dublin, 12 in Cork and 20 in Galway. I am sorry; there are 20 beds in Cork. I am sick of being beaten over the head about children going into adult mental health units when there are beds available within the CAMHS. I know that because I have been looking into it. We need to ensure that where there are beds available in the child and adolescent services, that is the first port of call. We have to do this. Serious work has been done on it. We have put an individual in charge of that alone. I know we all feel it is much better that people are out in the community, but why is there a waiting

list for inpatient delivery of mental health services? It does not exist in the adult service. It is a question of ensuring that the service works in a more productive way. I am very conscious of the fact that we are losing and will continue to lose nurses from the mental health services. They are entitled to retire at 55 because of the onerous task they perform daily. That is coming down the track very fast. A workforce plan is being developed because we know it is coming. I believe that if one knows something is happening it should not come as any big surprise. One should plan to alleviate whatever pressures it brings.

I am delighted that people take an interest in mental health. I know Deputy Ó Caoláin always has, as have Senator van Turnhout and Deputy Neville. That helps and has helped to change the narrative and the perception, which is good.

Deputy Caoimhghín Ó Caoláin: The pressures are there as we speak.

Deputy Kathleen Lynch: Absolutely.

Mr. Tony O'Brien: In a moment I will ask Mr. O'Connell to comment on the implementation of the maternity reports and Mr. Hennessy to comment on the community and midwifery aspects. Deputy Kelleher is no longer here, but this is the first time I have ever been accused of painting an overly rosy picture of the health service. I do not necessarily recognise myself in his description.

I cannot say the memo does not exist. I can say that at the moment I have a very large haystack and I am being asked to look for a very small needle. If the newspaper that published the suggestions can do something to help me find it, that would be very helpful. There is certainly no national-level policy that allows such a memo to exist, and if it does exist we need to find it. If the newspaper has a copy, it would be very helpful if it were made available.

The use of private health providers to provide first appointments for people on outpatient lists is valid. When a doctor refers someone for an outpatient appointment, he or she initially looks for an opinion which can result in the patient's being maintained or cared for by his or her general practitioner, GP, on a continuing basis, with the concern having been allayed, or it can result in the patient's requiring inpatient treatment. We have acknowledged that the process at the end of last year was flawed in that in some instances when patients were referred back into the public system for treatment there was a requirement for them to be seen again before they proceeded with treatment. We have made a commitment that will not recur. In principle, using private providers on that occasion was not wrong in and of itself.

In relation to the South Infirmary Victoria University Hospital, there is an issue with orthopaedic surgical capacity and there are plans to address that.

In relation to the Fair Deal scheme, it is not that the assessment is taking longer but the placement. That is a simple consequence of the demand exceeding the resource available. It is a cash-limited scheme and new placements can only be made available as funding becomes available. Unfortunately, that means someone going out of the scheme, which, typically, is at the end of life. That situation will not improve by itself. All the information we have provided is around the interval to placement, not the interval to assessment. Perhaps Dr. O'Connell would like to comment on the implementation of the report.

Dr. Tony O'Connell: I wonder if I might add something to the question about outpatient departments, which the director general partially answered. I merely want to reassure Deputy Kelleher that last year we sent out 15,000 patients who were waiting too long on the public

waiting list to the private sector to be serviced. A small percentage of those returned because they were not seen for whatever reason. If that was the case, they rejoined the list at the place they were previously; in other words, there was no disadvantage to them. At least they had the opportunity to see someone in the private sector. If they came back because they had been seen in that private clinic and required a procedure which was not part of what we had contracted with the private sector to provide, they came back to the public sector. Then, the doctors who were to perform the procedure often wanted to see the patients, which is quite reasonable from a clinical quality point of view. When that occurs, the patients are treated as review patients because they have already had an outpatient clinic visit and they are given priority above others. In the end, we had a system which, although it could have been improved, resulted in thousands of patients being seen sooner than they might have otherwise, with no disadvantage to themselves if they came back to the public sector.

With regard to the maternity strategy, I thank the Minister for those clarifications about how it is running. I merely want to add some details there. We will visit all 19 units, each of which is quite different. They have different caseloads and levels of complexity. It is important to have a sense of what is going on in both the small and big units. As the Minister stated, the Department has already done a literature review, which has only just been sent over to my office and which I have not yet had a chance to read. It arrived only in the past 48 hours. I will certainly look at that.

In the acute hospitals division, we have surveyed all 19 units for high-level information about the number of obstetricians, midwives, deliveries, procedures, etc., and all of that information is back and is being collated. Clearly, the next step is to drill down and look much more closely at the quality of service in each of these 19 units and whether there are other ways in which the service can be provided which represent a more efficient use of the mix of skills among midwives, midwife assistants and obstetricians. That work will be done as we visit the 19 units. We are, as was stated, setting up a guiding group which will steer this piece of work and which will also participate in the visits to the 19 institutions.

With regard to the tragic event that occurred in Cavan, as was mentioned, the High Court has insisted that the report not be released. I want to reassure the committee that those eight actions at Cavan and Monaghan hospital that Deputy Ó Caoláin referred to in the written answer to his question have been initiated and enhanced subsequent to any adverse events which have occurred, and they are a response to the desire of the management, the obstetricians and midwives in the hospital to continue to improve the services available. There will be a new investigation because of the quashing of the previous one. Yesterday the college nominated two independent doctors to be involved in that investigation, which will start in November. We are keen, for the sake of the family, to ensure the investigation is completed as soon as possible without in any way compromising thoroughness.

With regard to the question about Caesarian section rates, as the Minister stated, these vary across countries, but Ireland is broadly in line with other OECD countries. There is variation within Ireland: for example, Sligo has a 19% Caesarian section rate, whereas Kilkenny has a 38% Caesarian section rate. It is for that reason that we are pleased the Health Research Board has given a grant to Professor Richard Layte from the ESRI and Professor Michael Turner from UCD, who works at the Coombe hospital and who is also the chair of the obstetric clinical programme, to look at national databases to study the issue of variance in Caesarian section rates. Clearly, we need to put all of that together with the improving data collection that we are doing on the standard of quality in the hospitals.

As was stated, the unfortunate events surrounding the death of Ms Savita Halappanavar in Galway have resulted in numerous recommendations. We are implementing all of those recommendations, some of which take longer than overnight. We have been surveying all 19 units to ensure they are implementing the recommendations and we are in the process of reviewing progress on those implementations. Some of what we are doing is described in the answer we have given to the question, and I will not go into it in detail - for example, the implementation of the Irish maternity early warning score, which detects patients in a similar condition to the late Ms Halappanavar, who previously may not have been detected early enough. There is excellent penetration of use of that particular tool in the maternity hospitals. In our regular performance management process with the almost 50 hospitals in the country, we are utilising the Safer Better Healthcare standards and the recommendations that emerge from the various reports, especially the HIQA reports, to inform our conversations with the hospitals, and we are using national standards for safety and health care to ensure that hospitals are continuing to dynamically review the output of their self-assessments. We are also establishing a quality and patient safety profile, QPSP. This is a comprehensive, timely and reliable report which will be used by the senior and most accountable manager in each of the services, which describes the quality and safety of the health care provided within the service and the actions taken to improve those services where required. This is being overseen by a cross-divisional HSE steering committee which is developing that framework and supporting the services to implement that QPSP.

With regard to the question on foetal monitoring, this technique is not used in a blanket way across the system. The use of foetal monitoring is guided based on guidelines which have been developed by clinical experts in the Irish system, and it is only used when indicated. Overseas experience shows that electronic foetal monitoring can increase Caesarian section rates, but that is only in countries that do not concomitantly use foetal blood sampling. That is not the case in Ireland, because foetal blood sampling is available in all maternity units here.

Mr. John Hennessy: On the community midwifery case, the clear objective here was to minimise the disruption to the client list and to the women involved. The original client list for the midwife concerned was 12 - there were 12 women notified to the HSE and registered - but I am aware that a substantial number of further clients have emerged since then who were not previously known to the HSE. We have a team working on this to try to facilitate as many people as possible with alternative arrangements. That is dependent on the availability of community midwives to take up this work. To put that in context, the volume of this activity compared with the general activity level in obstetrics is tiny. There are approximately 200 births per annum, with approximately 20 midwives operating, but our intention is to try to facilitate as much choice as possible. More serious questions relating to choice will be dealt with as part of the maternity strategy review, with an open mind on maximum choice.

On the legal costs mentioned, the legal proceedings were not initiated by the Health Service Executive, HSE, in this instance, and we are the respondents in that matter, but further hearings are due to take place and I would prefer not to comment on that in view of those hearings.

Deputy Kelleher raised the issue of the dental list in Roscommon. We are checking the facts with regard to that but it appears some work is happening in the new endoscopy unit at Roscommon hospital which is disrupting theatre lists. We will examine the detail on that and try to make alternative arrangements to minimise the disruption to service.

Chairman: I am conscious that a vote is imminent in the Dáil. At least nine speakers have indicated their wish to contribute. Mr. O'Brien is leaving at 2 o'clock, and the Minister has another engagement. I know it is unfair on Members but I ask them to be concise in asking their

questions rather than making pronouncements. I will take members in the following order: Senator Burke, Deputy McLellan, Deputy Conway and Senator van Turnhout.

Senator Colm Burke: I thank everyone for attending this morning. My question 20 was specifically on consultant vacancies and I was astonished by the reply I received in that the information has not been given to me. I do not accept that the information is not available. We are talking about 41 hospitals. If I got the name of a porter in each of the hospitals, I have no doubt they would be able to give me the information I seek. It is appalling that a manager of a hospital cannot tell a central office the posts that are currently vacant.

I am surprised the reply refers to these changes happening over a short period. Consultant posts do not change over a short period. People are in a post for ten, 15 or 20 years, so I do not understand the reason for that reference. The second part of the reply refers to the recruitment embargo. I was not aware that the embargo applied to the recruitment of consultants. The reply is not adequate. If someone from the media asked the same question, I believe the information would have been furnished to that person. I am very annoyed that I cannot get what is basic information that is available to every hospital manager. We are talking about 41 hospital managers, and if they do not have that information, they should not be in their jobs.

Question 22 was on the implementation of the recommendations of the McCrea report. Again, the reply was fuzzy. No clear indication is being given that the terms and recommendations in the McCrea report with regard to changing the structures of how we employ general doctors are being implemented. That is something to which priority should be given. We have a huge problem on our hands with regard to the recruitment and retention of general doctors. Services are being affected and many consultants say that if some of the general doctors they currently employ had applied for the same jobs five years ago, they would not have been employed. Standards are falling. We need to address that, and the reply does not deal adequately with the question I posed. I ask that I be given the information I have requested.

Deputy Sandra McLellan: I will try to be as brief as possible. I thank the witnesses for their comprehensive updates which I found very useful.

I refer to the 704 people awaiting alternative care arrangements. I welcome the dedicated fund of €25 million, but we have an ageing population and many people await home care packages. The Fair Deal scheme waiting time in my area has increased to 16 weeks. I hope that will be examined carefully when the €25 million fund is being allocated.

I posed a question with regard to the orthopaedic surgeries, which Deputy Kelleher mentioned earlier. I noted in the reply that there was a significant reduction in so-called long waiters, at 59%. The reply also refers to a 15% reduction in the number of patients waiting more than 12 months. I do not know of anyone who has been waiting less than 12 months. I have received letters from people stating that there is a two and a half year waiting list. People tell me that from the time they go to their general practitioner, get an outpatient appointment and go on a waiting list to receive an appointment, it can take up to four years.

Question 13 concerned the drug Daxas. Constituents have told me it had been withdrawn under the medical card scheme but the reply, which I am sure is 100% correct, states it was never under the medical card scheme. If I understand correctly, the manufacturers were liaising with the pharmacies and making it available free of charge. Is that correct? I understanding they were dispensing it free of charge over the counter but they have now withdrawn it. It was mentioned that hospital stays have reduced for chronic obstructive pulmonary disease, COPD,

and emphysema, but Daxas is a drug that helps people with emphysema and COPD. One person I spoke to had an average of four hospital stays per year, but since he went on this drug three years ago he has not been in hospital. Another person told me they were in hospital on numerous occasions, with average stays of a couple of weeks, but this drug has resulted in them not needing to be admitted to hospital. Apparently, there is no generic substitute for Daxas. We are dealing with people on very low incomes. They can purchase it, but one man told me it cost him more than €60. Another man told me it cost €80. Results of clinical trials are expected later this year, but I would like the Minister to investigate that and revert to me on it because I do not believe he is aware of the answer I received on it.

Deputy Ciara Conway: I refer to the questions which I have raised with this committee and with the HSE on a number of occasions. We are going around in circles in this regard. We are a year on from the Higgins report when Professor Higgins established the hospital groups. Waterford University Hospital was given an undertaking that a 24-7 cardiac catheterisation laboratory would be available to the people in the south east. It currently operates from 9 a.m. to 5 p.m. on a Monday to Friday basis. Therefore, if one has a heart attack, one can get the required treatment only between those hours from Monday to Friday.

I see from the response I received that a business case has been prepared. There was no talk of business cases when Professor Higgins, at a meeting at which I was present along with the then Minister for Health, Deputy Reilly, said that this was part of the deal in Waterford becoming part of the hospital group in conjunction with Cork University Hospital. When will this service be delivered to the people of the south east?

Regarding my second question on the palliative care unit, I note there has been a development in that this plan has gone to service design, but I am alarmed to find that in a report published by the hospice association, which is available on its website, the south east is the only part of the country in which hospice home care packages are not paid for in their entirety by the HSE. The HSE funds a home visiting service, which is crucial to very sick people throughout the south east, to the value of approximately €200,000 a year, and it costs €500,000 to run. The €300,000 deficit is, therefore, made up by fund-raising by the people of the south east. People who fund-raise for the hospice in Cork or Kerry can buy nice added extras for people who are experiencing a difficult time in their lives. However, the money from fund-raising in the south east goes directly to pay for the service. How is it that we are the only region in the country that must do this? I want to know what will be done.

Furthermore, the people of Waterford and the south east have committed to fund-raising a total of €6 million for the construction of the palliative care unit in the grounds of the hospital. If we had the use of the €300,000 which we fund-raise every year to put towards that project I maintain that the project would be completed more quickly.

The Minister spoke about how HIQA has improved standards-----

Chairman: There is a vote in the Dáil.

Deputy Ciara Conway: I have a question for the Minister about an issue I have raised which relates to food served in hospitals and his views on having national standards for the quality of food served to our patients in hospital because we do not want them to get any sicker as a result of the food they are offered.

Chairman: I will take questions from Senator van Turnhout before we suspend for the vote.

Senator Jillian van Turnhout: I thank the witnesses for their attendance and for their replies to questions. In question No. 14 I asked about the resources for preparing staff for Children First. It was indicative that when I submitted this question I was asked whether I had directed it to the right Minister. I am asking about the training of more than 70,000 staff in the HSE who will deal directly with children. I am concerned by the fact that the question was kicked back to me. I specifically wish to know what money has been allocated to finance the training of the 70,000 relevant staff to enable the implementation of Children First.

I refer to question No. 15 on the model of care for neurology and, in particular, to progress the patient pathway for multiple sclerosis. The number of consultant posts has been increased by ten and it is evident that the number of outpatient appointments will increase. There is a clear business case for the recruitment of more consultants. What are the figures for MS nurses, physiotherapists and psychologists?

It is expected that the fourth draft model of care should be ready for the November meeting of the clinical advisory group. Will that be presented for public consultation and, if so, when?

The reply to question No. 15 states that the neurology programme has been working with the national director, Áine Carroll, on developing protocols for high-cost prescriptions. Will these provide a national prescribing guidance for prescribing all medications available for MS or just the two medications cited? Comprehensive guidance is needed because we need to avoid a postcode lottery type of treatment.

My third question is about cardiac rehabilitation. I note some progress. Ian Carter advised us that there would be progress this year. Is this view shared by Dr. Tony O'Connell? I refer to the survey undertaken by the Irish Heart Foundation, IHF, and the Irish Association of Cardiac Rehabilitation, that not one hospital providing cardiac rehabilitation is meeting the minimum staffing requirements.

On the issue of mental health, the Minister for Health, Deputy Varadkar, said that we often focus on what has gone wrong. My difficulty in the area of mental health is that we have no report. In 2012 the monitoring report of A Vision for Change was discontinued. I have no report to track the strategy so I cannot applaud the Minister because I do not know when we can applaud and when we can say it is not good enough. In particular, we need to have reports with regard to children. I know that children are being put in adult psychiatric wards-----

Deputy Kathleen Lynch: They should not be there.

Senator Jillian van Turnhout: I agree but I know that there are units which only deal with anorexia and certain issues and they will not take the children who need help and that is not acceptable.

Deputy Kathleen Lynch: No.

Sitting suspended at 1.25 p.m. and resumed at 1.55 p.m.

Chairman: We shall resume.

Deputy Robert Troy: There are three points I would like to make. In light of various replies I got, we are all well aware of the position on prices and the Fair Deal scheme. I understand money was taken out in last year's budget. Has the Minister any plans to address this matter?

My second two points concern two centres in my constituency, St. Christopher's and St. Hilda's, both of which provide services to those with intellectual disabilities. There has been ongoing consultation with these services. They are at crisis point and have endured difficulties over and beyond the cuts that others might have endured in the effort to create efficiencies. Comparisons are being made with similar units but they do not take into account the severe disabilities of some of the residents in these homes. One is not comparing like with like; it is a case of apples and oranges. People with intellectual disabilities getting on in life may require many more supports than others.

I understand the Minister met a deputation from St. Christopher's last week. It is disappointing that the deputation was associated with just one political party and did not represent all political parties. Perhaps the Minister will outline his plan for supporting St. Christopher's.

I understand St. Hilda's in Athlone is to endure a further cut this year. My information from the centre is that the local HSE did not support this cut and in fact recommended against it. Who identifies the value-for-money cuts to be implemented? Is it the regional or local office, or is it done at national level? Perhaps the Minister could come back to me on that.

Deputy Catherine Byrne: I welcome the Minister.

Let me refer to question No. 27 on aftercare and individuals who have lost their medical cards. The reply stated it is not necessary to have a medical card to avail of services in most areas. I assure the Minister that I have come across a number of cases in which it was essential to have a medical card to avail of a service.

The Minister spoke about community nursing homes. It is very important to be able to continue to provide community nursing home services. I have encountered two cases of people in their 80s who have lost their medical cards and who have genuinely sick partners. One individual was charged €50 for a nurse to come to his home to dress his arm because he had fallen. After contacting the primary care health centre and speaking to the doctor there, circumstances were reversed. The nurse attended a few times and helped to bring the man's health back to an appropriate standard.

I am very concerned about home help services and the effort to keep people at home. The Minister did not mention this because it is not in the question. In my area, where people are given half an hour in the morning and half an hour in the evening, the service is not adequate. I refer to where somebody has to be got out of bed and helped to make a bit of breakfast, and attended to in the evening also for half an hour. I am very concerned because many service providers are now telling me they are just not able to manage anymore consequent to people being given just half an hour. An individual might be entitled to an hour, but this would mean half an hour in the morning and half an hour at night. I do not know what can be done about it but I hope the Minister can consider it again. The more we can keep people in their homes, the more they can be with their neighbours and family. I hope that, through community nursing homes, we might be able to enjoy the added bonus of keeping people at home.

I ask the Minister to reconsider favourably the cases of people whose medical cards have been removed because they were somewhat over the threshold but who might be elderly or have a very sick partner at home.

Deputy Leo Varadkar: A number of questions relate to very specific services so I will leave them to the national directors for comment. I will leave to the Minister of State, Deputy

Kathleen Lynch, the questions on the Fair Deal scheme and mental health services in St. Christopher's and St. Hilda's.

Children First, which is covered in question No. 14 by Senator van Turnhout, is in the mix for the services plan for 2015. I do not know why the question might have been referred to another Minister. Children First is relevant not only to the Minister for Children and Youth Affairs but also to areas such as education, health, sport and others. There are statutory obligations in this regard, and provision must be made in the service plan next year for appropriate training depending on people's jobs.

Regarding the hospice in the south east, it is the case that in other regions people engage in fund-raising for services such as nursing care. It is not the case that fund-raising in other regions relates only to matters of capital expenditure; it can apply to service elements too.

Deputy Ciara Conway: That is not correct. Nurses are employed by the HSE in all other regions but not in the south east.

Deputy Leo Varadkar: In some regions additional nurses and therapists are paid for through fund-raising.

Deputy Ciara Conway: I am referring to skeleton staff.

Deputy Leo Varadkar: The chief medical officer has been tasked with linking with the HSE to develop a working group on the quality and nutritional value of food in hospitals. Much has been done on this in the Cavan-Monaghan region and I would like to see this across the health service. In Britain, the NHS has done much to improve hospital food. Some people attend hospital for short periods and need energy, so I do not think desserts should be banned. The bigger picture is about feeding people appropriately, particularly if they are in hospital for a long period.

The national director will say more about the catheterisation laboratory in Waterford. It is always the case that a costing is done and a business case made - ultimately, all capital investments require taxpayers' money. Failure to carry out a cost-benefit analysis and make a business case would breach the public spending code. This does not mean the matter is in jeopardy.

My understanding is that the medication Daxas was offered free as a trial. After a trial period a company must demonstrate clinical evidence that a medicine is effective and put forward a reasonable price. We cannot always pay the price sought by drug companies, and the company is obliged to show the effectiveness of the drug and the fairness of the price.

Deputy Kathleen Lynch: Deputy Troy raised the Fair Deal scheme with regard to St. Christopher's Services, and I will combine the two questions he asked. Waiting lists are increasing and €23 million was taken from the Fair Deal fund and placed in enhanced home care packages last year. This worked extremely well, as far more people now receive enhanced home care packages and home help. I have made inquiries relating to St. Christopher's Services and I have not met people based on their political parties - that is irrelevant, as anyone who is interested can come to a meeting. St. Christopher's Services tendered to provide the service it does and won out in the process because it provides a good service. The additional supports that are now being delivered were not part of the tender process and were not agreed with HSE so this presents a difficulty. I recognise that St. Christopher's Services is delivering the service that was agreed when it won out in the tendering process, and the HSE is funding this, but there is a difficulty that cannot be ignored. Mr. Pat Healy and his team will meet representatives of

St. Christopher's Services in the coming days to see what can be worked out. St. Christopher's Services is not the only service providing additional supports that were not originally part of a tender, and this issue has been worked out in other cases. There will be intense engagement on overcoming these difficulties. Everyone recognises the good work that the care centre does, but it was only asked to tender for certain services and it did so. The HSE pays for these services and has lived up to its side of the bargain, as has St. Christopher's Services.

Deputy Robert Troy: One cannot ignore patients when conditions are deteriorating.

Deputy Kathleen Lynch: One must engage in negotiations, so this is what we will do. I have heard the arguments relating to St. Hilda's Services and I visited that facility recently. It deals with people with a range of abilities and disabilities and we must ensure that service continues to be provided.

All I can say to Deputy Troy is we have got what we have got. Our budget is approximately €1.5 billion this year, so there has been a slight increase, but a range of services must be delivered. We must manage the budget while providing the services that people need.

Deputy Robert Troy: I asked a specific question on St. Hilda's Services, though, in fairness, I did not put it in writing. Perhaps I could send it directly to the Minister of State.

Deputy Kathleen Lynch: I answered that question, though perhaps not in the fashion sought by Deputy Troy. There will be interaction with St. Hilda's Services. I understood the question perfectly and I hope questions from St. Hilda's Services can be answered within the process.

Ms Laverne McGuinness: I am sorry the responses given to Senator Burke were not adequate. I will arrange for more comprehensive responses to the specific questions he raised to be sent to him early next week. Copies of the fresh responses will be given to the committee secretariat.

The specific questions on the neurology post will be dealt with by Dr. Áine Carroll. Deputy Conway raised cardiac issues in Waterford and Dr. Tony O'Connell will speak on this matter. Deputy Catherine Byrne raised the case of a specific medical card holder who lost access to services - we will follow up on this if the Deputy gives us the specific details of the case.

Senator Colm Burke: There are deficiencies in hospital services relating to junior doctors and consultants, and we must quickly identify the location of the shortfall. We are sweeping this issue under the carpet and it must be addressed.

Ms Laverne McGuinness: Vacancies can arise at any point in a hospital and they are referred to the consultants appointment committee, CAC, as part of the recruitment process. While this recruitment process goes on the vacancies are filled using an agency, so related figures are not accurate as they are not maintained on a comprehensive IT database. Such a database is currently being formulated. I can give the Senator the details of what we have, but figures in this area cannot be 100% accurate. Only accurate figures are published, so any figures provided cannot be published.

Dr. Tony O'Connell: A table entitled "Full-time consultant vacancies" was not included in the papers of Senator Burke, and I apologise for this. I will pass on this table, which lists consultant vacancies by hospital. I will mention only the four largest numbers, because they are worrying figures. Waterford hospital has 23 consultant vacancies, the Mater has 14, the

Louth-Meath group of hospitals has 21 and the West/North West Hospitals Group has 30. The Senator has correctly identified that, historically, the centralised collection of data on vacancies has been poor. I generated this list by phoning the hospitals individually. As Ms McGuinness stated, we need to measure this much more accurately on a central basis. We will need to give the Senator a specialty-by-specialty breakdown in a separate table.

Chairman: Will Dr. O'Connell send that on to Senator Colm Burke?

Dr. Tony O'Connell: I would be happy to give it to him now.

Chairman: Deputy Ó Caoláin indicated that he wishes to ask a question.

Senator Jillian van Turnhout: I did not yet receive all the answers to the questions I asked.

Chairman: We will get to those. I will take Deputy Ó Caoláin's question in the meantime. I ask members to confine their contributions to one minute, because the Minister is obliged to leave at 2.20 p.m.

Deputy Caoimhghín Ó Caoláin: I thank Dr. O'Connell for his detailed reply. Am I correct in stating that he said that the new investigation into the unfortunate outcome at Cavan Hospital in November 2012 would be up and running next month?

Dr. Tony O'Connell: Yes, it will.

Deputy Caoimhghín Ó Caoláin: Does he know how soon the report relating to the investigation will be submitted?

Dr. Tony O'Connell: As I said, it will depend on the need to interview staff and review the reports and clinical notes relating to the relevant patients. Based on the previous investigation, I would be surprised if the report was out before the end of this calendar year. We are keen for it to occur as quickly as possible.

Deputy Caoimhghín Ó Caoláin: Will Mr. Hennessy confirm that the 29 women to whom we referred earlier will be provided with appropriate and alternative midwifery services on the suspension or removal of the indemnification of their midwife of choice?

I do not doubt the sincerity and commitment of the Minister of State, Deputy Kathleen Lynch, in respect of the area of mental health. I have a great deal of respect for the Minister of State but I was absolutely astonished when she indicated to me that she had not even sought the additional €15 million required for the coming year. In light of the facts outlined today by Mental Health Reform in the context of the need that exists across the entire mental health service and of which the Minister is very aware-----

Chairman: In fairness, the Deputy made those points earlier. He must conclude.

Deputy Caoimhghín Ó Caoláin: -----it is beyond my comprehension why she did not seize the moment and seek the small amount of funding that might have been available.

Senator John Crown: I am conscious of the time constraints under which the Minister is operating and I thank him for agreeing to take supplementary questions. I have been asked by several entities to obtain some clarity around the welcome announcement he made with regard to some of the new hepatitis C drugs available to the subgroup of patients who are facing into the extremely severe prospect of impending liver failure and who do not have the luxury of

waiting for the conclusion of more prolonged approval or price-negotiation processes.

Senator Jillian van Turnhout: I inquired about the model of care relating to neurology, and Dr. Carroll may have some good news for me. I would, therefore, welcome it if an answer were provided in respect of the question I posed. On child and adolescent mental health, there is a need for national co-ordination. I am more concerned now than ever with regard to what is happening in this area, particularly in light of the evidence I have heard in respect of a number of cases throughout the country. I would like more time to explore this matter with Dr. Carroll.

Chairman: We will include it in our work programme.

Deputy Ciara Conway: I received an indication that one of the directors would answer my questions, but I have not yet received any replies.

Deputy Leo Varadkar: New medicines - direct-acting antivirals - are now available to treat hepatitis C. These are much better than the existing drug treatment, interferon. In possibly up to 95% of cases, these new antiviral drugs can clear the virus entirely. It is really a wonderful advance in modern medicine that we can now cure many patients with hepatitis C. The new drugs are, however, very expensive. My counterpart in France has said she believes they are so expensive that they could - on their own - undermine the future of her country's health system. That is saying a great deal. Obviously, these drugs must be subject to the normal processes in order to ensure that they are cost-effective, etc. However, there is a group of patients whose needs are exceptional. More than 100 patients have been identified as being at risk of irreversible liver damage if they do not receive treatment soon. It is intended to begin treatment within the next few weeks, via an early-access programme, for those patients who have been identified as being in the greatest clinical need. This will require an agreement with the companies that supply the medicine, which are both currently offering different deals in respect of an early-access programme. We will need to assess - very quickly - which deal is the best to accept. The group of patients involved will be treated differently by means of the early-access programme to which I refer because they cannot wait for the normal processes to be followed.

Senator John Crown: I am very grateful to the Minister for that.

Deputy Kathleen Lynch: The questions posed by Deputy Ó Caoláin and Senator van Turnhout are related. I have learned in the past number of years that the structure relating to and the way in which a service is delivered are as important as the service itself. Volumes of staff can be brought into a service but if they are not operating within a robust structure and if there is not a good team-building model in place for them, one could very well find one's self with the people filling additional posts having very little to do. We are intent on ensuring that there is such a robust structure in place in the area of mental health. The story with regard to mental health services is not at all as bad as it is being painted. I meet hundreds of people every week in respect of this issue and I am aware that the position is not as bad as is perceived.

Senator Jillian van Turnhout: What about the position in respect of Carlow-Kilkenny?

Deputy Kathleen Lynch: This will not be the last time the Senator and I discuss this issue, and she is aware that we have put a national co-ordinator in place for child and adolescent mental health services. We took the latter step on foot of additional information and I am of the view that it will pay dividends. Most people might not consider this to be a front-line post but I am of the view that it is vitally important that there should be such a co-ordinator. Sometimes it is as much about the structure used to deliver a service as it is about the service itself.

As a result of what has been said at this meeting and in the interests of doing something more positive, I will consider reinstating the monitoring report. I am of the view that it is time this was done.

Chairman: It is now 2.20 p.m., if the Minister wishes to leave.

Deputy Leo Varadkar: I again apologise for being obliged to leave. The oversight forum on drugs is meeting at 2.30 p.m. and I do not want to miss that.

Dr. Aine Carroll: With regard to the questions put to me, the clinical advisory group is scheduled to meet on 5 November. It is anticipated that when the group has agreed to the current draft of the model of care, it will be circulated for much wider consultation. The outcome from that consultation process will be fed back into the final model of care.

In conjunction with the medicines management programme, my colleagues in primary care and acute hospitals and I are in the process of developing protocols in respect of the prescription of high-cost medication. We will be examining the position with regard to rheumatology drugs in the first instance and we will then be looking at neurology drugs. My colleagues Chris McGuigan and Niall Tubridy have done a great deal of work in respect of high-cost neurology drugs. We will be developing protocols to drive the process forward and getting rid of the postcode lottery.

Dr. Tony O'Connell: With regard to the question on orthopaedic waiting times, the challenge across all outpatient settings is that there has been a 10% increase in referrals to clinics. We have been able to increase activity despite the budgetary restraints that apply. However, we have only been able to increase it by 8%. In other words, there is a gap between the levels of demand and supply, both of which are rising. This has been a challenge for us. Due to the effective squeezing out of scheduled elective activity in our hospitals as a result of the increases in emergency activity to which the director general referred, this year has seen a reduction in orthopaedic booked activity. I refer here to a 2.9% decrease in inpatient numbers and a 2.1% reduction in day cases.

Nevertheless, when one compares this year with the same time in 2010, there has been an overall increase in activity of 4.6%, which is extraordinary. This reflects the fact that despite the financial challenges we face, we are becoming more efficient through programmes such as the productive operating theatre programme utilising lean methodologies, as well as becoming more efficient in how we manage the overdues on the lists in order that we attempt not to have too many people waiting for too long. As for the questions about the cardiac catheterisation service at Waterford, I might just quote the exact words in the so-called Higgins report on this issue. It is referred to in only two sentences and states:

> Waterford Regional Hospital will continue to provide invasive cardiology services for the South East population. Working in collaboration with the cardiology service in Cork the current service should be extended with new joint appointments of cardiologists.

The Higgins report is actually a description of the way in which hospitals should be arranged into groups as it is not seen as a service planning exercise by the Department. Nevertheless-----

Deputy Ciara Conway: An undertaking was given at the time.

Dr. Tony O'Connell: Nevertheless, as to what has happened since the Deputy raised this

question at the previous meeting with the joint committee, a permanent consultant has commenced on 1 September and a third consultant has commenced on a temporary basis in August 2014 and, of course, there are other staff in the service. As the Minister stated clearly, to make investments such as a second catheterisation laboratory at a cost of €1.9 million with total revenue costs of €2.7 million for a 24-7 expansion, it is appropriate to draw up a business case to examine the benefits this provides. The service is addressing patients appropriately. The majority of patients within the existing nine-to-five arrangements certainly were not embarrassed by the planned maintenance that occurred on 13 August. There was no interruption to services, as additional sessions were put in place in the cardiac catheterisation laboratory to ensure patients were not disadvantaged.

Senator van Turnhout pointed out there has been a challenge in delivering cardiac rehabilitation throughout the country, and certainly a number of the rehabilitation co-ordinators believe the quality of service has been reduced. I am concerned about that and will meet the two relevant clinical programme leads tomorrow, that is, the programme for coronary care and the programme for cardiac failure. This is a long-standing appointment I have had with them, which will take place tomorrow, to sort out exactly what can be done about this within the current financial constraints. One comforting point noted in the written response is that there has been a highly successful development of the primary percutaneous coronary intervention, PCI, arrangements and, of course, one positive side-effect of this is that patients have their coronary ischaemia, that is, lack of oxygen to the muscle of the heart, corrected much faster. This means they are much less likely to have dead heart tissue, which results in them needing cardiac rehabilitation and experiencing cardiac failure. This is a highly positive spin-off from the great work that is being done by the clinical programmes. This does not mean we do not need any cardiac rehabilitation, as we obviously will, and I am keen to work with those two leads to make sure we do so in a way that increases the access of patients to those services.

Mr. John Hennessy: In a quick response to Deputy Ó Caoláin's question, I can confirm that all the women will be provided with an obstetric service. What I cannot guarantee is choice, as that depends on availability of community midwives and, as members are aware, they are in very short supply. I assure the Deputy that we will do our best to facilitate choice for the women concerned.

Deputy Caoimhghín Ó Caoláin: Mr. Hennessy will be aware this simply will not be a happy message. It underlines an area that needs serious address, because women have a right to make that choice. Members have a duty to respond accordingly, but are not doing it.

Deputy Ciara Conway: In respect of the planning of resources between Cork University Hospital and University Hospital Waterford, how would Dr. O'Connell describe the relationship between the two hospitals in their planning for future service provision? We have discussed previously the point that the idea behind establishing hospital groups was not about making patients travel to Cork but about consultants coming to Waterford. From my understanding, this is happening on a very limited basis even where there is a huge vacancy of consultants, as Dr. O'Connell read out earlier, in University Hospital Waterford. Why are we not seeing the throughput of consultants within the group into University Hospital Waterford?

Dr. Tony O'Connell: That is a matter for the group's chief executive officer, Gerry O'Dwyer, who will be overseeing how all the services between the hospitals in the group will interface with one another and how they will share rosters for the specialists. Cork itself is challenged in terms of its ability to mobilise staff. Clearly, the hospital groups give us a framework within which this is much easier to occur than previously. One thing I did last week was to issue a

directive to all hospitals in Ireland that all future consultants must be appointed not to an individual hospital but to the entire group, in order that we can make the most use of this resource and get the economies of scale that come from having people who will work across hospitals. In practical terms, this is challenging because of distances between and limitations within hospitals. However, the idea - certainly this manifestation of it - is to make the most use of this resource. Perhaps I can get Gerry O'Dwyer to provide more information to both the Deputy and me on precisely how he envisages this working over the next year.

Chairman: I thank the witnesses for their attendance and patience. I again apologise for the inordinate delay during the vote. I again thank the staff working in the Department of Health and the staff of the HSE for the courtesy and professionalism towards members, as well as to all their patients in the care of the HSE. The joint committee will adjourn-----

Deputy Caoimhghín Ó Caoláin: I have one matter I wish to raise.

Chairman: We will go into private session.

The joint committee went into private session at 2.28 p.m. and adjourned at 2.35 p.m. until 5.30 p.m. on Tuesday, 4 November 2014.