DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Déardaoin, 17 Nollaig 2015

Thursday, 17 December 2015

The Joint Committee met at 11.15 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Joe Costello,	Senator Thomas Byrne,
Deputy Regina Doherty,	Senator John Crown,
Deputy Peter Fitzpatrick,	Senator John Gilroy,
Deputy Seamus Healy,	Senator Jillian van Turnhout.
Deputy Billy Kelleher,	
Deputy Sandra McLellan,	
Deputy Mary Mitchell O'Connor	
Deputy Caoimhghín Ó Caoláin,	
Deputy Dan Neville,	

DEPUTY JERRY BUTTIMER IN THE CHAIR.

The joint committee met in private session until 11.25 a.m.

Acute Hospital Services: Discussion

Chairman: Apologies have been received from Deputy Ciara Conway.

Before we begin the main discussion, on my own behalf and that of the joint committee, I pay tribute to and congratulate Mr. Geoffrey Shannon on his appointment as a judge. As members know, he is the Special Rapporteur on Child Protection, as well as chairman of the Adoption Authority of Ireland. He has been an eminent spokesperson for and advocate on behalf of children. I formally congratulate and thank him for the work he has done and his courtesy and co-operation with us. He will be a huge loss to the committee, but we wish him well in his new career. I propose that we write to him to congratulate him. Is that agreed? Agreed.

This is the first of a number of meetings we will have, if we are back in the new year, that is, on the reconfiguration of acute hospital services. This morning it is the turn of acute hospital services in Cork and Kerry. One of the key aspects of the reform of the health service is the streamlining of services at group level. I welcome Mr. Michael O'Flynn, former chairman of the non-executive advisory board that produced a comprehensive report on the reconfiguration of acute hospital services in Cork and Kerry. He is joined by Professor John Higgins, a former director of acute hospital services in Cork and Kerry, who has also been very prominent and is one of the major drivers of health service reform in the region. We are also joined by Mr. Gerry O'Dwyer, chief executive officer of the South/South West Hospitals Group. All of our guests are welcome and I thank them for being here. I wish to advise members and witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not comment on, criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable. I invite Mr. O'Flynn to make his opening remarks.

Mr. Michael O'Flynn: I thank the committee for giving us this opportunity to share our experiences as members of a non-executive advisory board that supported and challenged from the outside a major health service reform project. As the Chairman has mentioned, l am joined by Professor John Higgins, who is the former director of reconfiguration for Cork and Kerry; and Mr. Gerry O'Dwyer, who is the CEO of the south and south-west hospital group. The project we are discussing today was based on a document, "Reconfiguration of Acute Hospital Services, Cork and Kerry: A roadmap to develop an integrated university hospital network". Much of this statement is covered in more detail in my chairman's report to the Minister, Deputy Varadkar, which was published by the HSE in December 2014. Everyone in Ireland is aware of the ongoing issues in our hospital emergency departments and the significant waiting lists for accessing some services. These issues remain major national challenges. Unfortunately, I do not bring any immediate solutions. However, I want to highlight a reform process that will bring long-term advantage to hospitals and communities in our region as they tackle health care

challenges, while ensuring there are adequate primary care centres with appropriate diagnostics for hospital avoidance. I want to make a few simple but fundamental points, before bringing in my colleagues to assist me in answering the questions that members may have.

The reconfiguration of services in counties Cork and Kerry was a significant health reform project. It brought about real change in the way health services are delivered in both counties. We sometimes lose faith in the capacity of the health service to achieve reform, but it can do so when it goes about reform in the right way. I would like to mention some headline outcomes from our experience. Over 800 staff transferred their places of employment without any major industrial relations issues arising. One hospital changed from being an acute hospital with an emergency department that was open 24 hours a day, seven days a week, to being a dedicated elective hospital with no emergency department. The number of emergency departments and hospitals performing emergency surgery in Cork was reduced from five to two. This was supported by the introduction of advanced paramedics and intermediate care vehicles throughout Cork and Kerry. Local injury units and medical assessment units were established at the other sites to support the two 24-7 emergency departments in Cork city. The local injury units have achieved a 65-minute average time from patient attendance to discharge.

The transfer of the stand-alone St. Mary's Orthopaedic Hospital to a dedicated elective hospital at South Infirmary Victoria University Hospital resulted in the same quantum of service being provided with a reduced number of staff. The remaining staff were redeployed to open 50 extra long-stay beds in community nursing units and to enhance support services at Cork University Hospital. The new model of care at South Infirmary Victoria University Hospital enabled the achievement of the best figures in the country for length of stay for hip and knee replacements and a 48% reduction in the number of patients waiting to be seen in the first year after service reconfiguration. Reconfiguring services at Bantry and Mallow by ceasing emergency and inpatient surgery and developing strong day surgical services, with visiting outreach consultants from Cork city hospitals, has provided safer and more sustainable services that comply with the recommendations of the small hospitals framework and the relevant HIQA reports.

The provision of cardiology services was consolidated from multiple sites to a new purpose-built unit at Cork University Hospital. The provision of pain medicine, plastic and maxillofacial surgery was consolidated from two sites to a purpose-built unit at South Infirmary Victoria University Hospital. The adoption of lean principles for the pain service led to a 49% reduction in the number of patients on the waiting list in the first 12 months following this transfer. The wait time was reduced from three years to nine months. The consolidation of all gynaecology cancer surgery at Cork University Maternity Hospital involved the reciprocal transfer of benign surgery to the South Infirmary Victoria University Hospital. Significant savings in the amount of time spent on call out of hours by non-consultant hospital doctors have been achieved through the amalgamation of services on one site or the introduction of cross-city on-call arrangements. Information technology improvements have been achieved through the roll-out of the integrated patient management and national integrated medical imaging systems and the development and roll-out of electronic referrals from GPs to outpatient clinics. The reconfiguration team provided the executive support and the pilot sites for this national project.

I would like to place it on the public record that my experience with this grouping is that this large-scale reform project achieved significant results over a five-year period with phenomenal commitment from front-line staff, clinicians and managers. However, this could not have been achieved without formal structures for managing the change and bringing people along

with the process. I will mention the key elements of this. The dedicated reconfiguration team, which was well resourced, had the singular task of reconfiguring the hospital system. A reconfiguration forum, which was chaired by the director of reconfiguration, met every two weeks and acted as a steering group. This forum, which comprised clinical directors, senior hospital and health service managers, a GP representative and representatives from the UCC college of medicine and health, kept going through thick and thin. It heard presentations, discussed issues, took initiatives such as commissioning lean projects and got medical students to upload data from theatre log books so theatre usage could be analysed. Over 40 clinical subgroups were formed to discuss and feed in the views of specific clinical services. This brought to the table a depth of understanding and a realism that informed all the detailed reconfiguration moves and ultimately resulted in the successful implementation of much of the report.

I had the privilege of chairing the non-executive advisory board, which brought together some of the most senior clinical, financial, legal and educational corporate executives in Ireland. For a period of five years, they gave their time and commitment freely to ensure the project did not fail. They supported and challenged the director of reconfiguration and his team and the HSE south directors. They mediated with the HSE corporate team and with the political system when necessary. Most of all, they gave the director of reconfiguration confidence that he was supported from outside the system by people who knew what was involved in managing and changing large organisations. I will give three specific examples. In March 2010, after six months in existence, questions arose over the respective roles of the director of reconfiguration and HSE south's regional director of operations. Members of the non-executive advisory board engaged actively with the CEO of the HSE and others in the HSE corporate management team to get all parties to agree a document on reporting roles and a series of actions to enhance communications. This was a critical moment in the project. I believe the actions of the board were vitally important in resolving the issues at stake.

In September 2010, the board was asked to advise on the launch of the reconfiguration roadmap, which had almost been completed. It offered a number of strategies to support a successful launch of the roadmap. For example, on 3 November 2010 it brought all reconfiguration clinical subcommittee chairs together to sign off on the draft report. I believe this was a major factor in ensuring universal clinical and institutional buy-in to the final report, which was successfully launched later that month. In particular, it allowed some last-minute issues to be raised and addressed that otherwise could have derailed the consensus. The board was anxious to assist and support the implementation of the roadmap. To this end, it established three subgroups, which met from 2010 to 2012, in the areas of governance and external partnerships; finance and strategic planning; and change management and communications. Membership included senior managers from HSE south and members of the reconfiguration team. Each was chaired by a member of the non-executive advisory board. It is clear to me, as the chair of the non-executive advisory board, that competency-based boards with business, finance, health care, legal and education skills will provide effective oversight and objective support to our health system and challenge that system. All external members of this board gave of their time *pro bono*. Many of their skills are transferable. People in the corporate world understand the power and pressures that are at play. Most of all, they know that all users of the health service want it to work for ourselves and our loved ones when the time comes.

The implementation of the reconfiguration roadmap is a work in progress. As we approached the end of the immediate implementation phase, we were greatly encouraged when the then Minister for Health, Deputy Reilly, published the report on the establishment of hospital groups in May 2013. This report provided for six hospital groupings, each with its own board and

principal academic partner. I was delighted when one of our advisory board members, Professor Geraldine McCarthy, was appointed chairperson of our group board in the south and south west. I am happy to pass the baton to her to finish what we have started. The establishment of hospital groups in line with government policy follows HIQA recommendations that boards should be competency-based rather than representative. From our experience, I would wholly support that conclusion. I encourage the current Minister to appoint the board and enable its work to commence. What is the work we are handing over to the new board? There are four large projects which are well under way to being completed and we may be assured that they will. These projects comprise the transfer of ophthalmology from Cork University Hospital, CUH, to South Infirmary Victoria University Hospital, SIVUH; the consolidation of paediatric services at CUH; the development of a regional gastroenterology service at Mercy University Hospital, MUH, and development of a regional laboratory service.

There is one which is complex and difficult and probably the issue which the board is most disappointed about not having seen delivered, namely, the reconfiguration of general surgery and a single on-call surgical rota for Cork city. One project was largely overtaken by events. However, it has become a great deal more likely now that the academic health care model has been accepted as a valid form of relationship between hospitals and universities. It will see the development of a memorandum of understanding between the HSE and UCC leading to an academic health care centre arrangement linking health and higher education in a single governance model.

The last project involves finding the location of a site for a new elective hospital for Cork which would, in time, replace the city centre sites of SIVUH, MUH, and the dental hospital and to allow the expansion of all diagnostic services as appropriate. What is needed is a second hospital site in Cork city which would be developed in a modular way over 15 years as an elective hospital with the latest facilities for day surgery, diagnostics and ambulatory care, as well as with a number of elective beds for inpatient surgery, which would replace the three existing hospitals in Cork, namely, SIVUH, MUH and the dental hospital, resulting in synergies in the services.

CUH and this new hospital would be a single hospital on two sites, one specialising in acute admissions and the other specialising in elective and day surgery but both managed as a single entity by the South-South West Hospital Group. Services would be truly complementary. The site needs to be within easy travel distance of CUH, linked by good public transport. The advantages are real and substantial. The new hospital should be designed and built in a modular fashion over time, using financial resources allocated to key reconfiguration projects to commence its development as those resources become available. Capital moneys would not be wasted on piecemeal developments on the existing sites but could be spent in a cost-effective and incremental way. Services at CUH and the new hospital would be complementary rather than competitive, both being managed by the South/South West Hospital Group. UCC, the primary academic partner of the South-South West Hospital Group, would be partner to the planning from the outset, thus creating a teaching hospital in the fullest sense and a flagship for the proposed academic health centre linking UCC to the South-South West Hospital Group. UCC has already indicated it wants to build a new dental school and hospital. This needs to be on the site of the new hospital. UCC really needs to know the location now. Accordingly, the urgency of this situation cannot be stressed enough.

The effect on staff morale and performance would be transformative, making the task of attracting and retaining high-quality clinical staff much easier across the hospital group as a

whole. CUH would be enabled to develop as a truly effective level 4 emergency hospital for the city and a provider of last resort care for the region. Outpatient and ambulatory services at the new hospital would serve the city as a whole, planned *de novo* with full account taken of patient flows, logistics, parking, diagnostics, clinical therapies, clinical teaching, day patients, pre-op assessment, etc. The transformation of acute service delivery on such a scale will have a major and increasing impact on hospital performance reducing average length of stay statistics and waiting lists.

This is a vision that is practical, necessary and urgent. There are no major impediments to delay its realisation. Both SIVUH and MUH are committed to it. The establishment of the hospital group provides the decisive management and governance initiative to facilitate and oversee the development. It does not even require major capital outlay in the initial stages. We are arguing for a staged commitment over ten to 15 years, beginning with site choice and acquisition, followed by concept planning, consultation with local authority planners on transport and logistics, as well as with other hospitals in the group. We are seeking support for a decision in principle to locate and purchase a site for a modern elective hospital in or around Cork city, with ready access to main transport corridors, and to commence planning for the phased transfer of services under the auspices of the South-South West Hospital Group. The new elective hospital would be planned so that it can be built in a modular way as resources become available. We also must future-proof it for the next generation by picking a site which is sustainable.

The past several years have been difficult for the whole country. I have had some well-publicised issues in business. However, while all that was going on, my involvement in this project gave me hope for the future of our health system and for our country. With this in mind Chairman, I commend the efforts of all those I have worked with over the past five years. I ask you and your committee for continued interest and support as we look to secure the future of our reforms with a second hospital site in Cork.

Deputy Billy Kelleher: I welcome Mr. Michael O'Flynn, Professor John Higgins, and Mr. Gerry O'Dwyer and extend my best wishes to them for the festive season. I thank them for their work on this issue.

The report was detailed in its content. Was it based on the Horwath and Teamwork review of acute services in HSE South? The delivery of acute hospital services in the south and the hospital groupings do not exactly mirror each other because we have an expansion of that hospital grouping to include Waterford and south Tipperary. This means it is a larger geographical and population area. Are there any issues that have to be addressed in the overall reconfiguration of acute hospital services? Will that change any of the strategies or long-term planning and vision in the general region or is it just an administrative and management issue? Does further research have to be done on this? South Clonmel has had 1,200 to 1,300 births every year, for example. There is a move to bring ophthalmology and other services from Waterford to Cork. Will services be sustainable? All of these will place further additional pressure on the tertiary hospital in Cork if we do not have a strategic plan to develop a second tertiary academic hospital there.

We often discuss acute hospital services in isolation. I accept this report has not done that. For too long, however, we have been obsessed with the acute hospital being the provider of all services. When we are looking at developing strategies across the health service, we need to take account of GP services, community services, primary care centres, urgent care centres and acute hospitals. In the overall report, does Mr. O'Flynn see a need for us to look holistically at the further development of policies and initiatives which provide health care across our

communities? Should it be a case that we are not looking at primary care centres based on one set of criteria which are not complimentary to the broader acute hospital service itself? Many people attending our acute hospital services, particularly our emergency departments, should not be there in the first place. That has been statistically proven time and time again. If we had a stronger primary care network with more diagnostic availability for GPs and more decentralised, then we have more capacity for elective care.

On the issue of academic research and innovation linking UCC and the teaching hospitals, Mr O'Flynn stated a memorandum of understanding would be required. Is there something similar in place already?

The reconfiguration of services often happens not because of strategic long-term planning but for the need to contain budgets. It is dressed up as reconfiguration. This has happened time and again across the State: a tightening budget, capital plans shelved and current expenditure rolled in so services are reconfigured. The theory behind reconfiguration is to centralise in centres of excellence and farm out the least complex surgery and treatments to primary care and the peripheral hospitals but traditionally that does not happen. Instead, there is centralisation but less complex treatments are not transferred. Is there any acknowledgement in this report of the need when reconfiguring to take a twin-track approach rather than centralisation? This is not a political point but an observation that is widely acknowledged.

When people see reconfiguration and concentration of services the elective issue is not the major concern but emergency services cause huge concern. People will travel a distance for elective care, surgery and diagnostics. Did the witnesses consider the ambulance and emergency services for the whole region when proposing the reconfiguration?

Every politician will be promising to have one of these services in his or her townland between now and February. When the witnesses talk about a modular hospital and space, I assume they mean physical space in terms of acres or square metres for sites, and by public transport they mean trains, buses and proper motorway structures. Have they also considered the additional, eastern part of this new hospital group in terms of proposing a hospital site? It does not have to be in the east of the city but there will be extra capacity required in the long term because the hospital groupings will take in an additional 200,000 people. Has that been taken into account or is there scope to amend this to allow for that to happen?

I thank the witnesses for their efforts. Public service, professional and voluntary is often not appreciated but should be acknowledged.

Deputy Sandra McLellan: I welcome the witnesses and thank them for their comprehensive report. It is detailed in content and not only does it tell us what they do but asks questions and provides some answers too, which is very useful.

What surgeries are they referring to when they say some have not gone well? What are they doing to address that? The one that comes to my mind is orthopaedics, the length of time some people have to wait to have knee and hip replacements. I know many who take out private loans because they are in so much pain and have to wait so long. The witnesses spoke of waiting lists coming down to nine months but I know of people who are waiting four years. What are the witnesses doing to tackle that?

Chairman: That would not be part of the witnesses' remit. They might be good but they are not that good.

Deputy Sandra McLellan: I thought they might have something to do with planning orthopaedic surgery and waiting times.

Chairman: We will come back to that issue.

Deputy Sandra McLellan: I apologise for that. I agree with Deputy Kelleher about the need for more primary care centres. Our accident and emergency departments are constantly full. I see a reference to a nine-hour turnaround in them. There are local injury and medical assessment units which have a 65 minute turnaround. This shows that we need more primary care centres.

People are always concerned about ambulance services and I see a mention of intermediary care vehicles in Cork and Kerry. Are they meeting their target times or what percentage are meeting them in the city as against the rural areas? Has the service worked out well? How can it be improved?

Deputy Seamus Healy: I welcome the witnesses and thank Mr. O'Flynn for his presentation. They have done huge work, to a large extent successfully. The proposal for an elective modular hospital in Cork city provides a key for the future.

Although the reconfiguration is for services in Cork and Kerry it seems to be more Cork and city-based. What has the effect of this reconfiguration been on the Kerry services, particularly those at Kerry General Hospital? What effect, if any, will the addition of half of the old south east region to the South-South West hospital group, including Waterford University Hospital and South Tipperary General Hospital, have on the future services in Waterford and Clonmel?

Deputy Mary Mitchell O'Connor: I do not know Mr. O'Flynn, apart from what I have seen publicly about him. I am very glad to see this work. At least it is not all negative. I am not going to talk about Cork and Kerry.

We are building a children's hospital in Dublin and it has been mired in controversy about where it will be located but mostly about the position of the car park. That stuns me because if I had a child, or when I have a grandchild in the next few months, I would be more interested in knowing the best place for that child to go if he or she is sick. Have the witnesses identified a site? This is very important because the nonsense that has gone on over the children's hospital is frightening. Maybe I am missing out on something but the transfer of the National Maternity Hospital from Holles Street to St. Vincent's Hospital seems to have gone seamlessly and I do not hear talk about car parking. I would like the witnesses to deal with the site issue. It has to be a hospital of excellence.

Modular schools are prefabricated buildings but when the witnesses talk about a modular hospital building I take it they are talking about, for example, putting in the maternity department first and adding to it. I wish them luck and hope they will tie down the best site for the children's hospital. They had better include the politicians in their deliberations or it will be going on for years

Chairman: The most startling comment in the Deputy's proposal is that she is going to be a doting grandmother. I call Senator Colm Burke.

Deputy Mary Mitchell O'Connor: Yes, in May, please God.

Senator Colm Burke: I thank all the witnesses for the work they have done in this regard.

It has not been an easy job because all sorts of power games go on all the time in the medical profession and within the entire hospital structure. Consequently, it is a great achievement to have effected the change that has come about. The position in Cork always intrigued me in that there were a number of different hospitals in which everybody did a bit of everything. The present position, with the grouping together of particular services into one hospital or another, has worked out reasonably well. Much work has been done and it was necessary to jump a lot of hurdles to achieve this goal. I thank the witnesses for the work they have done in this regard and it has been a huge achievement. There is further work to be done, such as with the maternity units, for instance. Cork had three maternity units but now is down to a single newly built unit and that has worked out effectively. Another example that always intrigued me was paediatric services and how such services were offered in all three units whereas people now are working towards having paediatric services offered in one unit.

At present, Cork has two voluntary hospitals, namely, the South Infirmary-Victoria Hospital and the Mercy University Hospital. In the proposals outlined by Mr. O'Flynn, what will be the role of the voluntary groups in this restructuring? In particular I am considering this from the point of view of funds that could be made available in that the sites of both the aforementioned hospitals are in the middle of the city.

Chairman: Might the Senator have an iPad near the microphone? It was buzzing but appears to have stopped now.

Senator Colm Burke: My apologies. I refer to the role of the voluntary hospitals and, in particular, the value of their sites. If the voluntary hospitals no longer will be part of the structure, what will be their attitude about the structures they own and the funding that could be realised from those sites?

The second issue I wish to raise concerns the roll-out of the modular building. My understanding is if one does this, one still must put in all the services, such as broadband, sewerage systems, water supplies and car parking, at an early stage if one wishes to build a large unit for the long term. Will this not entail spending a lot of money initially to put in the services? How is it intended to deal with that?

My third issue reverts to the point Deputy Mitchell O'Connor raised and is about access. I visited the Mater hospital recently for the launch of a new project and was struck by the fact that more than 4,000 staff members work there. My point is about people getting to the site, the issue of parking and the lack of public transport when trying to get there. Consequently, when a site is being identified, one must ensure there is access to public transport. How will that point be dealt with? It is not merely public transport from the point of view of patients or visitors but also from the perspective of staff members. For instance, I recently spoke to someone who works in Cork University Hospital and who now is inside the hospital by 7 a.m. to secure a parking space, even though work does not start until 8 a.m. This person tends to come in at 7 a.m. to park and have breakfast inside the hospital rather than having it at home. This is a big issue for staff members, and in the absence of a proper public transport service to the hospital, how will it be dealt with if staff members believe they must drive to the site to get there? In identifying the site, the manner in which this issue is dealt with will be important. Obviously, another important issue concerns the access of the university and its involvement in any unit.

The big issue for all members and for the two voluntary hospitals, namely, the South Infirmary-Victoria Hospital and the Mercy University Hospital, is about funding for services these hospitals wish to continue to provide. In respect of South Infirmary-Victoria Hospital in

particular, I refer to ear, nose and throat, ENT, dermatology and oncology services. How does one accommodate the fact that funding must be provided to them for the next ten to 15 years in order that they can continue to provide an up-to-date service while at the same time developing this other modular structure that has been proposed? I refer in particular to dermatology and note the dermatology service in the South Infirmary-Victoria Hospital is handling double the numbers being dealt with by St. Vincent's Hospital, Dublin. Despite this, I have heard of one secretary who has a desk under the stairs and people are sitting on the stairs while waiting for clinics because there is not enough room in the waiting rooms. Should people put up with this for the next ten to 15 years or should an attempt be made to improve services while at the same time putting forward this proposal? It is a case of how both are done at the same time and it is one thing about which I am concerned in dealing with this issue.

Senator John Gilroy: I welcome back Professor Higgins, Mr. O'Flynn and Mr. O'Dwyer. Deputy Mitchell O'Connor was concerned about the process being entangled in bureaucracy, as happened with the national children's hospital. However, Mr. O'Flynn has gone about his work in a dynamic and collaborative way and I believe he has brought most people on board with him. I congratulate him in this regard because he has done a fine piece of work. I note that within the ten to 15-year timeframe the board is considering with regard to the development of this hospital, many other infrastructural works will take place on the north side of Cork city. For example, the north ring road probably will come on board, something probably will happen at Monard and perhaps, on foot of the housing availability study, down at Ballyvolane, all of which are within a couple of kilometres of each another. In Mr. O'Flynn's submission, he stated the board is seeking support for a decision in principle to locate and purchase a site. Does the word "purchase" preclude the possibility of the campus at St. Stephen's Hospital, which I consider to be perfectly located and already in the ownership of the Health Service Executive, being the site or a site? There also is land at Stoneview, Blarney, on which there originally were plans for a hospital back in 2004. Have these sites been considered?

Deputy Regina Doherty: I thank the witnesses for their volunteering, for giving of their time and for their commitment to the project in recent years because it is a testament to the quality that currently is on the board. I wish to add a tiny note to the effect it is sad that Mr. O'Flynn was obliged to say - I know why he said it - he was pleased the boards now are based on competency as opposed to the way it used to be done regionally. It is just bonkers to think we would have done it the way we did, but that was then and this is now, so I say "well done" to the witnesses.

While I am merely being nosy, I have two questions for the witnesses. Two points Mr. O'Flynn made concerned the reduction of emergency departments from five to two and that in the reconfiguration of services, it was vital to have good transport between locations. What engagement did the board have with either sets of bodies, that is, from the National Ambulance Service, the national emergency delivery services, or from transport authorities or transport providers? Did it have serious engagement with them and did it change its plans? Will the witnesses describe this process to me?

Chairman: I invite Mr. O'Flynn to respond and Professor Higgins and Mr. O'Dwyer can come in as well.

Mr. Michael O'Flynn: I assure the Chairman they will be coming in on many of the issues. I thank members for their comments, kind remarks and observations. The questions are varied and many and I took note of many of the comments that have been made. I will deal with a few issues regarding the question of the site and then I will turn to Professor John Higgins. I

perceive the responses as being divided into those pertaining to reconfiguration and others that are touching on the system, which is not why we are before the joint committee. I will leave it to my colleague, Mr. Gerry O'Dwyer, as to how much he does or does not wish to comment on some of these issues at this meeting. As people are aware, my approach always has been to be open and frank about anything asked of me. If we can be helpful, that is why we are at this meeting.

As for the board, when Professor John Higgins invited me on day one to chair this grouping, everybody we asked agreed to serve. Many of them were not from Cork or might have had Cork connections, but it demonstrates the interest people have in being involved and in helping. This should not be ignored by the public system.

I will address the issues about the site quickly. As Deputy Mitchell O'Connor and Senator Gilroy referenced, we cannot have happen what happened with the children's hospital. Partly because I had a large interest in the children's hospital, having been on the board of the Children's Medical & Research Foundation in Crumlin for the past 15 or more years, I have a great deal of experience in this respect. I ended up in my position because I was seen to have only been involved with a Dublin hospital, albeit a national one, and I was invited to participate. I feel strongly and passionately about health, but everyone should be prepared to help. As to my involvement in Crumlin, I had a major interest in where the new hospital's site would be.

This cannot be political. No political grouping should believe it must be. The 20, 30 or 40-year vision for the region is so critical that there must be a site selection process. Let us be frank in that we have no public transport in Cork other than buses. We do not have trains or any other system. We must be practical and realise that, other than bus connections and good roads, the site selection will not be significantly influenced by public transport considerations. That said, we have not excluded or included any location. Having seen what happened in the case of the Mater, though, the selection of which I was against at the time because it was unsuitable, let the current site be what it will be. Since the process is under way, it would not be appropriate to comment, but we cannot afford delays that will hold up urgent projects.

Professor Higgins will go into this matter in more detail, but there is a need and it would be a crying shame if we did not progress with the site selection in the Cork area, devise criteria and arrive at a system to find the right site in the right location. It must be accessible to Cork University Hospital, CUH, for them to work hand in hand. Since Cork gets gridlocked like everywhere else, we must be practical about this. We cannot afford it to be otherwise. We have been spending money in recent years. I held this discussion with the prior Minister for Health when our engagement was at that point. We cannot justifiably spend money on brownfield sites and difficult buildings at existing hospitals.

One must plan ahead. The word we use is "Modular". I have seen good examples of it in Europe, particularly in Finland. A building can be created that is extensible. It is not modular in the sense of prefab modules. A point was raised about site costs. One can create car parks and buildings to be extended, so one should not create something that is not easily extended. A modular structure allows for extensions to be made in a way that has no impact on operations. It is designed so that, over a period of 15 or 20 years, extensions can be added continually without anyone realising it is a building site. I contend that some of the CUH site is overdeveloped. There is no point in saying otherwise. We must get away from that situation. I feel strongly in this regard.

We must consider a large site, albeit one that does not initially intimidate based on costs.

Hospitals should be accommodated in areas where developments should not be accommodated. This would give them a special position. We would not want the land bought to be sold for a hospital. We must ensure we get the criteria right, the site selection process right and people involved who understand that business and can lead it. We should not end up in the planning crux that affected the Mater site and was predicted by a number of people.

Chairman: Who drives the site selection process and puts the people together?

Mr. Michael O'Flynn: We need leadership from the political system. It is not difficult to find a suitable site in Cork. We do it all the time in the business with which I happen to be involved. Political leadership must say this should happen now. The requirement is immediate and we cannot afford to put money into buildings that are not cost effective or reflective of the future.

Chairman: By that theory, and reverting to Senator Burke's question, is Mr. O'Flynn saying we should not invest in the South Infirmary-Victoria Hospital?

Mr. Michael O'Flynn: We encountered this issue in Crumlin because we had to keep investing until we had a new hospital. One cannot stop investing in the structure. For example, the dental hospital is a current requirement, but include that as a catalyst project on the new site instead of trying to extend or build it piecemeal somewhere else. One cannot stop investing, but one must equally have an implementable plan. I cannot stress enough how desperate we are for that leadership decision to be made for the Cork-Kerry-Waterford region. I understand that more than Munster is served by CUH. My colleagues would know more about that.

A point was raised about surgery. It is a major disappointment for us. It was not that there was no effort.

Deputy Sandra McLellan: I know. I do not doubt that.

Mr. Michael O'Flynn: We held many meetings and much of this was new territory for me. The relationship between the executive and the advisory board was challenging at times, but co-operative and constructive. I will leave it to Professor Higgins and others to comment. I favour advisory board systems. They are not used enough in Ireland. We all could do with external help in our fields. Perhaps we did not have enough of that.

I am dealing with the site and I am happy to deal with specific questions on it, but I will hand over to Professor Higgins regarding the many points raised about reconfiguration. Mr. O'Dwyer will discuss reconfiguration as well, but also some of the system issues.

Professor John Higgins: I thank the committee for inviting us. The reconfiguration of the hospital system is unfinished business. We are focused on our area. I formally thank Mr. O'Flynn and the entire advisory board, the members of which were volunteers. They were acting as citizens of Ireland, which is what we expect and hope of people with great expertise. They helped us considerably. I also thank the staff of the hospitals in our region and the management within the HSE who worked closely with us.

Turning to the questions, I will start with Deputy Kelleher's. He mentioned Howarth and Teamwork and asked whether that report was our platform. We inherited it. On my first day, I dealt with a report that was going to be released within eight weeks under the Freedom of Information Act. The Howarth-Teamwork report provided some of the direction, but it confirmed for me something I had long believed, that is, when we want to change our health care system, there

is already significant expertise in Ireland and we do not need to get someone from Birmingham, Leeds or elsewhere to tell us how the hospitals in Cork and Kerry should be reorganised.

There were large gaps in that report in terms of detail. One related to a point raised about Kerry. There were no changes in Kerry because Kerry is a long way from anywhere else in terms of hospitals. Howarth and Teamwork seemed to have missed the location of Tralee. While the philosophy in the report was good and Howarth and Teamwork outlined fundamental changes that needed to be made, our first task was to put some distance between a report that was going to be published and what we were going to do in Cork and Kerry.

The larger hospital group will require us to re-examine some of the specifics of the services that might be in the second elective hospital, but it will not change the recommendation. The core issue is that we have two hospitals that are no longer fit for purpose. As Mr. O'Flynn mentioned, we need to look for a site for a new dental hospital and school. We are within weeks of saying that we will definitely go ahead with that. Since it needs to be built on the site of the elective hospital, we cannot spend money to build it in the wrong place. There is a bit of urgency about this.

The larger hospital group will force us to re-examine some of the individual services and the nuancing of where they are located. In fact, almost all the services at University Hospital Waterford and South Tipperary General Hospital are critical to the region they serve. In a city such as Cork, reconfiguration is much more important because it is a big urban area and there are not the distances and the access problems due to having a long distance to travel by car. Therefore, we have to achieve the efficiencies in the big urban areas. We have a requirement to produce a strategic plan, as a hospital group, and that is going to look at the whole region and will underscore the need for the elective hospital in Cork. Having said that, there will be a capital priority list. The building of this hospital, as opposed to the purchase and identification of the site, might not be the number one capital requirement, whereas the capital requirements in Waterford and Tipperary might be top of our immediate list.

Deputy Kelleher mentioned primary care in the context of configuration. We involved general practitioners in all of our working groups. They were central to all we did at the highest level of the steering group and the sub-groups that were working on project planning. We engaged with them in all the changes we made. I completely agree that we need to look at the services that could be provided in big primary care centres. However, there is a step before that, which is to say that, within our hospital system, we need to move away from thinking of a hospital as a place where people go in an ambulance but rather a place they go to for advanced diagnostics, outpatient work, elective work and ambulatory work. The problem is that the population has not trusted the system as it has changed, perhaps based on an experience that has not been as good as it should have been. We need to move to a space where we look at the development of hospitals in an entirely different frame and, in particular, where we underscore that the future of hospital care will be based much more on advanced diagnostics, ambulatory outpatient care, elective care and plannable care, and where the acute element will be more concentrated.

In terms of how we link the hospitals with primary care, the national clinical programme is one of the best things that has happened in the past five years. It is something Ireland is doing better than almost anywhere else and it provides the clinical framework for looking after patients across the two systems. This needs to be emphasised as it is beginning to have a direct impact on how patients are looked after.

With regard to teaching, training, research and innovation, we have existing memorandums

of understanding but the whole point of the hospital groups report is to move that on to a higher level. The world's best hospitals have embedded within them a shared mission for delivery of patient care with teaching, training, research and innovation. If that is how the best hospitals in the world do it, then that is how we want to do it - and how we should be doing it - in Ireland. That was a key element in the establishment of the hospital groups report. How do we do that when we have so many demands? Deputy Kelleher mentioned that reconfiguration has sometimes simply been a dressed-up version of cutting costs. While I agree, I do not think we took that approach as we had a small but very important ring-fenced budget that was critical as budgets fell across the entire system. When we launched the hospital groups report, I recall talking to the Deputies from the Opposition parties. It was Deputy Kelleher who emphasised that for the groups to work, no matter how much pressure we were under, we needed to find a small amount for a ring-fenced budget. We had that luxury and, while it was not a lot of money, it was critical in allowing us to make some changes while people were struggling. While we were trying to reconfigure, one of the phrases we used was that the urgent always replaces the important. One has to put some resources into what is important. Any ring-fenced budget is invaluable in terms of bringing about change.

With regard to the data on the use of our services, as mentioned by Deputy Kelleher and others, we had health intelligence embedded in our process which was coming from the public health service in the south. That was critical in that we could count every single patient and procedure. When we were not happy with the accuracy of the data around the number of operations we were doing in our 33 operating suites, we employed 50 medical students over a weekend to note down from the hand-written operating theatre logs exactly how many cases we dealt with in order that we could look at how these changes would impact. There is a lot of detail in that but if we are going to change the service, we have to roll up our sleeves and be willing to spend an endless amount of time on the detail. The big picture is easy and attractive but it is the detail that means there are no strikes and that patients do not fall through gaps.

Deputy McLellan mentioned surgery. We were talking about general surgery, for example, surgery on gall bladders and bowels. Orthopaedic surgery was reconfigured. In fact, the biggest thing we would have done was to close the stand-alone orthopaedic hospital and move that service to the South Infirmary Victoria University Hospital.

With regard to the intermediary care vehicles, ICVs, the key element in their utilisation is that those vehicles are bigger than the average ambulance and, while they would not be used for emergencies, it is possible to put two or three patients in them. Ours is a particularly big region which stretches from Wexford across to west Kerry, so we need vehicles such as these that can take two, three or four patients, if they are reasonably well, rather than using an emergency ambulance that should be available when a person has a heart attack. The ICVs were a long time coming. I have pictures of them in Bantry, where I go myself, and they are doing a very good job.

Deputy Healy referred to the Kerry hospital. We did focus on it at the very start but regardless of their report, we are of the view that while we accept their expertise and know they are very good international reviews, Teamwork-Howarth were actually wrong in regard to Kerry. We cannot close the maternity services or the emergency department in Kerry hospital because the facility is too distant from other options. It was great learning for us to accept that, within Ireland, we know our own system. If we are willing to accept change, we can provide the expertise, although, unfortunately, we had not been open to change in the past.

Our chairman referred to the children's hospital. I am not going to enter that debate. Sena-

tor Colm Burke highlighted the paediatric unit, which is one of the most important changes we got agreement on. We had not been able to get agreement on one single paediatric unit in Cork when we needed one, and we got that.

The two voluntary hospitals will have to be accommodated in a new group. The Minister said again this week that the Government is hoping to bring in legislation for the hospital groups by 2017, and I know he said that in two other important speeches in the last few months. It is very important that legislation comes through to make the groups a reality. Any legislation will have to deal with the legacy issues the Senator highlighted.

With regard to the modular build and the early spend, I would again refer to the UCC Dental School and Hospital, which is a university entity. We are within weeks of being able to make an announcement about the funding and the university has been working on putting the financial arrangements in place to be able to do that. We have to know where to build it, so we have to be ready. This will be a big thing for Cork and we need to know the site. That is where we are seeking help from all Deputies and Senators from Cork.

On the ongoing funding of dermatology, the second hospital will focus on ambulatory care and diagnostics because dermatology is a specialty that falls into that category, particularly in view of the fact that there are very few inpatients.

Some 250,000 patients a year attend the three hospitals in Cork. For different reasons, they find doing so next to impossible. Elderly people in particular dread having to go to any of our hospitals. There is either no parking or not enough and they find it very intimidating. This new hospital must be easy for them to access. If a shopping centre is being built, it is made easy for people to enter. The new hospital should be a different concept - it must be easy. It must have good transport links with the city but it must also have access for people in cars. We all go places in cars and we expect to be able to do so. Elderly people who are being dropped off need to be driven right to the front door in order to walk in. This seems impossible in our system whereas it happens all the time in American hospitals. They have got that worked out. The new hospital must address this. Dermatology is also a key objective. Those 250,000 people should be the first people to use the new hospital. Let us get the outpatient facilities onto that space and make access easy for patients.

In regard to St. Stephen's Hospital, I understand that the HSE capital projects have looked at all of the current sites and have done a fairly detailed assessment of them. One concern regarding this hospital is that in order for this to work, the same staff must be able to manage an operating list in CUH in the morning, finish by one and then go to the clinic. They will need to jump on a bus on a circular bus route that is continually going around. The process must be dead easy to enable the staff to be in the clinic on time ready to go. This means the clinic must be very close if the system is to work.

Deputy Doherty raised the issue of the reduction of emergency departments from five to two and asked what engagement there was on that. We engaged with the population and with the ambulance service in an unprecedented way. We met all the community organisations and the Irish Countrywomen's Association. I spoke to them several times in west Cork. We explained the importance of the change in the ambulance service and we explained to the ambulance service why what it did impacted on our ability to change things in the hospital. The ambulance service and its staff gave the Powerpoint talk in many venues, including secondary schools and local organisations, and explained why it was important to change how the services were being provided in the small hospitals, why it was important for them not to stop in many hospitals and

to go to the right one. They were terrific. Once they got going, they were impressive, engaging and quite inspiring.

I will finish on that, but I am happy to take any follow-up questions. I suggest the ambulance men should be used in presentations. They were better than us at it when they got going. The staff in the Irish ambulance service are very well trained and we should rely on them. If the reconfiguration process had an unspoken agenda, it was to energise, enthuse and motivate the hundreds of staff who engaged in the process.

Mr. Gerry O'Dwyer: On behalf of the executive, I compliment and thank the Chairman and the members for the work they did. I do not want to go back over issues raised by Professor Higgins, which have been answered comprehensively.

One of the issues is the focus for health in the future. The focus should be on ensuring that people are treated as close to home as possible. The focus of the HSE has consistently been to work with general practitioners and build up primary care centres. It aims also to work closely with the ambulance service to ensure we have a comprehensive service. Part of the roll-out of reconfiguration in west Cork was the advent in the area of a speedy response car. The effect of this has been that on a number of occasions an advance paramedic arrived, treated a patient and discharged the patient at the site or advised the patient to go elsewhere or called for back-up to remove the patient to hospital. This speedy response service has been provided while we have rolled out the reconfiguration in the south-west area.

The reconfiguration report feeds into a strategy which we must present to the Ministers in Q1 and Q2 next year. This will incorporate the three hospitals in the south east, Kilcreene Orthopaedic Hospital, University Hospital Waterford and South Tipperary General Hospital. Work has commenced on the strategy and there will be widespread consultation on it. Our chairman, Professor McCarthy, is adamant on that. This consultation will happen over the next 12 to 16 weeks, because we have a tight time frame on this.

On services, we are still in the process of completing the transfer of ophthalmology from CUH to the South Infirmary. Some construction is required to finish this, but it is in process. The paediatrics service is important to all of us. This needs to be centralised in Cork rather than leave it shared among the three hospitals that currently deliver it. Work is under way on that, phase one of the building project is under way and bids have been entered for phases 2, 2a and 3. Submissions are being made to the capital programme in that regard. The issue of site selection has been covered. A process must be gone through in that regard and it will be adhered to.

The role of the smaller hospitals, such as Mallow and Bantry, has been enhanced. We have a much safer sustainable service now, with good outreach from the centre. The figures show this. For example, approximately 15,000 people attended the local injuries unit set up in the St. Mary's Orthopaedic Hospital, run by the Mercy University Hospital, in 2014 and turn around time was noteworthy. In my view, the reconfiguration process is working and has worked. There is more work to be done and a decision must then be made in terms of where we go from here. We must incorporate the south-east component and there will be full and frank discussions with all parties on the strategy which we must present to the Minister in Q1 and Q2 of 2016.

Chairman: Can the reconfiguration model you developed be replicated across the country? Is that being done or has it been done?

Professor John Higgins: To be fair, we had the benefit of learning from the north east and the mid west, where the situation was quite fractious. On the first weekend we were in post, we had marches in Bantry and tractors half way from Bantry to Dáil Éireann. Therefore, we had to change the discussion. There is a template now. To go back to the point made about the urban areas, we have only one big urban area left as most of the country has seen significant reconfiguration. The big area left is Dublin and that is work for the new groups. Our advice would be to spend as much time as possible on engagement and to get expertise, like we did, from within Ireland but from outside of the system, who can provide business, financial, educational and clinical input that is independent and objective and to use that to ensure what is being done is right and will bring about change. We implemented significant change, which is better than to have a report that is not implemented.

Chairman: In the final part of his presentation, Mr. O'Flynn mentioned leadership within the health service area. Is that leadership in tandem with political leadership? I had to smile when he spoke about the orbital route and networking. Is there buy-in at local level from local authorities also? It is great to have the plans on paper. The work he does and has done testifies to his commitment to the development of the services, but how do we take it from the page to the next level? That is what we have to try to do.

Mr. Michael O'Flynn: The future is more important than the past in terms of the work that has been done. If there is no future for the work we have put in, we will not see it as a success. The former Minister gave us the go ahead to do initial assessment work, but we need momentum and energy to ensure a decision is made to go live with this. I am not saying initial work is not going on, but there is not enough energy or momentum behind this to deal with the critical future of health in the Cork region. That is my position and what I believe is necessary. Our group has finished its work and produced its report. I see this as very much the last event for it.

Chairman: I will call Deputy Kelleher shortly. The witnesses spoke about the site selection process. However, if the group has been stood down, as it were, what people are involved in the site selection process? Is it the Health Service Executive? I presume Professor Higgins's role in the reconfiguration is finished as well.

Professor John Higgins: My role in this area is finished. I am still on the leadership team and head of the College of Medicine and Health. I hardly need tell the committee that capital projects, above all else, are ultimately about the elected representatives making the decision. We are not asking to build a hospital. We are asking for a 20- to 25-year view to be taken, which we do not do well or often enough in Ireland, and to decide on a site. That is a political decision in which the HSE makes a choice on the site, hopefully with input from real expertise, the Government, the private sector and so forth. It is not that difficult because it is not as though there are 50 options. However, we must make the decision to look for the site. We are not building the hospital.

Mr. Michael O'Flynn: Having spoken to the current and the former Ministers, I am aware that there are always concerns about costs, but I believe we cannot afford not to make a decision. The site will not be the most expensive part of the equation, but with proper phasing and by incrementally planning it in a modular type of system, we can do it as we go, but with a master plan in a way that works for the future. I am concerned that people are saying we cannot afford to make the big decision. That is not a very economical thing to do. I am not saying the HSE is not doing its work, but as I finish in this role I must point out that it requires momentum or energy. I do not see that, but I hope the political interest the Senators and Deputies are showing will generate it. It is needed.

Deputy Billy Kelleher: Obviously, the site would have to be in the Cork city area. It must be near the hospital for collaborative work and ease of movement of staff, patients and so forth. I am sure a site can be found. What we must do is make a decision to find a site in the first place.

On a broader issue, we talk about the hospital groups, the collaborative work that universities do with industry and bringing that into the sphere. How far has that been developed with UCC, for example? There are many pharmaceutical industries in the Cork area, while in Galway there are many medical device industries, so there is huge experience available in industry. On top of that, and as we move to centres of excellence and a stronger academic and teaching input, with regard to the attraction and retention of consultants, do the witnesses see the current hospital group structure as the way to go to ensure we can attract the best because of the stronger emphasis on academic research and innovation, along with the potential for international collaboration? In addition, there are the sub-specialties. If we have a hospital grouping system, who decides at a national level about sub-specialties, which obviously cannot be in every hospital group? Who will decide that sphere of health care? Was that taken into account when considering the new hospital, elective surgeries and so forth?

Deputy Seamus Healy: Perhaps Mr. O'Dwyer will clarify something. Can I take it from what he said that strategic planning for the region either has started or is about to start? He said he would have to report to the Minister in the first or second quarter. He also said there would be consultation in that regard. The HSE and the Department of Health have not had a good track record on consultation. Are there proposals in place for a consultation and what stakeholders will be consulted? I certainly hope it will not be like the consultations in the past, where the decisions were made and, effectively, people were only consulted after the horse had bolted. Perhaps he would give us clarification on that process.

Mr. Gerry O'Dwyer: We have been asked very publicly by the Minister to present a strategic plan; all of the groups have been asked. The responsibility for that lies with our leadership team and the chair until the board is in place to do that. There will be consultation with public representatives and with all of the groups. The Deputy will see from the track record of Professor Higgins, as director of reconfiguration, and of Michael O'Flynn that they consulted people widely and came to a number of conclusions. It is our intention to follow that format in so far as we can. There will be widespread consultation. One cannot have a plan without consulting with people, securing the necessary buy-in and ensuring that there are no unnecessary battles or challenges. If one could eradicate those simply by consulting, why would one not do so? We will be consulting widely before the plan is submitted.

Deputy Seamus Healy: When might that start?

Mr. Gerry O'Dwyer: It will take off seriously in the new year. We have had some consultations with the nine hospitals and there will be more, because there are some internal mechanisms we must get right. At a point after that we will consult with all concerned. We have agreed on that and we will do it. We will present to the local HSE south forum on it and we will present to all of the Deputies, Senators and councillors, as appropriate, as we move forward. At all times we have offered to meet any groups of Deputies or Senators who wish to be briefed on any issues. That invitation has been in place all along and it has been utilised by a number of the Deputies in the area.

Professor John Higgins: On research and innovation, I could not agree more with Deputy Kelleher. A key element of the hospital groups was to embed that in the system. In terms of the value of manufactured goods and exports, health care is responsible for almost two-thirds in

value terms of what we produce as a country. We must be a place where not just manufacturing but research and innovation in health care are a central element of what we do. The health care system up to now has not accepted that as a responsibility. If the Deputy reads the report on the hospital groups, he will see a key change in policy where that is now accepted as part of the mission. It is very important. Cork has probably the biggest concentration of pharmaceuticals in the world bar none. As evidence of that, the demonstrator site for the national health innovation hub, which is a joint interdepartmental initiative, was based in Cork. It was part of the work we were doing. I am fairly sure that the national hub to be announced shortly will be headquartered in our region because of the fact that we joined the dots between clinical service, training, research, innovation and job creation.

I have a final comment about retention. We have had a long tradition of our specialists going to the world's best hospitals, becoming the best people there and then coming home to spend their working lives in Ireland. There is a grave danger of that long tradition coming to an end. What will keep them here? There is certainly an issue with salary, which has been mentioned and discussed previously, but there is also an issue with the culture within the Irish hospital system, which must be changed. A key element in that change, not the universal element, is that we have a system that is open to innovation, is ambitious and fosters enthusiasm and excellence. That is a different culture from the one we have at present. The young trainees are in hospitals overseas where that is part of the mix, and we must get them back here again. A key element in making the hospital groups a success is the link to the academic partner.

Deputy Billy Kelleher: What about sub-specialties?

Professor John Higgins: Sub-specialties cannot exist without the groups. That is the point. One wants the sub-specialties to provide service and access not just to the big hospitals but also in Bantry and Kilcreene. The way to do that is by having the groups.

Mr. Gerry O'Dwyer: I concur with Professor Higgins. It is really important from a different point of view. If we want to retain and attract the best people to our hospital group, which we intend to do, we must work in partnership with the universities and the institutes of technology. We have a strong relationship with the Waterford IT, Tralee IT and UCC, our major academic partner. The hospital system has to reform. This is the best opportunity for our hospital groups to have the best outcomes for our patients. At the end of the day, this is all about patient care. It is about ensuring patients are treated in the most appropriate location for them. It is about a seamless transfer from primary care to a local hospital and to what other service they need within our group. We need to have the best people working in our group. We need to have the freedom to operate in a different way than heretofore. That is the reason I see the new board and the groups working very differently from the system we have inherited in recent years. This is a new beginning.

The report is the platform by which we can move a number of issues forward, incorporating what needs to be done in the south east. The beneficiary at the end of the day will be the patient. The patient is at the centre of everything we in the hospital group do and is important as we move forward. We must instill that confidence. Five or seven years from now, I would hope to hear patients say they want to go there because the staff are the best and because the patients have been treated with respect, dignity and with understanding. That for me and for our group is very important. We need to change. If we get something wrong, we need to say we got it wrong and explain to people the reason we got it wrong and ensure it does not happen again. That is the reason what our group is trying to achieve is important. This is a major opportunity.

I am passionate about what we do. I am at the end of my career and I see this as a significant opportunity to provide a better service in the interest of our patients. I could be a patient.

Mr. Michael O'Flynn: To revert to the Chairman's comment on the site for the proposed national children's hospital, as Deputies and Senators have pointed out, we have seen where things can go wrong with a structure that one would imagine could not have taken the time and given rise to such a number of issues. We should not just leave it and hope it will work. We should create a structure to ensure it works. We cannot afford a delay and we cannot afford not to get it right. I would not want to have it misunderstood. We need to ensure it has public approval. It needs political input and leadership to make it happen.

Chairman: I thank all the witnesses for their presentations and, more important, for the significant amount of work in recent years. I hope it will not be a question of being stood down but rather that today will be a platform from which we can move the project forward.

I thank members for their participation. I thank Professor Higgins, Mr. O'Flynn and Mr. O'Dwyer. I hope Mr. O'Dwyer is not at the end of his career just yet. I thank them for their courtesy to us. I thank the staff of the HSE in the Cork region for the work they do.

I wish our three witnesses and their families every happiness and joy over Christmas.

Mr. Michael O'Flynn: On behalf of the non-executive advisory board, I thank everybody who has been involved with us and I thank Deputies and Senators for their interest in going through the report and understanding what we have been trying to do for the past number of years. The Chairman's closing remarks as well as the interest of members are encouraging. This is so important to us all.

Sitting suspended at 12. 55 p.m. and resumed at 1 p.m.

Task Force on Overcrowding in Accident and Emergency Departments: Discussion

Chairman: I apologise to our witnesses for the delay in starting this part of the meeting. We had an interesting and productive discussion in the last part.

I welcome Mr. Tony O'Brien, director general of the HSE, and Mr. Liam Woods, Mr. Pat Healy, Mr. John Hennessy, Ms Mary Day, Ms Angela Fitzgerald, Dr. David Hanlon and Ms Avilene Casey. I also welcome Mr. Ray Mitchell and Mr. Paul Connors. I thank them all for being here this afternoon.

This meeting was requested by Deputy Fitzpatrick to discuss the HSE's task force on overcrowding in accident and emergency departments. I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

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

I thank Mr. O'Brien for his flexibility in agreeing to a change in the meeting time today. It is appreciated. I now ask him to make his opening remarks. His PowerPoint presentation will be on the screen.

Mr. Tony O'Brien: I appreciate the invitation to attend the joint committee to discuss the issue of overcrowding in hospital emergency departments. The issue of overcrowding in our emergency departments is not just a problem for the emergency departments alone to resolve, but rather requires the entire health system to work together in order to address the issue and, hence, a number of senior colleagues from across the health care divisions are here today. All of them participate in the emergency department task force.

Before I outline the improvement measures, I would like to provide some background context in terms of hospital emergency activity. There have been almost 900,000 emergency department, or ED, new patient attendances for the year to date, as of October 2015. Some 83% of patients are seen and either discharged or admitted in nine hours or less. New ED attendances for October 2015 were 3% up on October 2014 levels. This is shown in table 1, which provides a breakdown and comparator between the two October periods, broken out by each of the hospital groups. New registrations at emergency departments were at their highest, year to date, in November 2015 at 99,418. Figure 1 shows the plot line for national monthly registrations. That shows the relative consistency, but slight increase, that is occurring there.

The week ending 9 November 2015 showed the highest number of new registrations of any week, year to date, at 25,055. This is against a backdrop of a 3.5% improvement on the INMO trolley count 30-day moving average in 2015 compared to 2014. The HSE TrolleyGAR, which is a separate measure, shows an 8% improvement for the same period. We can see that in figure 2 which charts the INMO trolley report. The blue line relates to the previous year, and the red line relates to the current year. As members of the committee can see, throughout most of the year we were consistently significantly above the previous year, but have recently seen those lines cross over as various measures kicked in.

Figure 3 shows the TrolleyGAR totals. I emphasise that these are 30-day moving averages, as opposed to day-by-day counts. That evens out some of the variability from day to day. The INMO count is a five-day week count, while the TrolleyGAR one is a seven-day week count.

The emergency department task force agreed a set of recommendations to address the issue of overcrowding in emergency departments. The HSE is implementing those recommendations and is working to ensure safer and timelier access for patients to assessment, treatment and admission or discharge. The recent escalation directive, issued on 27 November 2015, will ensure that attention and efforts are focused on new procedures and processes to prevent patients waiting any longer than nine hours for a bed following a decision to admit. It is intended that this mandatory directive issued under the accountability framework, which is part of our service plan for the current year, will drive a focus on good internal practices within hospitals such as the appropriate streaming of patients through medical and surgical assessment units; care planning and setting an expected date of discharge for every patient; use of centralised bed management systems to direct access to beds and direct the further development of short-stay, cohorted and specialty wards; and multidisciplinary team meetings planning for complex discharges. I have asked that the special delivery unit take a key role in ensuring adherence to this directive.

Within our emergency departments and acute medical assessment units, focus is being maintained on continuing to improve efficiencies in the internal processes around assessment and treatment. An immediate priority has been to reduce the number of patients having prolonged waits on trolleys. Recent improvements in sites allow for further focus on improving processes such as triage, time to first clinical decision maker, access to diagnostics, and development of rapid access pathways, such as stroke, fractured hip, etc. We are continuing to remain vigilant of the challenges that always present at this time of the year in the context of winter planning. We conducted a series of meetings in October with all hospital groups and community health organisations, CHOs, around their integrated winter plans, reinforcing lessons learned from previous years around preparedness, especially as it relates to the first two weeks following the Christmas and new year holiday period.

We are seeking to create additional capacity within the system by agreeing delegation of skills and tasks to other disciplines, for example, nurses performing IV cannulation, delegated discharge, 8 a.m. to 8 p.m. opening of radiology departments to support access to diagnostic investigations and progressing the opening of up to 440 additional beds. We are recruiting additional staff in all professions both within and outside emergency departments, EDs, who will support patient access, assessment and flow-through the services, for example, consultant geriatrician and support teams, inclusive of nurses, occupational therapists and physiotherapists, to work in the community to provide alternative to ED presentation or to facilitate earlier discharge from hospital.

For example, in Beaumont Hospital we have placed a physiotherapist and occupational therapist in the ED to assess older people in the ED and the acute medical assessment unit, AMAU, for frailty. This service, while relatively new, beginning in September 2015, has proven to be effective in avoiding admission for some patients and reducing length of stay for others. A 10% reduction of medical inpatients greater than 75 years with an average length of stay of less than 30 days is a baseline measure which compares that to 287 admissions in October with 259 admissions in the same category. It also serves to fast-track appropriate patients for comprehensive geriatric assessments.

We continually monitor and seek improvements in length of stay, LOS, and due to a reduction in delayed discharges we have seen improvements in two to 14-day LOS which in turn improves throughput and patient flow through both the EDs and AMAUs.

We are also changing services to reshape and reduce demand on ED services by improving services in primary care. For example, the primary care focus is on strengthening existing alternatives to hospital emergency departments and on creating new options for patients and referring clinicians which do not necessarily require attendance at hospital emergency departments. These include further development and expansion of the GP out-of-hours service to provide complete cover nationwide. This process will be complete in 2016, with activity levels expected to exceed 1 million patients per annum. There will be an expansion of the community intervention teams and out-patient parenteral antimicrobial therapy service, OPAT, which is now operational at 11 sites and has capacity to treat 24,000 patients per year. There will be increased diagnostic capacity to provide GP access to X-ray and ultrasound examinations without recourse to hospital radiology departments. This has meant 16,000 tests in 2015, which will expand in 2016. Minor surgery capacity in primary care will be developed, starting with 20 sites in 2015 and expanding to 80 sites in 2016. Palliative care capacity in the community will be expanded with additional specialist beds in Galway and Kerry and consultant and clinical nurse specialist appointments in under-serviced areas such as the midlands and the north east.

An increased focus on flu vaccination for vulnerable groups in partnership with the health and wellbeing division is also a key part of the hospital avoidance strategy this year. This will help to prevent flu outbreaks and the ensuing pressure these give rise to on hospital emergency departments during the winter months.

In the context of the national service plan and the additional €74 million investment package provided during the year, the HSE has been in a position to reduce waiting times on the nursing home support scheme, or fair deal scheme , to no more than four weeks as well as providing 600 additional home care packages. The funding has also enabled the opening of 214 additional public short stay beds on a permanent basis, including 65 beds in a dedicated community hospital for Dublin at Mount Carmel. We have also provided approximately 240 transitional care beds which provide 83 transitional care places every week to 17 acute hospitals across the country. This amounted to approximately 3,600 places provided in 2015. The impact of all this work in collaboration with acute hospitals and our primary care colleagues saw a reduction in delayed discharges from a high of 830 in November 2014 to a current November average of 568. This represented a 32% reduction in the overall delayed discharge numbers as detailed in the graph in figure 4 in the document circulated to members. The blue line for 2014 and red line for 2015 show the crossover that occurred as a result of the additional funding. This is a matter we discussed here in the committee in February last year.

Following their highlighting here, decisions were made at governmental level to address the key issues. Members can see how direct an impact that has had on delayed discharges. This work has helped free up bed capacity in acute hospitals for more acutely ill patients and there is evidence that this is having an impact in a number of hospitals. There are now 16 hospitals showing trolley waits below the same time last year, including six of the eight focus hospitals as per table 2 in the document on screen now. It shows the movement and percentage improvements. Some improvements are greater than others and there are some disimprovements also. As we have previously discussed, this is not one single nationally defined problem; it is a whole series of locally defined problems. The solutions are tailored and the results are variable.

With that and the sharing of this information, I conclude my opening statement. My colleagues and I will do our best to answer any questions the committee may have.

Chairman: I thank Mr. O'Brien. Before I hand over to them, I remind members that we are only discussing the emergency department task force, not the HSE service plan or any other issue. I call Deputy Kelleher.

Deputy Billy Kelleher: I wish the witnesses a happy Christmas and a successful new year, personally and in their endeavours in the context of addressing emergency department overcrowding. While it is known as the emergency department task force, we could rename it "the department of emergencies task force" given the amount of firefighting that has been required from time to time in our health services. I note with interest in the context of the previous discussion on hospital groups and primary care that new registrations at emergency departments were at their highest rate since May in November 2015 at 99,418. Given that 83% were discharged or admitted within the nine hour timeframe as laid down, one must ask why we continue to consistently send people to hospital who should not be going there. With the roll-out of primary care and primary care teams, that sector should be taking up more of those numbers if it were functioning at the level we anticipated or hoped. Nevertheless, we appear to be continuing to herd people to our acute hospitals system and primarily to emergency departments.

A cursory glance at the number of people attending our emergency departments shows that

the vast majority goes home. As such, what is wrong with our primary care strategy that it is not dealing with the issue of overcrowding in our emergency departments? We all say that it is the presentation of people at our emergency departments and the number of delayed discharges in our acute hospitals setting that is the difficulty people face on a daily basis in having to wait an inordinate time on trolleys. Of course, there have been some improvements, but there have also been disimprovements in the sense that an inordinate number of elderly people are having to wait a very long time on trolleys in our emergency departments. In that context, we have had cases that were investigated and in respect of which reports were published on the treatment of those persons. Apologies were made by hospitals and the HSE. It seems to be something, nevertheless, that continues to happen. Notwithstanding geriatric supports within the community and at step-down facilities and home care packages, it appears to be an issue that is still causing major difficulties for the HSE and, more importantly, patients themselves. I ask the witnesses to elaborate on why more and more people are presenting at our emergency departments given that the stated policy of the HSE, the Department and the Government in the primary care strategy is to have fewer people presenting. Why is that the case?

We have seen that in January every year, numbers escalate before dropping accordingly throughout the year until the following winter in November. Elective surgery was almost always blamed for the overcrowding in our emergency departments because there was insufficient throughput in the acute hospitals system. In terms of planning, the task force takes into account in winter proofing and assessment of patient flows, delayed discharges and, equally, elective surgery. Is there a policy to delay elective surgeries in January and February 2016 to allow for a reduction in trolley numbers in our emergency departments or is the same capacity and throughput for elective surgery still envisaged? Has the decision been taken to delay elective surgeries? While some elective surgeries can wait, not all are non-urgent. Very often, we seem to forget that.

In terms of the recently postponed industrial action by the INMO, what was resolved in terms of the late-night negotiations with the Workplace Relations Commission to address the issues of overcrowding, patient safety, patient wellbeing and patient dignity in our emergency departments? That was the primary purpose of the industrial action from what I could gather. It was centred primarily on the need to address patient safety. Could somebody explain to me what the outcome of the negotiations was that will impact directly on patient safety? In terms of recruitment and retention of emergency medicine consultants and nurse specialists in emergency medicine, approximately 144 vacancies exist in the emergency departments. There is also a difficulty with recruitment related to the retention and attraction of emergency medicine consultants.

An investigation was to be carried out into the leaking of an email concerning a consultant from Tallaght. A certain Dr. Gray was highlighting deficiencies in the Tallaght hospital emergency department, particularly in respect of overcrowding and care of the elderly. He referred to the pressure under which staff were working. What is the status of the investigation? It seems that when Dr. Gray came forward to advocate for patients, he was treated unfairly, at the very least, owing to the leaking of an email that had been circulated among a select few. Has the investigation been fully completed and will the outcome be made public?

Deputy Caoimhghín Ó Caoláin: I welcome Mr. O'Brien and his colleagues. On the first page of Mr. O'Brien's presentation, there is a reference to the fact that there were almost 900,000 new patient attendances in the year to October 2015. It is stated 83% of patients are seen and either discharged or admitted in nine hours or less. The reference to the period of

nine hours arises later in the document, on page 4, where Mr. O'Brien states efforts are focused on new procedures and processes to prevent patients from waiting any longer than nine hours for a bed following a decision to admit them. The period of nine hours arises in two sets of circumstances, but the reality is that the period is much longer. Mr. O'Brien talks about patients waiting nine hours for a bed following a decision to admit them. I have been dealing with the case of a person very close and dear to me who had to wait overnight for 16 hours in an emergency room before being seen this morning for a decision to be made on discharge or admission. The decision to admit was taken 16 hours after the patient presented by ambulance yesterday evening. The period of nine hours follows a significant waiting period for a decision to be made on discharge or admission. The case I am citing is not unusual; all too sadly, it is the norm. If a patient must wait the full nine hours after a decision is made, he or she could be waiting for in excess of 24 hours in total, which is not acceptable. This is an inordinate period for patients to have to wait. That 83% of patients are either discharged or admitted within nine hours still means that 17% are not discharged or admitted within that period, as in the case I have just cited. While I appreciate and acknowledge that significant efforts are being made, it is important that we recognise much more needs to be done to arrive at the necessary level of care.

Mr. O'Brien cited figures for the trolley count. Yesterday the number was 405. It has exceeded 400 again, having been relatively consistent between 300 and 400, yet we are not in the worst of weather conditions. We are experiencing mild weather; yesterday was a very mild day, as is today. The number on trolleys increased to 405 yesterday morning. I have not been able to check the figure for today. What is happening rings an alarm bell in that we are looking at the graph rising again. If the weather disimproves, it is likely that the number will increase further.

Will Mr. O'Brien confirm that the emergency department task force is temporary? If so, has the HSE considered its establishment on a permanent basis? I am not suggesting the reason for my proposal is we do not expect matters to improve.

I have covered the waiting period of nine hours following a decision to admit a patient. The opening hours of radiology departments, from 8 a.m. to 8 p.m., are without doubt very important. Will Mr. O'Brien confirm that these opening hours will apply seven days a week? Is that possible? Are the opening hours mentioned just for five days a week? Are the departments moving to opening for 12 hours straight, from 8 a.m. to 8 p.m., seven days a week? Would this apply across the board in the acute hospital network?

I welcome the inclusion of, and the reference to, the GP out-of-hours service. However, Mr. O'Brien has stated further development and expansion are required to provide complete cover nationwide. I know from the north-eastern experience that it has been very difficult to secure the participation of general practitioners and sustain the service. What particular investments is the HSE proposing to ensure a sustainable service across the board that can be developed and expanded? It was very clear on a number of occasions that the great difficulty concerned sustaining the service and access, even at the level initially envisaged.

On the 30-day moving average, why is St. Vincent's University Hospital - I do not want to invite a particular focus on it - absolutely against the trend for the eight focus sites, as mentioned on the final page of the presentation?

Deputy Seamus Healy: I welcome the HSE officials and thank Mr. O'Brien for his presentation. There are chronic circumstances in emergency departments that date back a long time, certainly to when the former Minister for Health and Children, Ms Mary Harney, announced an emergency in the early 2000s. While there have been peaks and valleys since, the situation

has effectively been chronic since that period and one wonders when and if it will be resolved. There were 18 patients on trolleys in South Tipperary General Hospital this morning, three of whom had been on trolleys for over 24 hours. That is not unusual in the hospital or in others across the country.

Surely at this stage, we need to accept that a significant number of acute and step-down beds need to be put into the system if we are to attempt to solve the problem. This must be done, together with various community-based initiatives. I welcome the community intervention teams. Specific initiatives that are required involve the reinstatement in the system of home help hours which have been cut in recent years. Where exactly will the 440 additional beds be provided? In what parts in the country are the community intervention teams to be provided? The teams were announced in Tipperary last year, but they have not arrived. Will they be in the system this year? There was also a proposal last year, which I note was supported by local and regional management, for a 12-bed step-down facility in south Tipperary. I wonder where that proposal currently stands.

I have two general questions on attendances at emergency departments. One concerns the possibility of direct admissions. A considerable number of patients attend emergency departments who have previously been in hospital not just once but on a number of occasions. They are referred by their GP to the hospital. Such patients are chronically ill, require admission and are going to be admitted even if it does take 24 hours. Has the emergency department team examined the possibility of allowing direct admissions so that patients do not have to go through the emergency department? There is also the question of elderly patients, which crosses over with the issue of direct admissions. How can we deal with very elderly patients to ensure they are not on trolleys for 24 hours? Even being on a trolley for six or nine hours is not acceptable for very elderly patients.

Chairman: I will take the other speakers now as well because, to be fair to them, they have been here all morning.

Deputy Peter Fitzpatrick: First of all, I would like to welcome the witnesses here today. I wish them a merry Christmas and a happy new year. They have appeared before the committee at various times over the last 12 months and I find them to be very honest and trustworthy.

I agree with Mr. O'Brien that the problem of overcrowding is not only for emergency departments. It requires all the health service systems to work together. The good news is that all the HSE directors are here today, so it is important for them to work together. I was delighted that the INMO called off the strike on Tuesday. That decision was important for patient safety. Mr. O'Brien spoke about teams, and it is important for everyone to work together. Citizens deserve a good health service, so it is a matter of putting our heads together and moving forward as one. What progress has the task force on emergency departments made in implementing recommendations to address overcrowding, particularly at Our Lady of Lourdes Hospital, Drogheda? As regards the escalation directive issued on 27 November, can we expect that patients presenting in Our Lady of Lourdes Hospital, Drogheda, will not be waiting more than nine hours for a bed? Mr. O'Brien said that discharges had decreased in November 2015 by 32%. Why was there such a big reduction in November? He spoke about care planning and setting expected discharge dates for every patient, so is that the reason? It is a dramatic decline, and is good news. He also referred to 440 additional beds; what progress is being made to open them up? In addition, Mr. O'Brien spoke about recruiting extra staff, which is good news for everybody both within and outside emergency departments. How many positions are available and what is the timescale for filling all of them?

The out-of-hours GP service is fantastic and Mr. O'Brien mentioned expanding it in 2016. How does he intend to expand it? The waiting time for the nursing home support scheme has been reduced to four weeks. In addition, an extra 600 home care packages have been provided. What effect will this have on the availability of hospital beds?

I had an experience at the emergency department at Our Lady of Lourdes Hospital, Drogheda. From the moment I went in the door with my family, I received an excellent service from the administrator, doctor, nurses, consultants and gardaí. All we seem to hear on television and radio are negative things. Do not get me wrong - a lot of people come to my clinic to say that the service is not great, but at the same time, many more people say the service is very good.

I want to put a challenge to Mr. O'Brien. I am a former football manager and team leader. Mr. O'Brien is the team leader for the HSE. He has all his generals beside him. I always emphasise that health is the most important thing for anyone. The old saying is that your health is your wealth. Together with Mr. O'Brien, the Minister and the money, we have everything going forward. It is important for all of us to work together into the future. As the Taoiseach says, Ireland is the best small country in the world in which to do business. Let us have the best health service in the world. With the INMO calling off that strike on Tuesday, there is a lot of goodwill among everybody. We should all work together for a good health service that people in Ireland deserve.

Deputy Joe Costello: I just have a couple of quick questions. First, I note the huge discrepancy between the two Dublin hospitals that are mentioned in terms of improvements or disimprovements in their emergency departments. The figure for James Connolly hospital is down by 18.2%, while that for St. Vincent's hospital is up by 46.7%. I wonder what the situation is at the Mater Hospital. Does Mr. O'Brien have any explanation for the huge discrepancy between those two hospitals? What I found most interesting about Mr. O'Brien's contribution was in the last paragraph at the bottom of page 5. Mr. O'Brien said:

> We are also changing services to reshape and reduce demand on ED services by improving services in primary care. For example, the primary care focus is on strengthening existing alternatives to hospital emergency departments and on creating new options for patients and referring clinicians which do not necessarily require attendance at hospital emergency departments.

These include a whole range of desirable developments that would no doubt reduce the impact on, and the workload of, emergency departments, if all of them were to be implemented.

Twenty primary care centres are currently up and running and Mr. O'Brien expects to have 80 operational next year. Do the existing primary care centres have any significant impact on accident and emergency departments in terms of lessening the workload? If so, has Mr. O'Brien assessed this? For example, in his opening remarks, Mr. O'Brien said that 83% of patients were either discharged or admitted after nine hours. I presume the vast majority of those are discharged. Presumably, also, most of those did not necessarily need to attend a hospital emergency department. Does Mr. O'Brien have any idea of the percentage that need not have been at the hospital at all but could have been dealt with alternatively, particularly by primary care centres? There is currently one primary care centre in my constituency, out of four promised, which is on the Navan Road. Next year there will be a second one in Grangegorman. Is there any correlation between the opening of this care centre and admissions to James Connolly hospital or the Mater hospital, which are adjacent to it? Might an ambulance not alternatively take somebody to a primary care centre rather than to an emergency department if minor surgery such as stitching is required? It seems to me that that will be the eventual solution. I

would like to see how it is working at present.

My second point is about delayed discharges. It is welcome that discharges are down from 830 to 568, which represents a 32% reduction. Do we have any clear figures on the delays? I have found one issue that is problematic. There seems to be no real relationship with the local authority. My constituency has a great deal of local authority housing. Let us say that somebody has a stroke and needs a ramp or some adjustment to his or her home, he or she may have to wait six months in hospital on a delayed discharge until that is done. There may or may not be alternative step-down facilities available. What is the relationship with local authorities and how effective is the HSE in that regard? My understanding is that one is simply in another long queue waiting for attention rather than being given the emergency treatment one deserves.

Deputy Regina Doherty: I thank everybody for coming in this morning and, in particular, Mr. O'Brien for his statement. What impact do the witnesses expect the negotiations, which are hopefully concluded and will be agreed by the INMO membership after Christmas, to have on the day-to-day running of the emergency departments nationally? Is it tangible? Is it possible to estimate by what factor it will reduce the hours spent in emergency departments when it is implemented in February? Money was included in yesterday's service plan for the additional 440 beds. Can the witnesses provide the committee with a breakdown as to where they are going to go over the next 12 months? Reference was made to 214 additional short-stay beds. It is easy to see the 64 in Mount Carmel because it is on stilts and highly visible. Where are the rest of them? Are the actually open? If they are open, where were the additional staff taken from to service them? There is chatter, which is not always idle, that the beds are not open and in fact remain closed in hospitals.

I could not let the opportunity pass without asking Mr. O'Brien about the article last week. At the risk of being called soft, I was very sad when I read it. I know it was probably reported in a particular context.

Chairman: In fairness to Mr. O'Brien, that issue is not on the agenda for today.

Deputy Regina Doherty: In fact, it is. If the Chairman does not mind bearing with me for one second, I am not being critical at all. The reason I was sad is that we have nearly 100,000 people, who Mr. O'Brien represents so ably, delivering what are, in the main, quality services. Mr. O'Brien is correct that we get beaten up 100% of the time for the 2% of the time that people make mistakes. While we do not always get it right for whatever reasons - be they related to functional or human error - it was sad to hear that Mr. O'Brien thinks we have no vision or plan or future. Can Mr. O'Brien describe to me the other context of that? Ms Day is here today and we have had people in before Mr. O'Brien this morning talking about the reparations programmes we have around our new hospital groupings, the delivery of primary care and our aspirations to service and remove some of the strain on hospitals by placing delivery in a primary care setting. Clinical programmes are delivering nationally and our GP services are delivering a plan. All of that represents a vision for the future of health care. While I appreciate that he might be talking long term and about 20 to 25 years in the future, Mr. O'Brien might explain to me the context of how he was feeling when he said what he said.

Mr. Tony O'Brien: I thank the members for their seasonal greetings and their questions. I was struck by the football manager reference. The last time I was here, I quoted the great prophet, Eamon Dunphy, in a similar way. I was certainly struck by the fact that the wee county that never gives up keeps trying. Success may have eluded it. Even when the ball gets carried across the line against them, they come back and play again. I hope Deputy Doherty will for-

give that reminder. The analogy is not lost on us at all.

I will be asking my colleagues to speak to the social care, primary care and acute hospital issues that are specific to their briefs. At an overview level, I note that Deputy Kelleher asked a very important question, namely, why we are seeing an increase in attendances at emergency departments. It relates to overall demand on health care. It is important to recognise that it is not a static environment. Our population, fortunately, is growing and it is growing older. That is a really good thing but there is an inevitable impact on certain types of health care services. Acute, unscheduled care is one of them. Since 2010, there has been an 18% increase in those aged over 65 years and a 17.5% increase in those aged over 85 years. People in those higher age ranges are disproportionately represented in the population of individuals who present at emergency departments and among those who require admission. That is why the issue of long waits at emergency departments is key. We know that they are disadvantageous for older persons and for frail elderly people in particular. While the fact that we are aging is a good thing, the changing nature of our population creates its own demands.

I can give the committee the exact data for the first half of this month on the patient experience time, which is the official measure we use for the experienced time in an emergency department. This relates to patients who are admitted and not admitted. In the context of the nine hours from registration to discharge or admission to a bed, of the admitted population, 61.9% were admitted to a bed within nine hours. That clearly means that some 38.1% were not. The issues relating to people who wait inordinately long periods are clearly in that proportion of the figure. We are not claiming that everyone is being admitted in the period they should be, we are simply quantifying the scale of the problem. Of the non-admitted patients seen, treated and discharged from the emergency department, 90.8% were seen and discharged within the nine hours. Together, that gives us the 83.5%. Interestingly, if we look at six hours, 44.6% of patients who needed admission were admitted to a bed within six hours of registration in the emergency department. Of those who needed to be discharged, 77.9% were discharged within six hours of registration, giving an aggregate of 69.3%. These figures are important because, over time, they will allow us to measure improvement. They tell us what is working and the scale of the challenge. We do not come here today in any way to diminish the scale of the challenge. The emergency department task force is here until further notice. Our aim is, obviously, reach a point where it is not required but it is here until further notice. To be clear, I am the co-chair of the task force and the other co-chair is Liam Doran, the general secretary of the INMO.

On delayed discharges, I ask the members to go back to page 7 of my submission and look the chart there. What is really interesting about this is that it shows the very dramatic impact a policy, funding and operationally cohesive decision can have. We clearly identified and discussed here at the committee the particular problem of delayed discharges which we identified as a key contributor to the significant increase in emergency department congestion and long waits in the first part of the year. We identified that with the fact that funding restrictions had given rise to long waiting periods for the fair deal scheme which in turn had contributed to delayed discharges. As the chart shows, while it was not quite like turning on a tap, it clearly had an instantaneous, dramatic and, thus far, sustained impact on delayed discharges. As a result, it has fed through, albeit slowly and in small ways, to the emergency department position.

In the context of the current figures in emergency departments, today's trolley graph figure is 289. It is not in the slides. The slides came yesterday. Today's figure is 289. For a little over two years, the INMO has been publishing two figures, which it aggregates together. It differentiates clearly between the two on its website, however. One is trolleys in emergency

departments and the other is other patients accommodated elsewhere in the hospital as extra patients under full capacity type measures. I have no argument with the fact the INMO does that. We do not bother arguing about figures because it is a pointless exercise. The trends in our figures and the INMO's are broadly similar. That is what we are looking at but the figure to concentrate on is the patients in the emergency departments. Part of the appropriate response to excess crowding in emergency departments is for that challenge to be spread to other parts of the hospital. Our focus is no longer on allowing this simply to be concentrated in the emergency departments, as if it were not a whole-hospital or whole-community problem. I make that distinction and I believe it is right to do so.

Yesterday's figure was a little against the trend, as was that for the day before. We saw about a 30% reduction the day before and about a 5% reduction yesterday. We think that was a direct impact of the expected industrial action. If one puts the two figures together, one actually eliminates the effect. When one does that, one sees a general trend of figures being down around 20%, day by day, in the current month. That still leaves us with a wicked problem because it is not where we need to be. When we discussed this before, as part of a more general discussion when I had just come into the co-chair role, it was clear we did not have an instantaneous solution or a magic wand. Our intention is to make it incrementally better, day by day, so the figures as we come out of this winter period, particularly in January, will be measurably lower than they were last year. Many of the measures in the emergency department task force recommendations are longer-term in nature. All commentators, including the INMO, acknowledge there is currently a measurable and perceivable improvement.

That is no comfort if one is the individual patient who is on a trolley for nine, ten, 15, or however many hours it may be. I acknowledge it is still occurring. However, the directive is designed to ensure that all of the agreed protocols are followed. In other words, no hospital should be tolerating patients waiting that length of time, unless it has exhausted all of the opportunities at its disposal. That does not mean that no patient will wait too long. It means they will not wait too long in circumstances where the hospital has not done all it should have done to minimise the numbers and the length of waiting time. There are financial sanctions for failure to follow the steps of the protocol. The financial sanctions that were there for elective targets will not apply if the hospital can demonstrate that it has had to defer elective work by following all the steps in the procedure, as a result of this situation. That is clearly stated in the directive published three weeks ago.

Deputy Kelleher specifically asked about elective care. There is clearly not a blame issue but an issue concerning the relationship between the total bed capacity of a hospital and the two pipelines of work, or demand, which feed into it, namely, elective - or scheduled care to give it its proper title - and unscheduled. There will be situations where, predictably, we will see certain events or dates where we expect surges in presentation in emergency departments. These will not be people who should not be in an emergency department but people who need admission to a bed. If the hospital is at full tilt on elective or scheduled care, it will not be able to accommodate the emergency admissions, rather than have late-in-the-day cancellations which are very inconvenient to all concerned. I accept and draw the distinction between urgent scheduled care and non-urgent scheduled care because there are categories of urgent scheduled care that are protected in this context. As part of the winter plans, we are directing that a sufficient amount of bed capacity should be retained for emergency admissions which inevitably will mean a reduction in the amount of scheduled activity. This must be on a pre-planned basis, rather than a night-before telephone call which is so troubling for patients who have prepared themselves for admission to hospital.

Mr. Liam Woods: Is there a policy to delay elective surgery in January-February? No. There is a cohort of surgery going through elective, planned or scheduled care which is urgent. Even what is referred to as non-urgent is still important. If one looks at our data, there are approximately 99,000 cases a year of elective surgery and it averages out evenly per month. When hospitals have a surge requirement, they do need to manage that and it can have an effect on elective caseloads.

On the proposed resolution with the INMO, we have a deferral of an action with a ballot to be completed by 5 January but there is still a potential strike notice for 12 January. We are in an interregnum at present. The intention of the agreement that is in place is that there would be in effect additional measures around the retention of nursing. The figure of 144 nurse vacancies in the emergency departments, quoted by the Deputy, is correct. These vacancies need to be filled, so we have targeted advertising taking place over this Christmas. This is a vital period for advertising, given the return of nurses from overseas. We should have advertisements going out this weekend. We are undertaking a campaign to seek to recruit. While we will do it on an ongoing basis, it will be in a targeted way over the Christmas period.

There are specific issues regarding the retention of nurses in services, particularly in emergency departments. This will be associated with supporting training after 12 months of stay within the services. We have 630 graduates within the service. Based on staying for an additional six months, there will be an incentive around training for the amount of €1,500 by a process to be agreed after the completion of the action. It is one of the feedbacks we get quite frequently, namely, that the capacity for career development and training is an important component of retention.

There are also some measures looking at the tasks undertaken by nursing generally within emergency departments and growing the total number of tasks to improve patient flow. That is another set of actions which will emerge from this dispute been resolved.

The escalation policy became an important part of dialogue. The deeper process we have worked out around escalation is one we have discussed in detail with the INMO. The latter was quite insistent that this policy would be included in the agreement. It sets out the steps and the escalations which are relevant when an emergency department comes under pressure. That is a document we can make available to the committee, if it would be helpful to do so.

Infection can prosper in mild weather during winter. It has done so in children services particularly. Hospitals such as Temple Street have been under a lot of pressure during the past several weeks. The respiratory syncytial virus, RSV, prospers quite well in this weather. In a strange way, cold weather would kill it off. We also monitor the influenza-like illnesses across several sentinel GP practices. At present, it has not escalated to a concerning level. However, the RSV rate in paediatrics has and has had a visible effect. We can graph and predict that and it is following a course we understand. It is set to peak in the coming week, so we are working on that. Paradoxically, bad weather has some positive benefit.

Access to radiology was raised. The eight-to-eight arrangement is in place. We are also investing in primary care and extended-day, over-the-weekend services to ensure access to diagnostics. When we look at what might cause slower flow than we might otherwise like in a hospital environment, access to diagnostics is one of those issues. If we look at some of the reasons why people are in hospital, access to diagnostics may be a contributory factor to that. We are investing in primary care and access to diagnostics outside hospitals, as well as an extended day. I would like to come back to the committee on the question of every hospital every

weekend, which is not necessarily required. There are 26 hospitals that will have emergency departments, EDs, and will primarily focus on the major areas of pressure. There is already an extended day and we are also looking to invest further in longer hours.

As the data in the director general's opening statement show, the 30-day moving average for St. Vincent's represents a disimprovement, which was associated with the change in the region as a result of St. Colmcille's going off call. It is a 30-day moving average which looks back over the past month. It has improved in recent days and St. Colmcille's is now taking more patients from St. Vincent's every day. The number is five over five days which the hospital is looking to grow to seven over seven days to ease pressure on St. Vincent's. The kind of cases that are going back are not the kind of cases that are coming in. There is work being undertaken around that at the moment. Access to Mount Carmel, which Mr. Healy can talk about more, also helps alleviate that because it provides transition care and quick step-down.

On the question of where the new beds are, I have a detailed sheet which shows where they are. I will leave it with the committee if it would be helpful. In summary, there are two components to those new beds. We are investing in 301 beds with a view to opening them in November, December and January. There were a further 150 beds that were closed but were available within hospitals. I will address those two cohorts at a summary level and I will leave the sheets which show the detail by hospital. By 18 December, we will have 206 of the 301 additionally funded beds open and the list will show where that is. It is across-----

Chairman: That is 206 of how many beds?

Mr. Liam Woods: There will be 206 of the 301 proposed new beds opened. During January, we expect to have 294 of the 301 open. Two issues affect us in opening new capacity. One has already been referred to by one of the Deputies, which is getting the staff to resource the beds. There are also some issues around physical infrastructure. If we are changing the physical nature of a facility, there will be a time implication. In summary, during January we will achieve 294 of the 301 beds and the remaining six are set out on the page.

Of the 154 beds that were closed at the end of October, as of 18 December, 111 of those will be open. In January, we expect 129 to be open. There are 17 beds closed in Galway but that is associated with a rebuilding project and they will open in the middle of 2016. They will be closed in the longer term. I will leave the schedule with the committee if it is helpful.

Deputy Regina Doherty: Can I interrupt Mr. Woods because I am a bit boggled? When he refers to the 301 beds, is that the 301 of the 440 or 214 beds?

Mr. Liam Woods: I am referring to the 440 beds.

Deputy Regina Doherty: There are 154 missing beds.

Mr. Liam Woods: Yes.

Deputy Regina Doherty: I thank Mr. Woods.

Mr. Liam Woods: That will go slightly over but the closed beds issue is moving - 301 are new beds that were not previously in the system and 154 are existing beds that are now re-opening. The 440 the Deputy is referring to is the total of the two. We have spoken about new beds.

There was a comment about the percentage of people who need to be seen in hospital. We study the propensity for hospitals to admit patients, which varies throughout the country but on

average approximately 25% to 27% of attendees are admitted from an emergency department. In some hospitals that is quite a bit higher but most studies clinically undertaken would indicate the propensity to admit is reasonable and proportionate in most circumstances. There is a separate point, which we have also studied, which is the need for a patient to be in the particular bed they are in on any particular day. It is a slightly different question. One finds that more than 20% of patients could be somewhere else on any given day but that is about investment in somewhere else. That is obviously helped by the clearing of delayed discharges and, as the director general has shown, the graphs indicate that.

The Deputy had a specific question on patient experience time in Drogheda.

Deputy Peter Fitzpatrick: Yes.

Mr. Liam Woods: I will address the question of the escalation policy and what will happen in Drogheda around that. There has been some investment in capacity in Drogheda, which the Deputy will see on the sheet. There has also been investment in some older person services around Drogheda. A geriatrician and nursing team have been provided, which has happened very successfully in Connolly Hospital to try to keep people out of hospital, or if they are in hospital, to move them very quickly back into community support.

The escalation policy is designed with a view to clearing the emergency department by escalating to additional capacity in the hospital, to which the director general has referred. There are many steps to take place before that, for example, consultants doing ward rounds or perhaps double ward rounds. It is proper practice within the hospital to ensure we are encouraging proper flow. We can leave a copy of the policy with the committee but its intention is to do precisely what the Deputy wants, which is to improve the patient experience. We know there is a challenge in some hospitals around total capacity and Drogheda is one of those. I hope that answers the Deputy's question.

I think I have answered all the questions on the acute services.

Mr. Pat Healy: I will go through each of the component parts on the social care side. One of the important steps taken with the additional investment, to which the director general referred, was stabilising the nursing home support scheme which had a very significant impact. We started that last year and brought it initially to 11 weeks in February. Once the additional resource was provided, we brought it to four weeks. This has continued throughout the year and will continue throughout 2016. It is a very important part of it because it was one of the difficulties that gave rise to some of the challenges at the beginning of the year. That addresses the nursing home support scheme. On average, 23,450 people per week will be supported in 2016 which is an increase of just under 650 people a week for 2016.

The other side of it is the short stay beds. As part of the investment the director general set out, we have added an additional 2014 short stay beds which are very important. Dublin in particular suffered because it did not have the same tradition of community hospitals as some of the rest of the country. The 65 beds in Mount Carmel have been very important and have worked very well. There are geriatrician teams which the hospitals link in with very well and it has proved to be very beneficial in supporting the type of integrated care between hospital and community, which is important.

In addition to that, an additional 214 beds have been provided. This includes 16 in Clontarf, 20 in Royal Hospital Donnybrook, 25 in St. Vincent's in Fairview, and ten in St. Mary's Hospi-

tal in the Phoenix Park. There were ten beds open in Farranlea Road, four in Heather House in Cork, two in Carndonagh in Donegal, eight in Killybegs, five in Merlin Park in Galway, 17 in the north Tipperary area, 15 in Ballinasloe, and five in Ballina district. Six beds were opened in both the Sacred Heart Hospital in Castlebar and Áras Mhic Dara. They are all open, working and staffed. Some of those only came on stream during the course of the year because we were trying to staff them. One of the benefits for winter 2016 will be that we will have the full capacity of those beds for the full year, which is an important part on the short stay side.

A number of members mentioned home care as being an essential part of that. With the additional resources, we were able to provide 1,650 additional home care packages over and above what was funded. We were approved for 600 additional people to benefit. That was put in early in the year but through the year 1,650 extra home care packages have been provided and the resource will be there in 2016 to continue that higher level of outturn. That is a positive development.

Two things have been happening in terms of home help. There will be 137,000 extra hours provided this year which will be resourced into 2016. An important part of delivery is providing a more flexible service on weekends and weekday nights. Some of the existing hours are being provided out of hours. That is an additional cost. It is obviously a premium time and we have been able to allow for that in the 2016 service plan, of which this is an important part.

The other point made was the issue of our relationship with the local authority, about which Deputy Costello asked. A number of years ago, as part of the reorganisation of public services, a number of services were moved from the health service to other Departments, and the move of community welfare officers was the largest change at that time. At that time also, EVE Holdings, which was a service in Dublin that used to do that kind of in-home work, was transferred to the Department of the Environment, Community and Local Government. The view at the time was that one should standardise that throughout the country within local government because it had the housing responsibility. There can be a confusion at times in that the HSE, in terms of home care packages or through primary care, provides aids and appliances such as wheelchairs, walking aids, commodes and that type of thing, whereas housing adaptations are dealt with by local government. Therefore, what we try to do is work closely with the local authorities, many of which at this stage have occupational therapists within their own systems. It is about trying to make that work in a joined-up way, which is something on which we will continue to focus.

Deputy Healy mentioned south Tipperary, an area to which we pay particular attention. I visited there in recent weeks. There is challenge there with a number of individuals who have complex care needs and require assistance right across primary care, social care and mental health. We have identified a support for three or four of those to enable them to go home. That type of collaborative working is a feature of the more focused work through the emergency department task force, and I use that as an example of the positive type of change that has been happening. I believe that covers most of the points.

Deputy Catherine Byrne took the Chair.

Mr. John Hennessy: I will try to address the four or five questions on primary care. I will then invite Dr. David Hanlon to comment on a number of these issues from his own experience as a practising GP and also as the clinical lead for primary care.

I will start with Deputy Kelleher's point on the big question of why people are going to emergency departments if they could be cared for elsewhere. It is a question that has been

having a lot of discussion and debate at the task force, as the committee can imagine. Clearly, people attend because they need care and treatment. The challenge for us is to ensure people can get the care they need in the most appropriate manner and the most appropriate place. For that reason, as part of the task force and under our service planning process, we have been working hard at developing and creating the capacity in primary care to fulfil that challenge.

Some of the measures will be familiar to committee members but they include, for example, the improved access to free GP care, on which we have seen developments in the current year, and the development of the GP out-of-hours service. To be fair, this has come a long way in the past ten years, from a time when each GP looked after their own arrangements to a far more structured arrangement where we have call centres, cars and drivers and clinical governance, and there have been enhancements in the current year in the north west in particular. It is a service that costs in excess of €100 million per annum and a review is under way and is due to conclude in 2016. I am hopeful we will use the findings of that review to look at issues like effectiveness, cost, value and so on to inform our future approach to GP out-of-hours cover.

That is not the only service. The activity of the community intervention teams has increased by 30% this year and will expand further in 2016 when we expect to treat 24,000 patients. Alternative diagnostic access for GPs is in the package, with, as the director general mentioned, 16,000 treatments this year and further expansion in 2016. Chronic illness management is part of the process of providing care for patients outside of hospital and, it is hoped, avoiding the necessity for patients to attend hospital for their routine chronic illness care. Diabetes is the most obvious one of these, and we have seen developments in the current year around that. End-of-life care is also part of that approach, in particular ensuring alternatives are in place through the palliative care service for end-of-life care without resorting to hospital access.

One of the questions focused on the ambulance service. An ongoing discussion, courtesy of the task force, is examining why all roads for the ambulance service lead to the emergency department. If we can create options and alternatives on that front, obviously we would like to do that.

The approach that is being taken under the auspices of the task force is to create capacity in primary care that will help avoid the necessity for people to attend acute hospitals. Again, some of that process involves changing clinician behaviour, whereby some of the practices are directing patients to hospitals who perhaps can be diverted elsewhere.

Deputy Ó Caoláin raised the out-of-hours service, which I have covered in terms of what we are doing on that front. Deputy Healy mentioned the community intervention teams and where they are located. I have a list of the ten which are currently operating and, in fact, it is now 11 as the Waterford service commenced this week. They are located in Dublin north, Dublin south, Galway, the mid-west, covering Limerick, Clare and north Tipperary, Carlow-Kilkenny, Cork, Wicklow, Kildare, Louth and Meath, and as I said, Waterford commenced its service within the past week. I am not aware of a commitment to south Tipperary.

Deputy Seamus Healy: It was announced by the local Minister last year.

Mr. John Hennessy: We will examine that. Obviously it is a priority to get as much of the country covered by community intervention teams as we possibly can.

Deputy Costello mentioned the impact of primary care centres. We have carried out a study which is being presented to the leadership team in the next week or so. It is a footfall study of

six primary care centres that might be of help to the committee at some stage to get a view of what goes on in these new centres. We would be happy to share that audit and information with the committee.

Deputy Billy Kelleher: With regard to the people who are discharged from hospital, is an analysis done of why they had to attend in the first place? Given we are talking about a 25% admission rate, 75% are not admitted, although I am not suggesting they did not have to be there. Of that 75%, is an analysis done of why they ended up in the emergency department when they did not need to be admitted? Was it lack of diagnostics or lack of supports for GPs to make a critical clinical decision in their GP practice?

Mr. John Hennessy: I suspect the diagnostic issue is a substantial part of that. I will ask Dr. Hanlon to comment on some of the rationale for that.

Dr. David Hanlon: It is a very good question. By focusing on trolleys, we have tended to focus on people who were admitted, but it is also useful to look at those who were not. As was said, anyone attending an emergency department is there for some perceived reason on their part. Again, our data are very good at collecting information around discharges and diagnostic groups, whereas much of the technology in terms of tracking the reason for people attending and what the actual diagnoses were has not been very well collated and analysed. We have looked at specific data for one hospital and it is interesting to see the patterns emerging from those. We hope to collect more information to see if that is replicated nationwide and what we can learn from it.

The large number of discharges points to a number of different things happening. For example, whereas sick elderly people are likely to be admitted, sick children are very unlikely to be admitted. However, they may need a period of observation or investigation and may need fluids for a number of hours to get them drinking again to resuscitate them and get them home. In some ways, that high level of discharge is in part a success in terms of senior decision-makers seeing them, deciding they do not need to be admitted and making an acute intervention in order that they are turned around and fit to be discharged. However, as has been said, it also hides some dysfunctionality. Within this are almost certainly elements such as problems with accessing diagnostics, and we are working on trying to improve access for GPs to services such as ultrasounds and other such elements. Some people need assessment in a timely fashion which cannot practically be done. A person may have a clot in his or her leg. I could do a blood test and look for a scan, but with the best will in the world, turning it around getting all the ducks in a row and making a decision might take one, two or three days, whereas I would really need an answer within a couple of hours. Some people are being seen, assessed, having a decision made and being discharged entirely appropriately, and it is a good outcome when these decisions are made.

It is an easy decision to make in an emergency department to admit someone. Discharging someone is always more risky as we need to be more certain. We take more responsibility when we send people home than when we put them in a bed. In some ways we should look at it as a success that we manage to discharge as many people as we do. As Mr. Woods stated, we look at the propensity to admit. We get caught both ways, depending on how one looks at the figures.

People attend because of problems accessing outpatient services or with difficulties getting services such as an endoscopy. People often feel something must be done, and a GP will wonder about the alternatives available. Mental health is another example. Acute assessment of someone with a mental health problem has been established in most of the emergency depart-

ments. Many of the people attending will be seen, assessed and supports put in place. For better or worse, it has become the access point for these acute services. There is a mix of the good and the bad. We do not have an analysis, but it is something about which we are very much aware and we hope to be able to make a bit more sense of it in the near future. We will try to inform decisions with information and intelligence and try to avoid anecdotally-driven decisions.

Deputy Buttimer resumed the Chair.

Mr. Tony O'Brien: Deputy Doherty asked me about an article in *The Sunday Business Post* last week and I am happy to have an opportunity to address it. Ms Susan Mitchell, the journalist, requested permission from us to have a little more access to the health service with a view to giving a slightly more rounded view than would normally be possible of the many different moving parts in it. As she was first to ask, we decided to grant it and she had an opportunity to sit in at part of a briefing of an emergency department task force. She attended various parts of the health service, which are generally reflected in the three pages of her article. Deputy Doherty stated what she understood by the headline, which was no vision, no plan and no future, but when I saw the tweet of the front page I noted the headline stated no vision, no money and no plan. I guess the words are similar enough. Having seen the tweet and not having access beyond the paywall, I waited anxiously to see what had been reported in the newspaper. Having read the article I must say I was satisfied with it. I thought it accurately reflected the various issues the reporter had seen and our conversations.

The headline was not made up of my words and neither were the words attributed to me as they were not in parenthesis. If one read the article one could not find those words attributed to me. This not a complaint. I understand that having invested a lot of time to get a three page insight into the health service one would want something on the front page to encourage people to buy it and which would grab attention. As I stated, it certainly caught my attention. I am glad to say they were not my words.

I spoke in the article about my view that as a country over a period of time, and I relate this right back to the foundation of the State and some of what is reflected in Maev Ann Wren's book, *Unhealthy State*, I do not think we have arrived at a place where we have a collective national settled will as to what in the very long term we want from our health service. It would be helpful if we do so. I shared this opinion with Ms Mitchell and she accurately reflected it.

I also think we have reached a point where we have a view about risk and safety in the health service which has become unrealistic. Providing health care, particularly in acute situations is an inadvertently risky business. Things do go wrong, and where they go wrong inappropriately it is appropriate there should be accountability. However, we must replace where we have what I described in the article as something akin to showtrials on performance issues. This is quite dangerous for the future of health care in this country and for the ability of professionals to make the types of decisions about which Dr. Hanlon has just spoken and have the confidence to do so. They are not charged with criminal offences but go in and out of buildings with camera crews outside, where everything is reported, including all of the allegations, but later, very little attention is often paid to the outcome of the review. Accountability is appropriate, but we perhaps need to find a different way.

I also referred in the article to the process around compensation for poor outcomes, particularly regarding significant critical and life changing outcomes. These are put into an adversarial framework, where we often hear reports of things that happened being settled in the courts eight, nine or ten years later. People feel, probably correctly, they have had to fight tooth and

nail to get the resources they need. This affects their relationship with the health care system on which they have a higher than average dependency. It also affects the general population's perception. I was effectively voicing support for moving towards a different system, which takes the adversarial nature out of it, recognises there are birth canal events which produce profound life-changing events with regard to cerebral palsy, which often feature. The truth is some of these cases go on for up to ten years and the State and the HSE loses 99% of them. Why do we have all of this trauma to get a point when people get the support they ultimately need but ten years later? This was my central point.

Something that has disappointed me is that the headline has been somewhat abused in recent days to do exactly what I was asking people not to do. I was asking that we have an adult and grown-up debate over time about the type of health system we want to have 30 years time against which we can then plan. Of course health care is innately political. Choices are innately political, but it saddens me that my words are being used by some, not many thankfully, in a knockabout way which does not contribute in any sense to the development of a real national consensus on what type of health care system we want. This is the context of the article. As I stated, I am actually very happy with how the article came out. There has been a huge response and debate and I am satisfied the article itself on the three pages inside is a pretty accurate portrayal of the encounters I and others had in the health system. People who read it will probably get a better sense of the complexities of some of the issues about which we are speaking today and how all of these issues join up, or not, as the case maybe. I thank the Deputy for giving me the opportunity to clarify this.

Deputy Catherine Byrne: I apologise I had to leave earlier, but I heard some of the contributions, particularly that of Deputy Joe Costello. If my mother were sitting here she would entirely agree with Mr. Woods that a good fall of snow killed many ailments, but unfortunately she passed away a number of years ago. I do not think the people down the country would be happy for us to be looking for snow at this time.

Chairman: Before Deputy Ó Caoláin leaves I thank him for his co-operation during the year and I wish him and his family a very happy Christmas.

Deputy Caoimhghín Ó Caoláin: I add my good wishes to Mr. O'Brien and the other witnesses in their new roles. I return the compliments of the season to the Chairman, all members and the secretariat.

Deputy Catherine Byrne: How many people apply for the home care package or are assessed for it? How long is the waiting time? I ask this question for a specific reason. A member of the public contacted me about the cancellation of their son's operation about three weeks ago. The reason given was that there were no beds. The two beds the hospital had were for absolute emergencies, but his son's operation was a planned surgery. Have things changed in this regard? It is not mentioned in the children's hospital section. Also, what numbers are waiting in the emergency departments of children's hospitals to be admitted, particularly in Crumlin children's hospital in my constituency?

Mr. O'Brien might not be able to answer my next question, but perhaps he would refer back to the committee on it. It has been mentioned by a member of the committee that the CT scanner has not been working in Crumlin hospital on a number of occasions. It is causing great difficulty not only for inpatients but also for outpatients. I have been seeking an answer on that for some time, so perhaps Mr. O'Brien could help in this regard.

I had a fall about two weeks ago and instead of going to the hospital I went to my GP. It was 11 o'clock on a Sunday morning and I was surprised to see there were 22 people ahead of me. The majority of them were very young children with their parents. Has the new GP card helped the accident and emergency departments in children's hospitals? Has it reduced the number arriving in the accident and emergency departments? I was astonished that Sunday. I am lucky that my GP's clinic is open on Sunday mornings. Some people's clinics are not. Regarding the primary care centres, I can only give them the highest compliments. However, perhaps it might be possible to enable them to open at weekends. I had a very bad sprain, which is recovered thankfully, but there was no need for me to sit in a hospital for a number of hours. It was dealt with by my GP and I had an X-ray the following morning. If the primary care health centre had been open in Inchicore, it is the first place I would have gone. If we are to relieve the emergency departments, we must be able to open and staff these wonderful centres at the weekends.

Chairman: I will call Deputies Regina Doherty, Fitzpatrick and Kelleher next and I ask them to be brief.

Deputy Regina Doherty: My question is for Mr. Woods. I thank him for the sheet he circulated. Regarding the eight beds that were opened in Drogheda and remain open, which is great, do they reflect the side bar deal that was done with Tony Fitzpatrick and the INMO six or eight months ago? I am continually told we reneged on that deal because we had not bothered to recruit all the nurses required to open the beds. Are they different or is it the same?

Deputy Peter Fitzpatrick: Our Lady of Lourdes Hospital in Drogheda is one of the busiest in the country. I have spoken on numerous occasions about the services provided by Louth County Hospital. I firmly believe that many people in the north east are not aware of the range of services available in Louth County Hospital in Dundalk. Has any progress been made in highlighting these services or are there plans to publicise them? When I was in the emergency department in the Our Lady of Lourdes Hospital, there were comments on the number of people who bypass Louth County Hospital to go to Our Lady of Lourdes Hospital. Only 25% of the people who present in that hospital's emergency department are admitted. Is there any way we can publicise the minor injuries units, MIU, in the hospitals in the area? Louth County Hospital is one of the best small hospitals in the country.

Senator Thomas Byrne: On that point, I live in the catchment area for Drogheda, Navan and Dundalk. My wife is a nurse but she did not know what she could get done in Dundalk or in Navan rather than going to Drogheda. I see that all the time in Meath. People do not realise they can go to Navan or Dundalk for something rather than going to Drogheda. I agree with Deputy Fitzpatrick that it must be publicised in a proactive way. It certainly could help matters in Drogheda.

Deputy Billy Kelleher: Mr. O'Brien referred to the issue I wish to raise, which is a duty of candour, openness and transparency in dealing with patients but equally in dealing with staff and, for example, encouragement for whistleblowers, as they are described, to come forward to voice concerns. When they come forward, there should be a process in place to address their concerns. There was to be an investigation of the matter involving Dr. James Gray in Tallaght hospital and how the information leaked out. I do not know whether that has been discovered. However, there is the broader principle of employees of the HSE being able to raise an issue without fear of vilification. I am not saying they are the circumstances in this case, but that issue must be addressed. If people are employed and see things in a hospital or workplace that are bad practice or otherwise, there must be some facility in place where they can go without fear of pressure from peers or from the employer. The Gray case brought it to a very important

point in terms of us addressing it.

Mr. Tony O'Brien: I omitted to address the Deputy's question in that respect. To be clear, Dr. Gray is not an employee of the HSE. He is employed by the board of the Adelaide and Meath Hospital. Liam Woods might be able to comment on the current position but that is an investigation of the hospital's. Clearly, there could be no criticism of any doctor who writes to the chief executive or another senior official of a hospital to raise concerns. I do not believe there was any intended. There were some concerns about the subsequent entry into the public domain of information which could have identified a patient and that patient's concerns, and obviously that would have to be examined. Liam Woods might say something extra on that if there is any current information, which there might not be.

I thank Deputy Fitzpatrick for his positive remarks about the staff of Our Lady of Lourdes Hospital in Drogheda. I have experience with that hospital and I can confirm that the staff there give of their best in what are often difficult circumstances. They will appreciate the Deputy sharing his experience in that regard.

The number of children who are awaiting admission in the emergency department at Crumlin at 8 a.m. this morning was one. No child had been waiting for an excessive period of time at that point. Typically, we would expect that to clear to zero during the day. It is relatively unusual.

Mr. Liam Woods: On the report for Tallaght, as the director general said, it is a matter for Tallaght hospital so I do not have an update. We could refer back-----

Deputy Billy Kelleher: It is the broader issue, not just that incident. I am referring to the issue across the HSE.

Mr. Tony O'Brien: My apologies, I should have addressed that as well. We have a procedure relating to protected disclosure. We also have a confidential recipient. On several occasions since I became director general I have written directly to all staff inviting them to ensure they avail of the procedures available to draw attention to issues they believe to be wrong. I did that in the context of Portlaoise and I did it again in the context of Áras Attracta. I also appointed Leigh Gath as a confidential recipient in a particular context. I established what is known as a suggestions to DG e-mail address in order that individuals can contact me directly should they need to do so. Obviously, I would prefer that they did not have to have recourse to that. There should never be any question of recrimination for the raising of concerns, which many staff have a professional obligation to do in any event.

Deputy Billy Kelleher: Is Mr. O'Brien satisfied the confidential recipient, Leigh Gath, and the mechanisms that are in place are widely known by the employees, staff and clinicians and that they have the confidence to use them?

Mr. Tony O'Brien: Across the relevant sectors for Leigh Gath we have put up posters in workplaces. We have included full page advertisements in our in-house *Health Matters*, copies of which the committee members might receive, and there are regular communications. Her view is that she is being used not just by staff but also by parents, carers and so forth. Clearly, one can almost never do enough to make these avenues known but in this case we have done quite well in drawing attention to the existence of that pathway.

Mr. Liam Woods: On the paediatric emergency departments, typically they perform well. As I mentioned earlier, there were problems in the past couple of weeks related to community-

based infection. I was not hoping for snow, just cold weather. The Deputy's mother went a step further than me on that.

Regarding the reference to the INMO, Drogheda and the Deputy's question about a side bar deal, I am not aware of that. What we were seeking to do with the 301 beds was identify anywhere we could reasonably and quickly open capacity. That was our driver.

The point about advertising was well made. We have a draft campaign to go locally for that purpose across 12 units throughout the country. That point was one of the findings of the emergency department task force, so we must act on that. We have done some work on it already. It is correct that people living proximate to these facilities do not fully understand the services they provide. It is something we could push a little more.

Those were the questions that were relevant to me.

Mr. Tony O'Brien: There was one question about primary care.

Mr. John Hennessy: I will follow up on what Deputy Catherine Byrne said about her experience on a Sunday morning. By the way, it resembles quite closely where the model of primary care is hoping to get to on a consistent basis around the country. The idea is that there will be a seven-day service that is based on accessible GP out-of-hours cover, ably supported by community intervention teams and nursing therapy staff, and well-connected and linked to mainstream services in hospital and primary care. The model we have been describing is based on building the capacity to do that in a consistent manner and on working with ambulance, hospital and primary care teams to ensure all that is joined up and patients can be referred, cross-referred and transferred to the most appropriate places in which care can be provided. By the way, a large part of this involves establishing the confidence of the public and our own clinicians in the approach that is being taken as opposed to everybody being directed to the emergency department.

Mr. Liam Woods: I forgot to assure Deputy Catherine Byrne that I will follow up on her question about the CT scanner in Crumlin.

Ms Angela Fitzgerald: I would like to respond to a question asked by Deputy Regina Doherty. I was party to some of the discussions regarding Our Lady of Lourdes Hospital that took place during the summer. I think the Irish Nurses and Midwives Organisation was seeking the opening of all beds at that hospital and at Louth County Hospital. In fact, it specifically referenced the potential for opening 12 beds at Louth County Hospital. Those beds are now being opened as part of what members will now see in their information packs. Although the Minister's announcement referred to eight beds in Drogheda, in fact 12 new beds are being provided in the modular unit, four beds are being provided in the surgical assessment unit and eight beds are being provided in the clinical decision unit. It is understandable that the Irish Nurses and Midwives Organisation was so concerned about the capacity issues. For most of this year, the big challenge we had was in attracting and retaining staff. The RCSI group has done very well to secure staff and those beds are all open. The requests of the Irish Nurses and Midwives Organisation have been met. In fact, the driver of the beds at Louth County Hospital came from that.

Chairman: I thank all the witnesses at this morning's meeting most sincerely for their thorough and informative presentations and answers to questions. On my own behalf and on behalf of the committee, I thank each of their staff for the courtesy and professionalism they

bring to their work every day. Like Deputy Catherine Byrne, I had a family member in hospital recently. The reception, care and attention he received in a hospital in Cork last Tuesday was unbelievable. I thank the staff of the hospital for that. Indeed, I thank all the staff of the HSE. Mr. O'Brien was right when he wrote in his article about the adverse events that sometimes occur. Medicine is not a perfect science, but we get 80% of it right. The staff who are under the care of HSE management are, at their core, men and women of decency and value who love the work they do. I ask the HSE officials to thank them on our behalf. I thank all the members of the joint committee and wish them a happy Christmas and a prosperous new year. The good news is that we have no meeting next week.

Senator Thomas Byrne: The Chair will be canvassing next week.

Chairman: The bad news is that we are back on 14 January.

The joint committee adjourned at 2.45 p.m. until 9.30 a.m. on Thursday, 14 January 2016.