DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 3 Iúil 2024

Wednesday, 3 July 2024

Tháinig an Comhchoiste le chéile ag 9.30 a.m.

The Joint Committee met at 9.30 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Cathal Crowe,	Frances Black,
David Cullinane,	Martin Conway,
Bernard J. Durkan,	Seán Kyne.
Neasa Hourigan,	
Martin Kenny,	
John Lahart,	
Róisín Shortall.	

Teachta / Deputy Seán Crowe sa Chathaoir / in the Chair.

Business of Joint Committee

An Cathaoirleach: Apologies have been received from Deputy Cullinane who has a Topical Issue matter for debate and will be late. Before we get to the main agenda item, the minutes of the committee meeting of 26 June 2024 have been circulated to members for consideration. Are they agreed? Agreed. I thank members.

Update on Neurorehabilitation Healthcare, Primary Care Centre Programme and CAMHS: HSE

An Cathaoirleach: The purpose of this meeting is to receive an update from the HSE on the challenges facing patients in need of neurorehabilitation healthcare services, the programme for primary care centres and decisions on their locations and the child and adolescent mental health services, CAMHS. To commence our consideration of these matters I am pleased to welcome Mr. Bernard Gloster, CEO; Ms Anne Marie Hoey, chief people officer; Mr. Tony Canavan, regional executive officer, HSE west and north-west; Mr. Brian O'Connell, interim national director of capital and estates; and Dr. Amanda Burke, clinical lead for youth mental health.

I must read a note on privilege. Witnesses are reminded of the long-standing parliamentary practice that they should not criticise or make charges against any person or entity either by name or in such a way as to make him, her or it identifiable or otherwise engage in speech that might be regarded as damaging to the good name of the person or entity. Therefore, if their statements are potentially defamatory in respect of an identifiable person or entity, they will be directed to discontinue their remarks. It is imperative that they comply with any such direction.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable. I also remind members of the constitutional requirement that they must be physically present within the confines of the Leinster House complex in order to participate in public meetings. I will not permit a member to participate where they are not adhering to this constitutional requirement. Therefore, any member who attempts to participate from outside the precincts will be asked to leave the meeting. In this regard, I ask any member participating via Microsoft Teams to confirm, prior to making his or contribution to the meeting, they are on the grounds of the Leinster House campus.

To commence our consideration of the current position regarding these three issues, I invite Mr. Gloster to make his opening remarks.

Mr. Bernard Gloster: Good morning to the Chair and members of the committee in the room and online. I thank them for the invitation to discuss child and adolescent mental health services, the challenges facing patients in need of neurorehabilitation healthcare services and the programme for primary care centres and decisions on their locations. I understand the committee is also interested in the current Covid-19 infection rates and some resulting visiting restrictions. I have attached a briefing note outlining the current position in respect of that. I understand the committee is also interested in discussing the issue of pay and numbers.

I am joined, as the Chair has noted, by my colleagues Ms Hoey, chief people officer; Mr. Canavan, the new regional executive officer for HSE west and north-west in our six-region

structure; Mr. O'Connell, national director of capital and estates; and Dr. Amanda Burke, who is an executive clinical director, a consultant child psychiatrist and also now the national clinical lead for youth mental health. I am supported by Ms Sara Maxwell.

Child and adolescent mental health services is a specialist mental health service for approximately 2% of children and young people who have a moderate to severe mental health disorder. For these children and young people it is particularly important to have access to integrated and person-centred supports provided by a multidisciplinary team of skilled professionals. However, CAMHS is challenged by a growth in demand for services, coupled with the impact of ongoing staff retention and recruitment difficulties. These challenges, alongside the Mental Health Commission review, the reports of the Maskey review, the prescribing audit, the audit of compliance with CAMHS operational guidelines and qualitative patient experience research have demonstrated the need to put national focus on improvements to CAMHS, bringing together multiple strands of activity. The national child and youth mental health office was established in September 2023 by the HSE and led by Dr. Burke and the child and youth mental health action plan is due to be published in the coming months. I want to make it clear we are not waiting for this to make improvements with some critical issues that have been well established.

There were 23,874 referrals to CAMHS in 2023. Waiting lists for CAMHS services remain too long in some areas of the country, and I acknowledge the huge pain and suffering this can cause for young people and their families. Between 2019 and 2022, our number of appointments delivered increased by 10%, while demand grew by 16%. Specific waiting list initiatives are under way in six areas of the country, targeting those who have been waiting the longest. At the end of May 2024, a total of 3,842 children and young people were waiting to be seen. This is 789 less than May 2023. It is important to stress that 97% of urgent referrals are responded to within three days, 57% of non-urgent referrals are responded to within 12 weeks and 87% overall are seen within 12 months. That is based on the most recent data for the health service from April of this year.

Referral and access pathways can be complex and frustrating for families to navigate. Work has commenced to develop a single point of access system in addition to validation of existing waiting lists, which will allow for closer integration and better working with primary care psychology waiting lists. The net point is that children are often to referred to multiple lists arising from the same concern. An assessment protocol for young people with suspected autism has also been developed. That will significantly aid the management of waiting lists.

On neuro-rehabilitation services, I am conscious there are members of the Neurorehabilitation Alliance of Ireland in the Gallery. It was a pleasure to meet with them briefly on the way in. The HSE is leading the delivery of the national strategy and policy for the provision of neuro-rehabilitation services in Ireland – the implementation framework. The success of stroke and trauma care has thankfully improved survival rates for conditions requiring neuro-rehabilitation. However, this has widened the gap between the demand and availability of specialist neuro-rehabilitation services for patients. We are reconfiguring our services to population-based managed clinical rehabilitation networks. It is a multitiered system that comprises a number of levels, which I set out in my statement for members. They go from national specialist service to local community teams on the front line in communities. A national mapping process has been undertaken to establish the baseline from which to understand and plan the inpatient bed configuration. This will inform the reorientation of existing neuro-rehabilitation beds as well as further submissions that will be made in 2025 Estimates process.

Regarding the community-based teams, following Covid-19 delays, demonstrator projects in two CHO areas, areas 6 and 7, went live in April 2023. Those two former CHO areas would now represent two of our new regions. Funding to expand these existing teams and establish two additional teams in CHOs 2 and 4 has been made available in the national service plan of 2024 and is currently progressing. It is intended to geographically align teams to the new health regions and establish two final teams after CHOs 2 and 4.

On the primary care centre programme, a national review of proposed primary care centre locations was carried out in 2012 whereby locations were prioritised on the basis of service need, availability of appropriate existing facilities and the level of deprivation in each of the areas considered. As part of this review and prioritisation exercise, the most suitable delivery model for each centre was also set using one of three mechanisms: the traditional build route by HSE itself; public-private partnership bundle, which was organised on behalf of the State by the Department of Finance; and the operating lease model, the latter being the most used and most successful. Since 2012, local and regional reviews in the intervening years have changed locations. Some 294 identified locations are included in the programme and 175 of those have been delivered to date through the three mechanisms. Fourteen came as one bundle from the PPP between 2017 and 2019. The operating lease model has been the primary mechanism, with priority and others delivered by HSE itself.

Early in 2023, a number of landlords and developers raised concerns about the financial viability of some operating lease model priced offers due to inflation rates and other economic factors impacting the construction and investment sectors. A review was undertaken, incorporating legal advice. Following the review of the overall operational lease model in 2023, all future primary care lease locations will be advertised via the e-tenders platform with a two-stage process. Six primary care centres are planned to open in 2024, a further seven to open before the end of 2026 and eight more by early 2028, and the latter have been subject to planning approvals.

On pay and numbers, at the end of May of this year, employment levels show there were 148,159 whole-time equivalents, WTEs, employed in the health service and section 38 hospitals and agencies. That equated to 167,000 directly employed people. The overall increase since December 2019 stands at an unprecedented 28,346, or 23.7%, and when adjusted for variations, 22%. The staff category reporting the greatest increase is nursing and midwifery at 9,504, or 24.9 %, and 8,471 when adjusted. The staff category with the greatest percentage increase is management and administration at 34.4% - 6,489 WTEs - and reduced slightly when adjusted. The majority of these posts support front-line services. These continued excess numbers above funded levels result in a continuation of the pause on recruitment of a number of grades and exemptions in others. This is a challenging environment for services to operate in. I hope to bring clarity to that position shortly.

I am currently engaged with the Departments of Health and public expenditure regarding the overall financial position. I am happy to report that these discussions are extremely positive for future planning and overall sustainable workforce numbers.

Deputy Bernard J. Durkan: I welcome the witnesses and I thank the chief executive for his opening statement.

Regarding the extra staff directly employed by the health services over recent months, was a particular effort made to identify the most sensitive areas where increases in staff were most urgently needed to address the issues being experienced in those areas? What was specifically

and precisely done about that?

Mr. Bernard Gloster: When I came to this position in March of last year, as the Deputy will be aware, the narrative and conversation was very much about not being able to recruit all the people the health service wanted to recruit. In 2023, that changed significantly under our recruitment approach, and our recruitment ability improved enormously. I am not suggesting that was because I arrived, but just that was part of an overall improvement process. The result is we ended up with more than we could afford, putting it simply.

Regarding prioritisation, a lot of thought went into planning for many of the posts that were recruited. The control environment was weak and, therefore, we would end up with jobs that one might say were not the highest priority at times. Since I introduced the pause temporarily in October of this year, we prioritised derogations for specific grades. That is why, even with the pause, the total number in the health service grew in November, December, January, February, March and April and, for the first time, only fell slightly in May of this year. They were all prioritised and focused exactly at the heart of maintaining front-line services.

Deputy Bernard J. Durkan: Has there been a noticeable improvement in the quality and rapidity of the services in those areas in line with the extra staffing levels?

Mr. Bernard Gloster: People are often blinded by figures. Do figures represent the lived experience of people? I am very conscious there are many people today who still have a difficulty, particularly in accessing services. To answer the Deputy's question directly and based on the evidence, we have reduced the real number of people admitted to hospital on trolleys by substantial proportions – in excess of 12% and up to 14% in some cases - compared with the previous year. We did that in a winter where the demand increased further. Against a 10% increase in demand, 400 more people a day have turned up in our emergency departments since the beginning of this year. Approximately 125 to 130 of those are being admitted extra every day, yet we have still managed to reduce the delayed transfers of care, which means the system is more productive and efficient. We have also managed to reduce the number of people on trolleys. We do have pressures in some sites, and there is no denying that.

Equally, there has been improvement in the scheduled care waiting lists. Some might say it is modest but, given the volume of people now presenting for care, this is all a sign of good return. This is considering the substantial increases in the number of people being referred to outpatient departments, this year on top of last year, and last year was an unprecedented year. I would certainly say, and I do not want to avoid Deputy Durkan's question, that our focus this year must be on the productivity of the resources that we have. There is certainly more in that, and I am very focused on that.

Deputy Bernard J. Durkan: There are a number of CHO areas that are extremely deficient in the degree and extent of the services. There are some areas that are very deficient, where an improvement is absolutely necessary in order to address the immediate issues in those areas. What is the extent to which the Department has planned in selecting first those most deficient areas, which we know about and have discussed on numerous occasions?

Mr. Bernard Gloster: Is Deputy Durkan talking about general CHO performance?

Deputy Bernard J. Durkan: Yes.

Mr. Bernard Gloster: There are three things that are essential to that. First, the CHOs have been subsumed into the six regions and are working hand in glove with the hospitals. There

is now one single management system. That puts a different lens on the CHO and its value. Second, on making sustainable improvement, the investment in CHOs over the past three and half years, particularly with the enhanced community care which we have presented at the committee previously, and Sláintecare, has shown remarkable levels of response to need. While it does not often look like it is impacting on lists, services or systems, it is impacting with huge benefit to the public. Third, the CHOs that might be challenged in a particular care group could not be said to be consistently poor or weak. An area might have a strong challenge in mental health services but might be the best area in the country for delivery of older person services. Much of that is influenced by history, availability of skill set and by different things like varying degrees of investment historically. Investment is much more level now, or is at least moving in that direction.

There is a lot of focus on performance and accountability. For example, what was traditionally called the home help service, the home support service, has reached the delivery of its full target of home support hours and more. This is the first year that the health service, in my recent memory, has done so. There are arguments about how it was adjusted up and down and that it should be more, but leaving that aside, for many years the amount of money and the amount of hours that was available could not be achieved. It is now being achieved. There are underpinning improvements being made that are helping what were CHO areas to improve their delivery and performance to the public. I do, however, accept that we have a way to go in that.

Deputy Bernard J. Durkan: What progress is being made in neurological and rehabilitative services, given the commitment made not so long ago to target those particular areas as a matter of urgency?

Mr. Bernard Gloster: My colleague Mr. Canavan will respond to the details of that, but there are two things to say on that. There were representations, and a query was raised with our chair, Mr. Ciarán Devane, when he appeared before the committee on his recent reappointment, regarding several nursing posts, specifically within the hospital system, for neurology. There had been 21 new posts announced for that. Six were filled but there was a difficulty with 15 of them. Part of that difficulty is because neurology spreads across health and also aspects of our disability services, in both Departments last year. We now have two Departments for the HSE as opposed to one, due to the transfer of function in respect of disability. That, the recruitment pause and many other things that I will not annoy people with got in the way of that. Those 15 posts are now protected to be filled and established this year. That is important. Along with the community and neuro-rehabilitation teams that I mentioned in my opening statement, anything that is approved for 2024 service development is not affected by the pause. Mr. Canavan might want to specify where the teams are at.

Mr. Tony Canavan: We received additional funding in the service plan for 2024 and we made progress in apportioning that out to two of the regions. One of those regions is the one I work in myself, in Galway, Mayo and Roscommon, where a team is currently being appointed with funding that was approved. There will be 12 members on that team, including therapists, speech and language therapists, occupational therapists, nursing-----

Deputy Bernard J. Durkan: How noticeable will that become? When will that happen? How noticeable will the improvements that the HSE expects to follow be, and how will they be monitored? For instance, are we going to see the results in three months, six months or a year?

Mr. Tony Canavan: It is fair to say that the service will evolve and develop over time. That means it will take time, several years, for it to become fully established. This is the first step in

a process that will also require additional inpatient beds to be developed on a regional basis, as well as rolling out those teams across all the regions in the country. At present, it is focused on two of the regions. There will be further beds in service planning processes for 2025 to try to support that. The recruitment process itself will take time. In my area, where we are progressing the recruitment on the basis of funding we received, we expect that most of those posts will be in place by the end of this year. One of the posts is a consultant post, which will take longer, but all of those will add to the overall service as they come on stream.

Deputy Bernard J. Durkan: Will there be sufficient prioritisation to bring about a visible improvement in the shorter term?

Mr. Tony Canavan: Several steps that have already been taken are helping with that. For example, there is now a single referral system for the country that helps to ensure that when patients are referred, they do not need to be referred through multiple sources or locations. That is helping. It means people are getting to the appropriate service more quickly. There is a requirement, however-----

Deputy Bernard J. Durkan: I have one final question. I apologise for cutting across Mr. Canavan. Reference was made to primary care, which is a very important issue. In my backyard, I notice a change of policy. I certainly was not consulted, and I do not know who was, but it looks like some people who are wiser than the public representatives decided that there should be a change to the policy. We are now going to get two smaller centres and a big centre somewhere else. The towns in north Kildare are now bulging with population. It is very difficult to travel from one town to another at any time because of traffic problems. I strongly urge that we revert to the original proposals and that the major centre in Maynooth, a university town with a bulging population and more to come, be the location for a primary care centre with all the bells and whistles attached. A primary care centre should also be provided for Leixlip, which is another a very large town. I wanted to raise that issue, and I am sorry to parochialise things, but these issues are local to us on the ground. They become very sensitive when the public ask what happened there.

Mr. Bernard Gloster: I do not know the specific change issue that occurred, but I will talk to estates and the new regional executive officer for that area. I promise Deputy Durkan that whatever change was made, the rationale for that will be set out for him and there can be a discussion with him. I do not know the details-----

Deputy Bernard J. Durkan: I might not accept the rationale.

Mr. Bernard Gloster: I do not doubt for a minute that could be part of the discussion, but I am not armed with the information to have that discussion with the Deputy.

An Cathaoirleach: The next member to come in is Deputy Cullinane, who apparently celebrated his 50th birthday last night. He is very welcome.

Deputy David Cullinane: I know I do not look 50, folks, but what can I do? It is the moisturiser I use. I will pass it on to the Chairman.

An Cathaoirleach: The Deputy looks younger without his glasses

Deputy David Cullinane: I thank the Chair. My first question relates to the pay and numbers element of Mr. Gloster's opening statement. He talked about engagements with the Department of Health and the Department of Public Expenditure, NDP Delivery and Reform

regarding the overall financial position. The last time Mr. Gloster was at the committee, my understanding was that at the end of the first quarter of the year, spending was €500 million ahead of profile. Does Mr. Gloster have an updated figure on where we are - either ahead or behind profile - in terms of overall spend?

Mr. Bernard Gloster: To the best of my knowledge - I do not have the exact figures to hand - that run rate from the first quarter continues into the second quarter, although maybe slightly slower. I do not have the full second quarter figure yet but the pressure on the run rate has continued.

Deputy David Cullinane: What does that mean in figures? We were told it was €500 million ahead. Is it likely to be less or more than that figure now?

Mr. Bernard Gloster: It is likely to be more than that.

Deputy David Cullinane: More than €500 million. This is ahead of profile.

Mr. Bernard Gloster: When we are running ahead of spend, the profile of it does not change during the year. That becomes the amount on which we have a dependency at the end of the year. Thankfully, much earlier this year, we were having exceptionally positive discussions on that. I hope clarity will be brought to that very soon.

Deputy David Cullinane: Okay. Has the pay and numbers strategy for 2024 been published yet?

Mr. Bernard Gloster: No, it has not.

Deputy David Cullinane: Why not?

Mr. Bernard Gloster: For two simple reasons. The out-turn at the end of last year left us with a very significant surplus of jobs beyond what we could afford and what the economic position was able to allow for the health service allocation. While we were waiting for that, we did two things. First, the service plan development posts for 2024 were allowed to go ahead and are going ahead. They are ring-fenced and protected. Regardless of what controls come in for the rest of the workforce, they will go ahead. Second, we derogated a significant number of essential front-line services to ensure reasonable continuity. That is matched by the use of some agency support.

Deputy David Cullinane: That is in the public domain and has already been explained. I am asking when we will see the actual numbers and the strategy published. I am being contacted, as I am sure others are, by healthcare trade unions and others who want to know what the numbers will be. Even when that strategy is published, are we likely to see a continuation of what Mr. Gloster called the recruitment pause, notwithstanding whatever might come from that pay and numbers strategy?

Mr. Bernard Gloster: As I have said to the committee before, each region will have a full pay envelope. It will have a number of people-----

Deputy David Cullinane: I understand that. Sorry, Mr. Gloster, I think you understand the question I have asked. Notwithstanding what the number is when the Minister for Health gets around to publishing it - I think it should be published as soon as possible - will we still be looking at a pause when it is published or will the pause be lifted?

Mr. Bernard Gloster: Well, you recruit within that number. If you have 100 jobs and you have two vacancies, you fill two jobs. If you have 100 jobs, you do not fill 110-----

Deputy David Cullinane: So there will still be a pause.

Mr. Bernard Gloster: Well, there is a natural pause once you hit your limit. That is in every sense of the word. It also means-----

Deputy David Cullinane: The pauses are based on circulars the HSE has issued.

Mr. Bernard Gloster: Yes, that is right.

Deputy David Cullinane: Either those circulars will remain, post the publication-----

Mr. Bernard Gloster: No, they will not remain.

Deputy David Cullinane: They will not remain. They will go.

Mr. Bernard Gloster: The circulars will not remain because they are national, blanket circulars at the moment.

Deputy David Cullinane: They will go.

Mr. Bernard Gloster: They will go.

Deputy David Cullinane: They will be replaced by a new strategy.

Mr. Bernard Gloster: They will be replaced by regional allocations. Even if one region reaches its level and has to pause at its level, that will not affect another region.

Deputy David Cullinane: Can I just ask a parochial question? I understand from the previous speaker that as part of an agreement, a business case was submitted by University Hospital Waterford for services for the cath lab. I think 12 additional staff were needed. Are they part of the ring-fenced staff Mr. Gloster spoke about?

Mr. Bernard Gloster: It is being looked at in the context of what will be available, yes.

Deputy David Cullinane: There is "being looked at" and there is actually being ring-fenced. Is it certain that those staff will be recruited and part of those numbers?

Mr. Bernard Gloster: Once I am able to confirm the numbers, the regional executive officer for the south east will clearly have within that what her total number for the region will be.

Deputy David Cullinane: It is not certain at this point.

Mr. Bernard Gloster: It is as certain as it ever was, but I just have to finalise the number.

Deputy David Cullinane: It is either certain or it is not.

Mr. Bernard Gloster: But sure-----

Deputy David Cullinane: Hang on a second here now. A press statement was issued by the local Minister of State on the back of meetings with the HSE to say this was guaranteed. Either it is guaranteed or it is not.

Mr. Bernard Gloster: It is protected within the developments for this year so it will be

recruited. I still have to give the region its overall number to include that and allow that to happen. Otherwise, I give the region a number and then I start to defend every single line of service development within that and the number gets out of control.

Deputy David Cullinane: Mr. Gloster can only defend what he puts out there. Mr. Gloster had the meeting with the Minister of State, and then the Minister of State went out and said these were guaranteed. I am asking a question around posts I have been told are guaranteed.

Mr. Bernard Gloster: They will be in the number, yes.

Deputy David Cullinane: Okay. Can I get around to the neurorehabilitation teams? The last time Mr. Gloster was before the committee, a commitment was given that they would be funded and in place as soon as possible. I will read a paragraph from Mr. Gloster's opening statement because I do not really understand what is being said. I have some sense of it but it is not clear. Maybe Mr. Gloster can provide some clarity. He said, "Regarding the community-based teams ... demonstrator projects in two CHO areas, areas 6 and 7, went live in April 2023". He might talk to us about what is meant by "demonstrator projects". He continued, "Funding to expand these existing teams and establish two additional teams ... has been made available ... and is currently progressing". What does "currently progressing" mean? I ask him to set that out in clear terms for this committee because commitments were made in the past. When will the neurorehabilitation teams for CHOs 6 and 7, and CHOs 2 and 4, actually be functioning, available and providing the services? Organisations that are advocating on this issue came before the committee a number of weeks ago, as Mr. Gloster knows. They were raising questions around the commitment given by Mr. Gloster and others - I am sure it was made in good faith - about these teams being funded but also delivered. Will Mr. Gloster explain to the committee, in clear terms, where we are now with those four teams?

Mr. Bernard Gloster: Just before the Deputy came into the meeting, my colleague had contributed-----

Deputy David Cullinane: I heard that. I am asking Mr. Gloster because he made the commitment.

Mr. Bernard Gloster: Yes. The four teams are all approved and moving through recruitment. They are protected despite the reference to the employment controls. The essential line in my opening statement was that once the teams were in the national service plan for 2024, they were protected.

Deputy David Cullinane: We have been here before. We have been here several times in this committee, as Mr. Gloster knows. The reason we asked him to come before the committee earlier this year or maybe late last year was to provide clarity on the issue of when these teams will be up and running. I hear what Mr. Gloster is saying - that money has been made available and recruitment is happening. We need to know when these teams will be fully funded, fully staffed, operational and providing the services like the other teams are. What is the timeframe?

Mr. Bernard Gloster: Does Mr. Canavan wish to respond?

Mr. Tony Canavan: Funding has been provided in the 2024 service plan for two of those teams to be established. One is in CHO 2 and the other is in CHO 4. As the CEO pointed out previously, those CHOs are now forming part of the regional structure. CHO 2 is under-----

Deputy David Cullinane: Is there any areas where funding has yet to be provided?

Mr. Tony Canavan: Those are two of the six regions. Two out of six regions have received funding under the service plan for this year and the recruitment to those posts-----

Deputy David Cullinane: Will Mr. Gloster state how many areas have not been funded yet?

Mr. Tony Canavan: As the Deputy described, there are also teams that were put in place-----

Deputy David Cullinane: No, I am asking how many areas have not been funded. I just want clarity on what is funded and what is not funded. We were promised six teams. How many of those six teams have yet to receive the funding they need?

Mr. Tony Canavan: Two out of the six teams have yet to receive any funding. Two of them have received-----

Deputy David Cullinane: Why have they not received the funding, Mr. Gloster? We were told the funding would be provided and these six teams would be up and running.

Mr. Bernard Gloster: They are all sequenced through what is available to be allocated in the service plan for new developments. That is essentially-----

Deputy David Cullinane: Mr. Gloster is telling me that, but I was not the one who made the commitment.

Mr. Bernard Gloster: Yes. We are committed to developing the six community neurorehabilitation teams. We have two factors to consider in that. If somebody wrote a cheque for it tomorrow, that would not mean all the posts would be filled tomorrow given the recruitment pipeline for those six teams and the specialists.

Deputy David Cullinane: Hang on a second here now. This is part of the problem. The funding needs to be provided to allow the work to be done. I accept it takes time to recruit staff. Unless the funding is provided, staff cannot be recruited into the teams. The clock only starts once the funding is provided.

Mr. Bernard Gloster: That is right.

Deputy David Cullinane: If the funding is not provided, we cannot recruit. This is exactly why we are in the situation we are in. There is no clarity yet on when two of the teams that were funded will be up and running. Maybe a straight answer can be given to that question. The clock will only start to tick when the funding is made available for the other two teams. I am not the person who made the commitment. A commitment has been given time and again that these six teams will be funded and operational. They were meant to be operational last year and here we are, in 2024, still being told that two of the teams have not been funded and with no clarity on when the two teams that have been funded will be operational.

Mr. Bernard Gloster: The simple reality, as I have said many times in this committee, is that there is no hiding of it from anybody. The 2023 out-turn meant that the health service was running above its level of funding in terms of the staff it could afford. Therefore, previous commitments on staff have to restart through a controlled process and a series of service plans. The two teams that will come on this year, which have been funded in the service plan, will bring it to four funded teams and I have no doubt the other two teams will be a priority for the 2025 subsidy.

Deputy David Cullinane: I will leave it at this but it seems these teams are, again, victims of a recruitment pause. Whatever about the strategy on how staff are recruited into the health service, this is a casualty of it. It is casualty of mismanagement that a promise and a commitment were given that six teams would be in place but here we are still not clear as to when the six teams will be up and running. This is leaving down patients with neurological conditions. I will come back if there is an opportunity for a second round of questions later.

An Cathaoirleach: There will be.

Deputy Róisín Shortall: I thank the witnesses for the presentation. I want to stick with the issue of neurological services. I want to tease through what has happened in recent years. Many thousands of people have neurological conditions in this country, such as Parkinson's disease, MS and epilepsy. Many of these conditions are extremely debilitating if they are not diagnosed and treated early. They can have major personal, social and economic implications for the country and specifically for the families involved. It is one of those situations where it does not make sense not to have early intervention for many reasons. It is yet another example of how things are not done properly in the health service. People scratch their heads and ask if this is a no-brainer why has it not been dealt with.

We know that in 2022 a total of 21 neurological nurse posts were funded. How is it that more than two years later there are still 12 vacancies out of the 21 posts that were funded? Whatever about when the word came out about the funding in 2022, why were these posts not all progressed then from early 2023? A number of them remain vacant. We know that because the go-ahead was delayed in 2023 to very late in the year the recruitment could not start because it was too late in the year. Now we are into 2024. When I tabled parliamentary questions in May, I was told these posts were impacted by the embargo, which was not the case. The Minister for Health in the Dáil established it was not the case and that they are exempted. How is it that posts which were approved and funded in 2022 are still not filled? Will Mr. Gloster explain this to us and to the many thousands of people impacted by what I regard as a serious failure on the part of the HSE?

Mr. Bernard Gloster: I have no doubt that, as with other developments announced, there were shortcomings in various ways as to how they were or were not implemented. I can only deal with what is in front of me. I have clarified this week that part of the confusion that arose in respect of these posts was with the transfer of functions between two Departments. I have clarified where the origin of these posts is and that they will be recruited. If people are available to fill them they will be recruited. This is the only delay. There will not be a delay because of any pause or control issue.

Deputy Róisín Shortall: Where did the error take place? It is significant. Why did the message go out that the embargo impacted these posts? I also want to know what happened last year and why these posts were not filled at an early stage last year.

Mr. Bernard Gloster: I do not know who was recruiting them last year in terms of how they were or were not filled. Many jobs people were expected to fill last year.

Deputy Róisín Shortall: Ms Hoey could reply to this question.

Mr. Bernard Gloster: Sure. There were many jobs people were expected to fill last year and they did not. There were many jobs we were not expected to fill last year, which we did.

Deputy Róisín Shortall: The HSE is certainly not going to be able to fill jobs if it does not

start a recruitment campaign. What happened with the recruitment of these posts?

Mr. Bernard Gloster: I absolutely understand this. The reality is the jobs were not recruited. I am not here to-----

Deputy Róisín Shortall: Yes but why? I accept Mr. Gloster was not around-----

Mr. Bernard Gloster: Yes.

Deputy Róisín Shortall: -----for a big part of that year.

Mr. Bernard Gloster: Yes.

Deputy Róisín Shortall: I want to know why these posts were not recruited.

Mr. Bernard Gloster: I would imagine that in the volume of what the organisation was trying to recruit last year, and in what local services and hospitals were trying to recruit, they just did not get there fast enough. I imagine this is part of it. I imagine that the reason there was a reference to a recruitment pause was that essentially we had to stop everything other than urgent front-line services to try to get some grip on the number when we finished the end of the year with the volume we did.

Deputy Róisín Shortall: We know that almost 23,000 people are waiting for outpatient appointments with queried neurological conditions. It is not good enough for Mr. Gloster to say he does not know what happened because these are real people's lives that are directly impacted by the failure of the HSE in this. I accept Mr. Gloster is not in a position to answer on what happened in the early part of last year but perhaps Ms Hoey can answer the question. Why were these posts not recruited?

Mr. Bernard Gloster: Before Ms Hoey does this, to be fair to everybody and the 23,000 people to whom the Deputy referred, their appointments and access to services are not wholly dependent on the existence of these jobs alone-----

Deputy Róisín Shortall: I know that-----

Mr. Bernard Gloster: -----so just let me-----

Deputy Róisín Shortall: -----and it is disgraceful figure. What I am saying is this it is the scale of people who have not yet been assessed.

Mr. Bernard Gloster: Sure.

Deputy Róisín Shortall: It gives an indication of the level of need that exists in the country.

Mr. Bernard Gloster: Yes.

Deputy Róisín Shortall: How is it that more than half of the approved posts remain vacant? It is a basic question.

Ms Anne Marie Hoey: I will take it away to look at the timelines.

Deputy Róisín Shortall: No, sorry.

Ms Anne Marie Hoey: No, Deputy-----

Deputy Róisín Shortall: That is not good enough. We have had a number of sessions of this committee about it. There have been umpteen parliamentary questions. There are thousands of people depending on the HSE doing what it is funded to do.

Ms Anne Marie Hoey: I do not disagree with any of this but, in fairness, as the CEO said, we had unprecedented levels of posts approved last year. There is a time to recruit. These are specialist posts. The recruitment pause was introduced in the fourth quarter of last year. We understand the reasons for this and they have been covered. These posts were most likely caught in it. I will have to take it away to look at the timeline, from the time they were approved to the attempts that were made to recruit them. This is my undertaking to the Deputy today.

Deputy Róisín Shortall: That is utterly unacceptable. I do not know how many times this issue has come up here and in the Dáil. Umpteen questions have been tabled. It is simply not good enough that we are being told the HSE has to take it away and see what happened. It is just not good enough.

Mr. Bernard Gloster: I know and I understand the importance of it.

Deputy Róisín Shortall: Perhaps Mr. Gloster can tell us exactly where we are going from here on these 12 outstanding posts.

Mr. Bernard Gloster: In fairness, I have told the Deputy that I have identified where the issue of the balance of these posts are and they are approved to go to recruitment. This is resolved. Part of this is because neuro-rehabilitation crosses health and disability services and the transfer of functions last year means two Departments are involved. This took some clarification in recent days on my part, which I now have, and I have committed to it. I will resolve this issue.

In the context of how something was or was not recruited for, I genuinely do not want to be unfair or disparaging to anybody. I cannot look individually at every post. We are speaking about 162,000 people. This is the number of people in the recruitment domain of the HSE and on the payroll. It is a very complex workforce. When jobs are given out to be recruited, approved and announced, they are done so in good faith. If they are not filled because somebody is not available to fill them, or somebody is waiting to fill something else, it can happen that they then get caught in a timeline where the circumstances of the organisation change. It does not mean we are indifferent to the needs of the people who are at the end of them.

Deputy Róisín Shortall: We would imagine the-----

Mr. Bernard Gloster: I just want to be fair. I will take it away and look at it. These are 21 posts in neuro-rehabilitation. There are another 21 posts in some other expectation. I am telling the Deputy it is resolved and they will be recruited if they are available to be recruited and it is protected.

Deputy Róisín Shortall: With all due respect, it is the job of the management to sort these things out and pick up on mistakes that are made.

Mr. Bernard Gloster: And that is what I am doing.

Deputy Róisín Shortall: It should certainly have been picked up long before now. This is the point I am making. Will Mr. Gloster outlined to us what steps will now be taken to fast-track their recruitment of the 12 neurological nursing posts?

Mr. Bernard Gloster: With regard to the final number, there is a dispute as to whether it is 12, 13 or 14 but it will be confirmed this week. The specific sites that were to host or receive them and have not filled them will be given their notification and the jobs will be advertised to be filled.

Deputy Róisín Shortall: I have had to devote all my time to that. I will come back in later to ask about two other issues.

Deputy Neasa Hourigan: I will also stay on the issue of neuro-rehabilitation. Will Mr. Canavan outline where the last two unfunded areas are?

Mr. Tony Canavan: It is easier to describe the whole picture to be clear.

Deputy Neasa Hourigan: I trust Mr. Canavan to respect my ten minutes.

Mr. Tony Canavan: I will be quick. Funding has been provided in this year's service plan for CHO areas 2 and 4. They cover counties Galway, Mayo and Roscommon, and Cork and Kerry. That funding is being used to recruit community neuro-rehabilitation teams in both those locations. The approvals are in place and the recruitment process has commenced. We expect to have significant progress made on most of those posts by the end of the year. The consultant posts within that will take longer - there is no question about that - and the functioning of team will depend on those.

Deputy Neasa Hourigan: That will bring us to four, the two demonstration projects and-----

Mr. Tony Canavan: No, they are the two teams that were funded in this year's service plan. In CHOs 6 and 7, funding was also provided under Sláintecare in 2020 and subsequently a budget was provided in 2024 to top that up. Again, this is for community neuro-rehabilitation teams in CHOs 6 and 7, which are on this side of the country and the recruitment to those posts is ongoing.

Deputy Neasa Hourigan: Will Mr. Canavan be a bit more exact about what he means by "this side of the country"? I know where the CHOs are, but people watching might not.

Mr. Tony Canavan: In the east, in the Dublin area.

Deputy Neasa Hourigan: Okay, they are in the Dublin area.

Mr. Tony Canavan: Yes, they are the four areas that have received funding. There are-----

Deputy Neasa Hourigan: Will Mr. Canavan outline where are the two areas that have not received funding?

Mr. Tony Canavan: CHO 1, in the north west, is one of the those areas. It includes counties Donegal, Sligo, Leitrim, Cavan and Monaghan. However, having said that - and this is true in other respects - there are some posts historically in that area that are involved in the service, but there is a question of them being pulled from the service.

Deputy Neasa Hourigan: Where is the last one?

Mr. Tony Canavan: I would have to check on the last one, but we have the east.

Deputy Neasa Hourigan: Is it in CHO 9, the north Dublin area?

Mr. Tony Canavan: Yes, CHO 9 is the north Dublin area.

Deputy Neasa Hourigan: I raised this in the past when we discussed this issue. I have skin in the game with respect to CHO 9 because it is an area I represent, but is also an area that provides a lot of the acute care in neuro-rehabilitation. What I would like to understand is the decision-making behind the phasing process. I expect that any area that does not have the kind of at-home, outpatient scheme that these demonstration projects show works well will see a respective pressure put back on acute services and we have chosen to leave to the end the area that provides a huge amount of acute services to a highly populated area. In a short time, will Mr. Canavan outline that decision-making process and how the HSE will deal with it in the next few years while this is being rolled out?

Mr. Tony Canavan: I am not sure whether I can outline the decision-making process. I certainly agree with the Deputy on the consequence. Patients are currently being cared for in acute hospitals, who would or could otherwise be more appropriately cared for if the services were available outside that. If we had proper-----

Deputy Neasa Hourigan: Are we not snaring up places like Beaumont Hospital with patients who could be treated in an outpatient setting for the next few years?

Mr. Tony Canavan: It is probably true of all the hospitals around the country to a greater or lesser extent. It is a particular issue, for example, in the south.

Deputy Neasa Hourigan: I am just giving an example.

Mr. Tony Canavan: It will also be a particular issue where we are developing our trauma services, for example those in Cork University Hospital or in Dublin. They will have a particular impact.

Deputy Neasa Hourigan: The issue for someone like me looking at how the recruitment pause has affected this, is that no funding has been given to an area that should have been higher on the list in the phased roll-out, not only because I represent the area, but because it has a particular set of acute services that are affected by that decision. The fear is that, with the recruitment pause, it will be a long process for it to be rolled out. Mr. Canavan stated that the recruitment pause is a direct result of the €500 million ahead of profile that was discussed with Deputy Cullinane. Will the witnesses give a timeline for the recruitment pause in the next few years if that overrun ahead of profile persists?

Mr. Bernard Gloster: There are two or three parts to that. The recruitment pause in any part of the service is not only as a result of the overrun in the run-rate this year. We are still recruiting people. I want to be clear about that. The recruitment pause is predominantly because the workforce grew way beyond its projections and levels that were funded for last year. Turnover reduced, which is something we have often been criticised for not reducing. Our attrition rates have changed and that is good in healthcare terms.

The development posts for this year have been protected from any pause. Some 1,850 new paid jobs as well as 400 agency conversions have been approved for this year for specific initiatives and they are going ahead. The disability sector is completely exempt and there are 600 or 700 posts in that sector this year, which are going ahead and some of those cross into the space of the support systems we are talking about. As I said in my statement, to be fair to the Government, I am having an earlier than ever discussion with the Government about the financial position of the service for this year and the resulting recruitment possibility, which has not

yet concluded and I expect that to be resolved shortly. I am working closely with the Minister, Deputy Donnelly. I am due to meet him about it again tomorrow. The difference-----

Deputy Neasa Hourigan: Does the HSE have a cut off for the recruitment pause? I apologise; I did not mean to cut across Mr. Gloster.

Mr. Bernard Gloster: Will the Deputy elaborate?

Deputy Neasa Hourigan: No matter what the overrun or the ahead of profile number might be, is there is a hard cut-off point after which we cannot sustain a recruitment pause and we will stop? Has it ever been stated that on this month of this year we will have to pause the pause? Has that discussion been had or could we see an extended recruitment pause?

Mr. Bernard Gloster: The problem at the moment is that the only pause mechanism I have is nationwide or blanket because that is the way the system is built.

Deputy Neasa Hourigan: Mr. Gloster described earlier how he will move to regional.

Mr. Bernard Gloster: I will recap that to regional and national services, which will mean a much more nuanced approach.

Deputy Neasa Hourigan: Will those regional pauses be based on the regional health areas, hospital groups or something else?

Mr. Bernard Gloster: They will be based on the whole region.

Deputy Neasa Hourigan: It will be the full primary care system.

Mr. Bernard Gloster: The region Mr. Canavan has is the Saolta hospital group as well as CHOs 1 and 2. It includes everything inside those. However, he will have flexibility within his envelope to be able to prioritise.

Deputy Neasa Hourigan: If the area in which the current CHO 9 sits was subject to a regional recruitment pause, could the phasing-in of the rehabilitation schemes be damaged or delayed? Is the answer "No" because we will hold on to developing programmes.

Mr. Bernard Gloster: New developments are separate to the pause. The reason is that part of what contributed to where we are was a weak control environment. I am changing the control environment so that we cannot get here again and that protects new developments. If there are new developments for anything in CHO 9, whether it is the community and neuro-rehabilitation team or anything else - it could be public health nursing - with identifiable money, it will be protected from anything because it will have been provided for. A new ceiling will have been provided.

Deputy Neasa Hourigan: Is it viable to add on new developments continually in the face of a recruitment pause across the rest of the sector? Will we see that in the system going forward? I can imagine workers in the HSE might question that if they are seeing gaps in staffing in other areas.

Mr. Bernard Gloster: The difference is that going forward we will have reset the number. When we have done that, within that number any post can be replaced or recruited and new prioritisations can be made. However, resetting the number is a difficult task, as the Deputy will imagine. It is complex because people will say that they lost out because it was reset today

rather than yesterday. It is a careful consideration. It is linked to money, but it is also linked to many other considerations. I know people are frustrated by it. We are frustrated by it, but I would genuinely say that with regard to both the budgetary position and the associated issue of pay and numbers, I have never been in a more constructive and positive engagement to resolve it. I am very hopeful there will be clarity on that very soon.

Deputy Neasa Hourigan: On a related matter, Mr. Gloster referred to the overlap between health and disability in rehabilitation. In recent weeks, the committee has been looking at the regulation of home care. Something emerged in that discussion I definitely think we should flag. It relates to regulation and the complexity of the overlap between those two systems of the disability sector and health, which we see in other countries as well. The development of that regulation has not clearly made a distinction between disability and those, for example, in the elder care sector. There has not, therefore, been a review of those regulations in the context of the UN Convention on the Rights of Persons with Disabilities, UNCRPD.

This is never more relevant than in the area of neurorehabilitation, where people might have a health event that then leaves them with a long-term disability requiring long-term care. I would expect, from both the Department dealing with disability and the Department of Health, that when new legislation is being developed, temperature-checking it against the UNCRPD and doing a review would be an automatic thing. There should be somebody in the office who is the expert on the UNCRPD and does a check. The fact that has not been done is of significant concern to me. Is that something the HSE is looking at?

Mr. Bernard Gloster: It is. This is not just in the context of home care or anything else; it is in terms of the totality of integration. We have two parent Departments. While that can sometimes help, some people argue it causes other issues. However, the primary objective, job and task of the six people I have appointed, including Mr. Canavan, is their one region. It does not matter if there are two Departments. For people with a disability, or with an illness event that might cause a disability or element of disability, the response of an integrated care system means they are treated the same in everything and are considered in everything. To be fair to the Ministers, Deputies Stephen Donnelly and O'Gorman, they are very alive to that. We certainly are. I had discussions with the Minister, Deputy O'Gorman, about disability services last week. I talked about primary care services and access to them for people with a disability and vice versa.

Deputy Neasa Hourigan: I am delighted to hear that. I know I am over time. I will say to Mr. Canavan that we are still seeing legislation being brought before the committee that has not been checked against the UNCRPD.

Mr. Bernard Gloster: I will raise it with the legislation drafters-----

Deputy Neasa Hourigan: I will raise it with them too. Mr. Gloster might back me up on that one.

Mr. Bernard Gloster: -----and the Departments. From our end, we are very alive to it. We are very much anxious to keep pointing out to people that these are not two separate worlds. People do not live in a policy or care group.

Senator Martin Conway: Our guests are very welcome. I thank them very much for attending. We have dealt in great detail with hiring in respect of neurological and so on. I will ask about recruitment. I acknowledge that there has been a significant increase in recruitment

in the past 12 months. What worries me is that there has been a bigger increase in management and administration than front-line staff. Will Mr. Gloster explain why that is? We often hear that the HSE is top-heavy with management. Yet, the figures we saw today indicate there is a greater increase in management and administration than those in the front line. Will Mr. Gloster provide some detail on that?

Mr. Bernard Gloster: Sure. We can go through the numbers with the Senator. I will make two points. I often feel that administrative and support staff fall victim to the title "management and administration". I repeatedly remind people that when I recruit a grade IV clerical officer, for example, that person could be the medical secretary to a doctor or the person you meet at the emergency department reception at midnight, when a patient is booked in and so on. I wanted to make that general point. There is a notion that administration is about us all being back in the dark days with pencils, quills and paper. That is not the case. These people are very dynamic professionals who contribute to services. That is the first thing.

To answer the Senator's question directly, while the greatest percentage growth from 2019 to 2023 was in management and administration, equally, the greatest growth in numbers was in nursing and midwifery, which I welcome. The group that had the biggest reduction since the introduction of the moratorium, and three groups have reduced since Christmas, is that of management and administration. It is continuing to fall.

Senator Martin Conway: Okay. I accept that. Deputy Durkan asked about the change in approach for primary healthcare centres. I have no doubt there is a good rationale for it. Like Deputy Durkan, I may not necessarily agree with the rationale, but I am interested in hearing about it. I will be parochial. Mr. Gloster is well aware of the circumstances in Ennistymon, County Clare. It has been promised a primary healthcare centre for many years now. It has got to the stage that none of the GP practices in the north Clare area are fit for purpose. All of them are too small to deal with the number of patients they are dealing with. All of them are waiting for this new primary healthcare centre, yet nothing seems to be happening. I have tabled questions in the Seanad about it. Timelines are given but none of them have been honoured or committed to. It has got so bad that GPs are now looking at opening their own primary healthcare centre, which they should not have to do. I would like clarity, once and for all, on exactly what is happening with the primary healthcare centre in Ennistymon. Will this new rationale or methodology that is being used benefit the people of north Clare as regards a primary healthcare centre?

Mr. Bernard Gloster: I will ask Mr. O'Connell to explain the methodology that is being used. The Senator is either fortunate or unfortunate compared with other committee members in that I happen to know everything about the area where he lives. I advertised the first primary care centre in Ennistymon. Nobody regrets more than I that it never materialised. The Senator will know, and I am not being defensive when I say this, parties other than the HSE are involved in these developments. That can cause inordinate delays and problems. That said, at the end of the day, the public rely on us. I accept that. Ennistymon is on the readvertisement list for this year, as a reboot of a new project. Mr. O'Connell will explain the actual process. We have tried to refine the process to avoid the type of thing the Senator talked about.

Senator Martin Conway: I ask Mr. O'Connell to outline timelines if he can.

Mr. Brian O'Connell: We have already got a small number out using eTenders. Over the past number of years, construction inflation and a hike in interest rates have made it very challenging, under the operational lease model, for private developers or private entities to deliver

these models on historical rates. We have had a refresh of the process and are also rebooting and going back out to reinvigorate the market. Although there has been a challenge, and they have not always materialised in a number of areas, we have delivered 108 primary care centres through the operational lease model. It is by far the greatest delivery mechanism we have in primary care and it has worked well. We are committed to continuing it. We had engagement with our stakeholders on both the service and development side.

Ennistymon primary care centre will be advertised in quarter 3. It is hoped we will have a provider, subject to the response from the market, by the end of the year.

Senator Martin Conway: How long does Mr. O'Connell envisage it will take for the building to be physically in place and operational?

Mr. Brian O'Connell: Primary care centres generally take somewhere between three to five years, depending on whether there is a greenfield site solution subject to planning permission, or an existing building that is only subject to a possible change of use.

Senator Martin Conway: My understanding is Ennistymon will be a greenfield site so-----

Mr. Brian O'Connell: It depends on planning. If it is straight-through planning permission, the timeframe would be approximately three years. If there is any challenge to the planning permission, the timeframe can be extended for a longer period, unfortunately.

Senator Martin Conway: That is fine. Thank you very much.

I will move on to CAMHS, particularly in the mid-west. We saw that the waiting list in County Clare was the highest of the three counties in the mid-west and among the highest in the country. I suggested at the committee some time ago that perhaps resources could be redeployed from other areas to try to deal with the waiting lists that are particularly high in certain areas. Has that happened? What is the latest on the CAMHS situation in the mid-west?

Mr. Bernard Gloster: I will ask Dr. Burke to answer that.

Dr. Amanda Burke: First, I want to say that any child waiting for any period is unacceptable. We will start with that but actually, we have made significant progress with the waiting list. We got additional wait-list funding last year and our over-12-month waiters are down by more than 33% and the total waiting list is down by 17%. I am looking at CHO 3 and its waiting list is down 19%. There have been targeted initiatives there. We continue to do targeted initiatives as well as looking at external providers while we are building capacity. We were lucky in CAMHS this year, we did get new development funding, we got 68 posts that were not part of the moratorium. The primary notifications for those have issued. Local areas were allowed to decide for themselves what was most important to them. The mid-west was one of those areas and they got a number of posts that they are progressing at the minute. They have been quite successful. The new public-only consultant contract is bearing fruit in CAMHS and we have had six additional consultant posts in CAMHS since the beginning of the year. The mid-west has benefited from that as well. Things are improving.

Senator Martin Conway: I have to stop Dr. Burke there because unfortunately, the last time Mr. Gloster was here he was able to tell us that take-up of the new consultant contract in the mid-west was the lowest in the country.

On paper, one would expect that it would be the case but unfortunately, I dread that it is not.

Mr. Bernard Gloster: To assist the Senator with that and my apologies if there was any misunderstanding, I was referring specifically to the UL Hospitals Group. In the context of mental health, it would be better.

Dr. Amanda Burke: It has improved-----

Senator Martin Conway: Good. My apologies.

Dr. Amanda Burke: It has improved. We have a new clinical director in the mid-west who is specific to CAMHS. That in turn improves recruitment, because people tend to go to areas with clinical directors.

Senator Martin Conway: My final question is on MS Ireland and the €800,000 plus that was committed to it by Ministers and so on over the past 12 months for the physiotherapy service. Mr. Gloster might give us an update on when it can expect to receive that funding.

Mr. Bernard Gloster: I am not sure of the specific timeline for that.

Senator Martin Conway: Perhaps Mr. Gloster could give us a note on that in due course.

Deputy Gino Kenny: I thank the witnesses for their statements. I will start with CAMHS. In the his opening statement Mr. Gloster stated that 87% are seen within 12 months. Is there a percentage that have not been seen within 12 months? I mean those who have not received any kind of intervention in terms of waiting for more than a year.

Dr. Amanda Burke: There is. As of May, and obviously this data is dynamic, there are 491 young people nationally who have been waiting over 12 months.

Deputy Gino Kenny: Could Dr. Burke elaborate on that?

Dr. Amanda Burke: We have looked at referral symptomatology and approximately 60% of those have ADHD-type symptoms and 20% anxiety symptoms. There would be 20% that are non-specific and we need to see them to know exactly what they are waiting for. As I said, we have targeted initiatives specifically at those patients, particularly around attention deficit hyperactivity disorder and we have made substantial gains. We have more work to do.

Deputy Gino Kenny: Why would somebody be waiting more than 12 months for an intervention?

Dr. Amanda Burke: We always clinically prioritise and the urgent and emergency take precedence. I asked the same question in my own area as to why somebody would be waiting 12 months if the nine-month list is being shortened but we will prioritise on clinical need. Even within those categories we might prioritise. For example, if there was a young person coming up to an exam year, we might prioritise that young person for an attention deficit hyperactivity assessment to help him or her with his or her exams. It is always done around clinical need.

Deputy Gino Kenny: Could Dr. Burke explain the single point of access? What is the rationale for that?

Dr. Amanda Burke: It is to smooth the pathway for people. We get criticised because people find it very hard to navigate but also, and I can understand it, referral agents will refer to a number of pathways to see who will pick the patient up quickest. That artificially inflates some waiting lists. A single point of access is the GP or any senior professional sending people

to a single point where they will be clinically triaged. This, hopefully, also will include self-referrals down the line. This will allow us to say when something is for CAMHS or for primary care or for disability. As well as statutory agencies, around the table we will have our partner agencies. This means the main providers - and I do not want to be exclusive here - are the likes of Jigsaw, Pieta, Barnardos and SpunOut, can also pick up those referrals and see the young person. If they are not appropriate for that young person, that is not an issue, they will have been date stamped when they came in. However sometimes we see a young person and think that he or she is not for CAMHS but would be better off with Jigsaw. Such people will not be in any way compromised, they will go back in through that process and be re-referred to the Jigsaw process. It streamlines the pathways and referers do not need to worry about where they send people. We will then have absolute visibility of who is waiting for what, which we do not have at the minute, and we will be able to target resources accordingly.

Deputy Gino Kenny: In respect of recruitment in that service, are there still huge gaps there in recruiting staff?

Dr. Amanda Burke: Does the Deputy mean in CAMHS?

Deputy Gino Kenny: Yes.

Dr. Amanda Burke: It has been widely publicised that CAMHS was chronically under-funded over decades. We are playing catch up, yes. We do have significant gaps but we are targeting our recruitment at our community mental health teams in particular.

Deputy Gino Kenny: In terms of those gaps, what are we talking about? Where are there huge gaps in respect of recruitment?

Dr. Amanda Burke: It is different in different areas. It can be very difficult to get nurses in Dublin because it is expensive to live here. It can be difficult to get consultants in particular areas of the country. We are organising a targeted CAMHS recruitment campaign, through service in the spotlight, to look at these vacancies. We particularly want to get our talking therapies increased, that is, the health and social care professionals, the psychologists and the social workers with family therapy. We are trying to increase those. It can be slow to get people.

Deputy Gino Kenny: Are there any particular incentives the HSE can use to entice professionals to come into this area? This might be a question for Mr. Gloster also. People are looking at the profession and at the cost of living in terms of rent and all of these kinds of things and are telling themselves there will be huge financial difficulties. Are there any incentives that say to people that if they take these jobs, there will be an incentive?

Dr. Amanda Burke: It is about selling it. It is about selling the areas like the Wild Atlantic Way, it is about selling the schools, it is about publicising the areas. People want to come to where they have a team of colleagues to work with, where there are research opportunities, where recruitment is flexible and where it is family friendly. All of those pieces we are selling-----

Deputy Gino Kenny: Regarding accommodation, is there any incentive?

Mr. Bernard Gloster: It is exceptionally difficult. I do not know a single discipline in the public sector that would not argue it has those challenges. In the cases of gardaí in Dublin, teachers, nurses and so on, incentivising is a public policy-wide issue. I am not indifferent to it or necessarily against it, but it is very difficult.

Deputy Gino Kenny: It is very challenging?

Mr. Bernard Gloster: It is very challenging even to construct it, yes.

Deputy Gino Kenny: Has it even been thought about? This has been bandied about for a number of years.

Mr. Bernard Gloster: When I first appeared before this committee 15 or 16 months ago, I was asked that question and I made it very clear that the HSE would not be a very good landlord in my view. If there was any incentivisation of accommodation for public servants, it would be better through housing associations. I do not want to kick the can but it is probably above my pay grade.

Deputy Gino Kenny: At least Mr. Gloster is being honest. My final question is around the neuro-rehabilitation services. At the moment how many optimal beds are in the State in terms of neurological services?

Mr. Tony Canavan: First, there is a plan to develop additional beds and there is a requirement to invest in beds over the longer term to build up the overall service. There are beds currently, as I mentioned earlier on. In the CHO 6 area, in Donnybrook there are currently ten beds funded but they are operating up to 15 beds. There also are beds in Peamount.

Deputy Gino Kenny: From my research, there are 100 beds in the State for neurological services, which is two thirds below what should be in place. Am I correct in saying that?

Mr. Tony Canavan: The work done in developing a strategy for the country overall would suggest we need beds in each of the regions. The aim is a minimum of 20 beds colocated in each of those regions but up to a requirement of 60 beds.

Deputy Gino Kenny: Are most of them concentrated in Dublin?

Mr. Tony Canavan: That is correct.

Deputy Gino Kenny: Are all of them?

Mr. Tony Canavan: Yes. Having said that, a bit like the answer I gave earlier, there are rehabilitation beds in different locations. For example, in my area, there are rehabilitation beds in Merlin Park. The exact function and purpose and patients who use those beds and get benefit from them is not as well streamlined. Part of it is about co-ordinating existing stock. There is a need not alone for co-ordination but additional beds as well.

Deputy Gino Kenny: In my constituency, there are 15 beds in Peamount Hospital. There are plans for possibly another 25 beds in that hospital. Is there any update?

Mr. Tony Canavan: The plan is to expand to 40 and there will be two requirements. A modular build will be required and there may be a staffing and funding requirement as well.

Deputy Gino Kenny: Is there a timeframe?

Mr. Tony Canavan: In the absence of a commitment to funding for the additional beds, it is impossible to put a timeframe on it. It will be part of our submission for the 2025 service plan.

Deputy Gino Kenny: Will Mr. Canavan explain what exactly a managed clinical rehabilitation network is?

Mr. Tony Canavan: It is best understood as the team we described earlier. There are 12 staff on each of the two teams funded for this year. The teams include a combination of speech and language therapists, physiotherapists, occupational therapists, consultants and nursing and clerical support. They are based in the community as opposed to in a hospital. In some cases, they may be based across a couple of locations to try to make sure there is good geographical spread. They will be linked with the beds we referred to earlier so that the pathway for referral for the patient is seamless if inpatient care is required. We are in recruitment for two of those right now and establishing those would be an important step.

Mr. Bernard Gloster: To clarify for Senator Conway, rather than having to wait for the written answer, the funding position on MS Ireland from our disability services 2024 allocation as registered on the system is €2.867 million. In fairness, frequencies of payment may be a particular challenge. I am happy to look at that if necessary but that is the allocation for this year.

Senator Martin Conway: I appreciate that clarification. I was particularly interested in the additional funding provided to allow it to extend its respite service to a seven-days-a-week model. Perhaps there is more Mr. Gloster could have a look at in his own time.

Mr. Bernard Gloster: I will have a look. I know there are some issues with beds in the context of CHO 7. I have some detail on that but I might look at it further.

Senator Frances Black: I thank the witnesses for coming in today and for their work. I wish to discuss the neurological piece. The committee heard from the Neurological Alliance of Ireland, NAI, in the past few months. I will ask a few questions in order to keep its concerns at the forefront of our work. Mr. Gloster mentioned that a national mapping process which will inform the 2025 Estimates has been undertaken. Organisations like the NAI invest significant time and resources in identifying service gaps. Delays in finalising the mapping process could hinder these efforts, particularly as they prepare their pre-budget submissions. Will the witnesses clarify the current stage of the mapping process and when it is expected to be complete? Will the witnesses share any other insights gained from the process so far?

Mr. Bernard Gloster: Mr. Canavan may wish to add to this, but, in general, mapping exercises can be interminably slow. The problem is, quite frankly, when they are produced, there will also be some stakeholder who will say it should not be that way, it should be this way, and there are different views. I do not want to delay it. I am confident we will have enough information to make a strong bid in respect of the Estimates for 2025. Whatever information we have that can assist the alliance or advocacy groups, I have no difficulty sharing and including that. It is not a state secret. I am not sure if we have intelligence beyond that on the exact completion.

Mr. Tony Canavan: Except to confirm that it is not complete yet, which the Senator already knows. We do not have a timeframe for its completion. However, I expect we will have sight of it before the end of the year. It will not impact on our ability to perform bids in the Estimates process. It impacts some key decisions we have to make. For example, the location of inpatient beds in the south or in my area. The mapping process will help to inform that decision-making, so it is important that it is completed.

Senator Frances Black: It would be helpful to get a timeframe, particularly when that will be finished. It will impact the NAI in particular. It does phenomenal work. I am a big fan of advocacy groups, the work they do and the experience they have. It is important, because of their experience, to keep that engagement going with them.

Mr. Bernard Gloster: In this case, the term "advocacy group" sells it slightly short. Its members are highly skilled. Sometimes, that is beyond what we have. It is important to us.

Senator Frances Black: Going forward, the HSE should remain engaged with it. Will the witnesses provide an update on the specialist nursing posts funded in 2022 and remain frozen? What will happen to this funding if the next budgetary cycle begins? On the hospitals in Mayo, Portlaoise and Wexford, where there are no neurology posts at present, will the witnesses give more detail? The specialist nursing posts are vital, particularly in Mayo, Portlaoise and Wexford where there are none.

Mr. Bernard Gloster: In my discussion with Deputy Shortall earlier, I indicated that we clearly have come up short. I accept that. I can explain the circumstances and so on but when you are explaining, you are losing. To make it clear, I have a resolution for those posts to be recruited - up to 21. The only issue will be availability of skilled personnel. There will be no other obstacle.

Senator Frances Black: Will that be a priority?

Mr. Bernard Gloster: It is happening as we speak.

Senator Frances Black: There seems to be a major problem. Everybody is bringing up recruitment. In the context of CAMHS, what are the gaps? I do not mean the gaps in prevention, I mean numbers-wise with regard to therapists and people who work in the CAMHS area. How many more are needed? What is the ideal scenario? Is there a timeframe? I know it is not easy; I understand the difficulties with recruitment. What is the ideal number?

Dr. Amanda Burke: Never ask a doctor what the ideal number would be. At the moment there are 716 clinical staff. We probably need about double that in community mental health teams. That is not to say we have not made progress. We are prioritising some posts over others to get services started. It will take at least five years. We are improving the pipeline, which is one of the main limiting factors in terms of training people for these specialised posts. There are particular areas that are difficult to recruit such as mental health and intellectual disabilities. Essentially, we have to get in at the training programmes and train enough psychiatrists, psychologists and social workers to do these posts. The current deficits relate mainly to qualified psychiatrists and health and social care professionals.

Senator Frances Black: With regard to recruitment, what are the numbers in Dublin compared to the rest of the country?

Dr. Amanda Burke: I have a breakdown but I will not go through them all completely unless there is a particular area-----

Senator Frances Black: I have a bit of time and I would like a brief synopsis on the numbers in Dublin in particular.

Dr. Amanda Burke: There are seven consultant psychiatrists in CHO 6, 12.7 in CHO 7, and 13.5 in CHO 9.

An Cathaoirleach: Perhaps it might be easier if Dr. Burke circulates them.

Dr. Amanda Burke: Yes.

An Cathaoirleach: It might be easier for people to take them on board.

Dr. Amanda Burke: With regard to total staff we have 105 in CHO 7, 106 in CHO 8, and 100 in CHO 9.

Mr. Bernard Gloster: Proportionate to need it is way off where we want to be. Proportionate to fill rate in the Dublin area, it is quite good. In other services in Dublin we do not reflect as well.

Dr. Amanda Burke: I can circulate the numbers with regard to proportion.

Senator Frances Black: Will Dr. Burke also circulate numbers on the parts of the country where there is more of a need? It would be very helpful.

Dr. Amanda Burke: Dublin is not the greatest area. There are other areas of the country, such as CHO 5, and CHO 8, which have our lowest numbers, as does CHO 2.

Senator Frances Black: Does burn out among therapists happen a lot? Are there numbers on this? How is it measured? I imagine when there are very long waiting lists it can be quite-----

Dr. Amanda Burke: You would think this but I have been around the country to every area except CHO 7 and I have to say I have been completely bowled over by the enthusiasm and energy among the staff. Everybody who works in CAMHS is very passionate about their job. They are frustrated in part but I would not say burnout *per se*. I have not seen massive evidence of it although it is reported in the literature.

Senator Frances Black: I thank Dr. Burke.

An Cathaoirleach: We will now take a comfort break and Deputy Cathal Crowe will have the next slot when we resume.

Sitting suspended at 11.02 a.m. and resumed at 11.14 a.m.

An Cathaoirleach: I call Deputy Crowe.

Deputy Cathal Crowe: I thank the witnesses from the HSE for their engagement. I have a number of questions. I will begin with child and adolescent mental health services, CAMHS. The Department of Education last year launched a pilot in-school therapeutic support scheme in counties Cavan, Laois, Leitrim, Longford, Mayo, Monaghan and Tipperary. Have the witnesses any metrics as to how CAMHS waiting lists have fared in those counties? Over the past academic year, which only ended in the past week, children in schools in those counties had access to psychotherapists, play therapists and counsellors that children in other counties do not ordinarily have the same access to. Has the HSE seen any improvement in CAMHS in those counties specifically?

Dr. Amanda Burke: Would the Deputy mind giving me those counties again?

Deputy Cathal Crowe: They include counties Cavan, Laois and Leitrim. Perhaps we could take Cavan as a sample county.

Dr. Amanda Burke: My information is divided by community healthcare organisation, CHO. CHO 1 has had a 50% improvement in respect of its lists of people waiting for longer than 12 months. Six young people have been waiting for longer than 12 months.

Deputy Cathal Crowe: That is interesting. Only seven counties were included in the pilot

scheme but two of them, Cavan and Monaghan, are in CHO 1. That is an interesting improvement. I was interested to hear the figure because I come from the primary school profession and there is a long-held belief that many of these supports can be provided in schools if the resources are in place rather than putting children on the CAMHS waiting lists.

Mr. Bernard Gloster: I want to be sure not to misunderstand the Deputy's question. Apart from the children on the CAMHS waiting lists, he also asked about the impact of those services on reducing referrals to CAMHS.

Deputy Cathal Crowe: That is correct.

Mr. Bernard Gloster: Would there be a reduction in those areas?

Dr. Amanda Burke: We have seen an overall increase of 16% in referrals to CAMHS in their totality. We would need to dive down a bit. There would also be a reduction in referrals to primary care as well as CAMHS. I can get the specifics, insofar as we have them, for the Deputy. Speaking anecdotally, it has had a great impact. I know that because I have been talking to the clinicians on the ground. As the Deputy said-----

Deputy Cathal Crowe: Did Dr. Burke say it has not had an impact?

Dr. Amanda Burke: It has had an impact. In our engagements with CHO 1, medical professionals have spoken favourably of the pilot scheme. We have had an overall increaser in referrals anyway so we may not have seen the impact of the pilot scheme.

Deputy Cathal Crowe: There is a lot in that question and many counties are involved. Perhaps at some stage the witnesses could come back to the committee about the comparisons between a CHO area that has this pilot scheme and one that has not. I would love to see if the scheme has worked from the perspective of the HSE. The Department has its metrics that are pulled from the same pot. I am wondering if the pilot scheme had a real impact across the school year. In due course, the witnesses might come back to the committee on that point.

Dr. Amanda Burke: We will come back to the committee.

Deputy Cathal Crowe: I raised the following point previously with Mr. Gloster. We know that people avail of the National Treatment Purchase Fund for eye treatment and for varicose vein treatment. As I said before, it would be another way to reduce CAMHS lists if we brought more children into that realm. Of course, someone has to be seen in his or her locality first of all through a primary care referral but surely some continuous support could be acquired privately or beyond the jurisdiction.

Dr. Amanda Burke: That is absolutely so. We are actively looking at that at the moment. We have engaged with a large provider in the UK to consider online assessments for our waiting list. A clinical group is engaging with that provider at the moment. We hope to stand up one or two sites in August and to see how that works out. People get nervous when we talk about online interventions. The assessment would take place online. It would be completely optional and people could decide to stay on the waiting list. The assessment and some intervention would take place online and the patients would continue to be seen by their local CAMHS teams.

Deputy Cathal Crowe: In the short term, that is a game-changer.

Dr. Amanda Burke: It absolutely is.

Deputy Cathal Crowe: I say that as a former teacher. We used to despair looking at those lists so that approach would be a game-changer in getting assessments and diagnostics at least out of the way. The therapeutic requirement could be met at a more local level. It needs to be routine and regular but to move some of the diagnostic and assessment phase online at a crisis time, which this is, would be great.

I will next ask about neurorehabilitation. I am sure others have already welcomed them but I welcome to the Gallery Ms Magdalen Rogers and Ms Alison Cotter from the Neurological Alliance of Ireland. They are fantastic champions in this realm and keep the witnesses on the hot seat in this regard. I want to ask superficially about what I see as the poor relation, CHO 3, which has a chronically low staff total of 5.6 whole-time equivalents instead of the 12 whole-time equivalents available for funded teams in CHOs 2, 4, 6 and 7. Why the disparity and how will the HSE be addressing it?

Mr. Bernard Gloster: We dealt with this earlier in response to another question. It is a sequencing issue. I would hope and expect that the four teams we have referred to already will be well up and running this year, subject to the availability of staff to populate them. I am very familiar with the team of 5.6 whole-time equivalents in CHO 3. I started it there many years ago, ahead of the community team strategy that we are now pursuing. The strategy we are now pursuing is the right way to go. I would hope that the 2025 Estimates will provide for the six regions of the country to have their full teams. I refer to our six new regions. CHO 3, as Deputy Crowe would know, is the mid-west region, so that team would get finished out. I am not going to be a hostage to fortune because I cannot promise what the 2025 new developments will be.

Deputy Cathal Crowe: I ask that it be a priority because as Mr. Gloster knows well, across many metrics CHO 3 is the poor relation.

Mr. Bernard Gloster: I do not dispute the need at all.

Deputy Cathal Crowe: It is very much needed.

Mr. Gloster mentioned that 167,000 people, or thereabouts, are currently working in healthcare. Are there breakdowns available of how many of them are agency staff or staff who have come from non-EEA countries on a visa? As I have mentioned many times to the HSE and to the Minister for Health, Deputy Donnelly, yet again in September we will have graduation ceremonies in our third level campuses with the best and brightest nurses and doctors graduating and going overseas. They will probably be in Melbourne, Dubai or some other place that is not very useful to the Irish State. Mr. Gloster said earlier that some issues were above his pay grade and this issue possibly is too but the Department, the HSE and the Minister need to grasp the nettle and find a way to entice our graduates to stay here. It is a bit of a false economy if we have so many agency staff, who are hugely valued, and so many staff who have come here through the visa route from non-EEA countries. We need to have some mechanism to retain graduates here for at least a number of years after they complete their studies.

Mr. Bernard Gloster: Again, I do not disagree. Healthcare systems the world over are challenged around how to incentivise people to stay and what that means. It relates to work-life balance and lots of other things. It is not just about money. The 167,000 people I talked about who make up almost 150,000 whole-time equivalents are not agency staff. They are all full-time staff in the HSE and section 38 agencies of the HSE. The dependency on international recruitment is quite high, both in nursing and in some elements of the non-consultant hospital doctor, NCHD, profile, as well as to a lesser extent in the allied health professionals area. Ms

Hoey will be able to elaborate further on that. The global workforce is rapidly changing and the day of any graduate taking a job with us and it being a whole-of-life job has probably passed. It is much more dynamic than that. There are always things we can do to improve the situation. On the international nurse recruitment, we have continued with it.

Ms Anne Marie Hoey: Yes, we have. To speak to Deputy Crowe's point, in terms of the graduate nurses and midwives and the health and social care professionals, for the last four years we have given an undertaking to graduates of positions with the HSE. In terms of the nurses and midwives, this will be our fourth year to do so. Our experience in the last few years is that north of 95% take that opportunity and take the contract with the HSE. That said, some will travel but our experience is that they come back. They take a career break a year or two after graduating but they do come back. We try to keep in touch with them through our-----

Deputy Cathal Crowe: I want to squeeze in one last question. I thank Ms Hoey for her comprehensive answer.

There is quite a detailed section in the report on primary care centres. There is a proposed primary care centre in CHO 3 at Sixmilebridge in County Clare about which I am concerned. It has been held up for a long time. Additionally, I have contacted the Department in the past, as has Councillor David Griffin who is here in the Public Gallery, about the village over the road, Newmarket-on-Fergus, which is the fifth most populated part of County Clare. It is at risk of losing the Saffron and Blue Medical Clinic. The Department is aware of this because the Minister, Deputy Donnelly, met an action group last year. The facility seems to be gone. Is there any update on Sixmilebridge and the idea of a health centre somewhere on the main street in the hub of Newmarket-on-Fergus? If the witnesses could provide an update on that today or after this meeting, I would be very grateful.

Mr. Brian O'Connell: Sixmilebridge has been readvertised. It was one of the first ones out through the new scheme. That is up on the e-tenders website at the moment. I will have to come back to the Deputy on Newmarket-on-Fergus.

Mr. Bernard Gloster: We will come back to the Deputy on Newmarket-on-Fergus. Sixmilebridge has been bedevilled by the decisions not just of the HSE, but of others, over many years.

Deputy Cathal Crowe: It is still years away, it would seem.

Mr. Bernard Gloster: I am very familiar with it. It has been readvertised and is up on e-tenders. We are hoping that the new process will expedite but we are not negotiating with ourselves in that particular scheme. It is up and we are hoping to do it. The commitment to do it is there; the issue is the wherewithal-----

Deputy Cathal Crowe: I thank Mr. Gloster for that. The gap in Newmarket-on-Fergus could be very easily plugged if the HSE purchased or took out a long lease on a number of vacant buildings in the village. There is a huge gap there. The HSE's estates and property team has looked at it but it is very much needed. I ask that fresh eyes are put on the situation.

Mr. Bernard Gloster: I will look at that with the new regional executive officer. If a proposal stacks up to need and stacks up to the estate's team assessment, then we generally would support it. To be fair to the Deputy, I will come back to him on it.

Deputy Cathal Crowe: That is great, thanks.

Senator Seán Kyne: I welcome Mr. Gloster and the team. I will begin by touching on two issues that I have raised on numerous occasions and which, thankfully, have seen progress The first is the Clifden district hospital, which has reopened. I would like to acknowledge that and thank the HSE for continuing to push that. Hopefully, it will remain open but I expect it will. The second issue is the extension of the Westdoc service to Moycullen and Oughterard GPs, which I also acknowledge.

On 15 May, I raised the issue of a lack of neurological services in Mayo hospital when members the Neurological Alliance of Ireland presented to this committee. The lack of neurology cover for Mayo University Hospital results in patients having to travel by ambulance to either Galway or Sligo for assessment or treatment. They then undergo a return journey, having been seen. Some of these patients, as one would expect, are very ill and having to take such a long journey is not easy for them. In addition, neurology services in Galway are under pressure and the waiting lists are considerable. Are there plans to provide neurological services in Castlebar? I understand that under the 2016 model of care report, all model 3 hospitals should have neurological cover. Eight years after that report, Mayo still does not have them.

Mr. Tony Canavan: It is a significant gap and it reflects the comments made by the CEO in his opening statement relating to the growth in demand for neurological services generally and our ability to respond to that with our current level of resources. We do not have a firm or funded plan to provide neurological services at Mayo University Hospital currently. We need to look at the provision of those services in the context of an overall strategy for the region and within the hospital group. There are other model 3 hospitals in our region that are also struggling to provide adequate neurological services. Even the model 4 hospital in Galway, with the current resource, is struggling with the workload. There is a clear and demonstrated need for additional support but how we provide that and where it is located is the issue. We have to be very clear that we are doing the best that we can on that.

Senator Seán Kyne: There is no clear plan at the moment but-----

Mr. Tony Canavan: There is no clear, funded plan.

Senator Seán Kyne: I would assume that for very serious cases, patients are transferred but it is the less serious cases that I am concerned about. People I know have had loved ones in Castlebar. Thankfully, they have recovered but there was no neurological service available there, which is of concern.

Families for Reform of CAMHS appeared before this committee on 17 January. They said there was insufficient and inadequate staffing and resources, that therapeutic supports were extremely hard to access and that children were often only offered medication. Some 35% of members of that group would have liked to make a complaint but chose not to because they were worried about how that would impact their children's care. They call for the end of the discrimination against autistic children and children with intellectual disabilities in the provision of mental health services. The practice they have is not to disclose an autism diagnosis because that would be seen as a barrier to gaining access to CAMHS. There is a considerable range of conditions under the autism umbrella, from mild to more severe. If a diagnosis is acting as a barrier to CAMHS, that is not good enough considering the number of children who get a diagnosis of autism.

Dr. Amanda Burke: There is no question that CAMHS has a role in autism. It is not that CAMHS excludes somebody who has a diagnosis of autism. All CAMHS teams will see some-

one with a diagnosis of autism and a moderate to severe mental illness. There are, however, barriers to assessment for autism. We know there are gaps in the disability teams and at primary care. This is where the diagnosis of autism is usually made. Through our single point of access, we are trying to smooth that pathway for parents so that the person does not have to be either in primary care or disability or CAMHS but can attend both simultaneously.

There are pilot areas that have been working through the autism protocol, which states that people can attend both services. In those areas, CAMHS have prioritised in-reach into the children's disability network teams, so they will join the CDNTs and do joint assessments and joint care planning together, which is obviously preferable for the families, rather than going from one service to the other. There is more work to be done and depending on the area of the country, there can be patchy coverage in terms of CDNTs, primary care and CAMHS. Some areas are experiencing more difficulties than others. We are working hard on this but we accept that for some people it is really difficult and we are very sorry.

Senator Seán Kyne: Does Dr. Burke understand that people are not disclosing a diagnosis of autism to try to improve their chances of accessing services?

Dr. Amanda Burke: I would be concerned if that were the case because it is very important in terms of viewing a young person to have the full picture. I would be concerned if that were the case. Sometimes young people are referred to the area that has the lowest waiting lists. Someone might arrive somewhere saying they have anxiety and then when we see the young person they clearly have a diagnosis of autism. The autism-specific supports are provided by a different service. It is up to us to work together, which is what we are doing through the single point of access. That should not be for parents to navigate; it should be navigated at a professional level.

Senator Seán Kyne: I am sure Dr. Burke can understand the parents' point of view-----

Dr. Amanda Burke: Absolutely.

Senator Seán Kyne: ----- if they are advised, or if someone says to them on the quiet, "Look this is a mild form of autism, so don't say anything". This is what the parents are facing and it is not good enough.

Dr. Amanda Burke: No, it is not. We are working through the autism protocol and smoothing those pathways.

Senator Seán Kyne: On the primary care centres in an Spidéal and Oughterard, is there any progress on those two projects?

Mr. Tony Canavan: Both projects have been in the pipeline for some time. We have visited them on a couple of occasions. Both will be readvertised this summer. Perhaps Mr. O'Connell will have more details on the readvertisement.

Mr. Brian O'Connell: The third quarter of 2024 is when we are trying to get the majority-----

Senator Seán Kyne: They have been advertised a number of times.

Mr. Brian O'Connell: They have been advertised. We can only respond to the market. In Spiddal we would be confident. With Oughterard, again, before we go back out to the market we do an assessment to see what would be the most valuable option. We do not just stick blind-

ly to the operational lease. We do a trawl of all options available to us before we readvertise. Those reviews have been done. We still believe that for those two locations the most viable mechanism is still the operational lease. We will know if a viable option comes back towards the end of the year but if one does not come back, we will have to reconsider that decision. At the moment, that is still the preferred mechanism to deliver those two locations.

Senator Seán Kyne: That is obviously developer led.

Mr. Brian O'Connell: Yes.

Senator Seán Kyne: It would require a developer to provide a site on long-term lease.

Mr. Brian O'Connell: Yes.

Senator Seán Kyne: When does the HSE draw the line, decide it is not going to work and look at alternatives?

Mr. Brian O'Connell: It is still the most expedient manner to do it like that. If we make the decision to go the capital route, we have to source a site. That can be fraught with delays in our own delivery arm. If there is an opportunity out there, that is the lens through which we look at things when we are making this decision. We have not gone lightly into readvertising them, especially those that have been readvertised several times at this stage.

Senator Seán Kyne: On the increase in the HSE workforce since 2019 of 28,246 whole-time equivalents, obviously a share of those have gone into the CAMHS, I imagine. What is the main driver of the waiting this? Obviously demand is increasing but is it posts not filled and funded or a difficulty getting the required skills? What is the main reason?

Dr. Amanda Burke: It is all of the above. We have not had the funding so we are trying to make up for CAMHS being underfunded over decades. That is one thing. The posts in certain areas are difficult to fill. There is a shortage of professionals, particularly as they come on stream. Certain areas are more difficult to fill. There has also been a huge increase - 16% - in demand. That is good because it means there is more recognition of mental health difficulties and people are more aware of the issue, but we are struggling to catch up. We have a plan. With the multi-annual commitment to funding, we will fill these posts over the next number of years.

Mr. Bernard Gloster: Senator Kyne has raised with me a number of times at the committee, and has been very focused on, the issue of the development plan for the Galway University Hospital. I gave an undertaking that this will be completed by August of this year. I have checked with Mr. Canavan and we are still on course to complete that. I am aware the issue was troubling the Senator at our last meeting, so I just wanted to say it is still on course.

Senator Seán Kyne: I thank the witnesses.

Deputy John Lahart: I thank Mr. Gloster and his team for the updates. I have four areas to discuss. I will dispense with the quick ones first because they might just need a report. I want to keep chasing Mr. Gloster, the HSE and the Land Development Agency, LDA, on the accommodation piece. Perhaps we could have an update in writing on that. The HSE needs to get aggressive about this. Accommodation costs are one of the key drivers of nurses leaving Ireland and Dublin. I and several other Oireachtas Members visited the Northern Assembly and Queen's University, where we met a number of the academics. Apparently the HSE is poaching a lot of their nurses because we pay them better, but they do not have accommodation cost

issues. The idea of spare HSE land - I am being very loose with language - hanging around the place and not being utilised is unacceptable. I accept fully that the HSE says it is not a landlord or property developer, but there is an exciting potential opportunity there. That is the first issue.

Second, the CAMHS in CHO 7 is not good. Will the witnesses give a brief update? CHO 7 is the community health area that covers north Kildare, north Wicklow and south Dublin, some of which is in my constituency of Dublin South-West.

Dr. Amanda Burke: Could the Deputy give more specifics on that so I can answer more specifically.

Deputy John Lahart: It is the waiting times for assessments.

Dr. Amanda Burke: For CHO 7-----

Deputy John Lahart: It is the worst.

Dr. Amanda Burke: It is not the worst in the country. There are 25 young people who have been waiting over 12 months and 474 young people waiting in total. CHO 7 has made a 40% improvement in the waiting list over 12 months last year.

Deputy John Lahart: I acknowledge those improvements. To follow up on Deputy Cathal Crowe's point, is there any way that we can buy these services from other community health areas or is that being done? Who carries out the assessment? There is an historical or legacy issue, whereby parents were getting assessments done privately and these were not accepted by the HSE. Is there any way that can be surmounted? There could be a list of acceptable private service providers.

Dr. Amanda Burke: Each clinician has to be confident in the diagnosis of a young person, particularly if he or she is going to prescribe a treatment regime as the result of an assessment. Every clinician would validate an assessment. In CAMHS, we do multidisciplinary team assessments. We triage the referrals and then they are allocated to team members, depending on the presenting symptoms. We are looking at buying in, however, and we have engaged very actively.

Deputy John Lahart: What stage is the HSE at in that regard?

Dr. Amanda Burke: We have four areas that are interested in starting this. They will be starting in August.

Deputy John Lahart: Community health areas.

Dr. Amanda Burke: Yes, community health-----

Deputy John Lahart: Is CHO 7 one of those?

Dr. Amanda Burke: CHO 7 is not one of those, but it has been at the table. It is waiting to see what the other areas will do first. It is-----

Deputy John Lahart: Who is in charge of these services in CHO 7? I do not need a name, but what is the job title of the person in charge?

Dr. Amanda Burke: The head of service for mental health. At this stage, however, people are asking whether they can just wait to see how this works out. There is a reason for that. I

am going to take attention deficit hyperactivity disorder, ADHD, as an example because that accounts for the highest proportion of people we have on the waiting list. If we remotely assess a young person as having ADHD and say that part of his or her treatment plan is medication, we cannot do that remotely at this moment in time.

Deputy John Lahart: Good.

Dr. Amanda Burke: That would have to be done by the local community health team. What we do not want to do is create a second waiting list. People have the assessment now and the parents ask whether they can have the treatment, and we say that we are sorry but they will have to wait to get into the CAMHS team. What we are doing at the moment as part of these assessments is trying to build up local capacity to take these assessments and treat them quickly within the areas. We will be phasing them in. CHO 7 will be part of it, but it is not going first.

Deputy John Lahart: I welcome that lateral approach and that fresh thinking around it. Dr. Burke might keep us updated on it. Even an additional note might be appropriate on that, Chair.

Can Dr. Burke give us any information regarding data around this in the context of geographical areas? Are there particular locations that have red flags? For assessment of need, not just in Dr. Burke's experience but according to the data she or the HSE has, is the profile higher in areas of economic deprivation or in other strata of society? If the HSE is able to pinpoint that a particular area is one in which the presentation of children with additional needs and additional neurological challenges is higher, are we targeting those areas with additional resources?

Dr. Amanda Burke: We always take a deprivation index into account when we are looking at our allocations. The answer is "Yes". We do look at areas of particular need and try to target resources. However, we were starting from a relatively low base. We need to bring up all areas at this moment in time. We are not at the level where some areas are doing really well. We have to bring everybody up at the moment.

Deputy John Lahart: What data is the HSE using?

Dr. Amanda Burke: In terms-----

Deputy John Lahart: Has it any data registers of children or areas?

Dr. Amanda Burke: I will need to come back to the Deputy regarding data in respect of disability and assessments of need because that is not specific to just mental health. It would be across all the areas in terms of disability, primary care and mental health. Can we come back to the Deputy on the data?

Deputy John Lahart: If Dr. Burke was looking at a map of Ireland, would she be able to identify the areas that are hot spots in terms of children presenting with additional needs, while other areas are not as hot? Are the resources being targeted to the hot spots as opposed to every CHO getting a spread of things?

Dr. Amanda Burke: We target depending on presenting symptomatology. However, the vast majority of young people currently waiting are awaiting treatment for attention deficit hyperactivity disorder. We had a surge of eating disorders. Eating disorders have a particular profile.

Deputy John Lahart: I am asking whether the children presenting are coming from par-

ticular geographical locations. Is there a concentration of them in some areas? If so, is there a commensurate allocation of resources to those areas?

Dr. Amanda Burke: There is not a massive difference between areas. There is an increase in need everywhere at this time, particularly post Covid.

Deputy John Lahart: On the primary care piece, again, the HSE is looking at different things. On page 5 of the report, it states that a review was undertaken following a number of landlords and developers raising concerns about the financial viability of the operating lease model. I am thinking of Ballyboden Primary Care Centre, which is an excellent and fantastic centre. I have availed if it myself. It is an absolutely fantastic primary care centre and location. I want to hear a little bit about that. I would have thought that was a very generous model that the HSE operated.

On the Covid lists, is Tallaght University Hospital an outlier in terms of Covid? I know ward visiting was shut down. The witnesses might say a little bit more about that.

My final question is with regard to the neurorehabilitation piece. I commend Dr. Burke personally, but also her team, for the interest they have taken in this, specifically with regard to Huntington's disease. I thank them very generously. They are not thanked enough for the interventions they make. Is the HSE going to publish an action plan for inpatient neurorehabilitation to address the two thirds shortage in beds? The witnesses might comment on the neurorehabilitation piece, the Covid piece in Tallaght and the primary care.

Mr. Bernard Gloster: On the neurorehabilitation piece, yes, we do intend to publish the mapping exercise and, if you like, what the profile looks like and what the gap and the need look like. I hope we can do that sooner rather than later. I make the point that we are not waiting for that in totality to try to pursue improvements, be it in the Estimates or other things.

With regard to Covid and Covid restrictions, we are very conscious that when we have visiting restrictions, it creates lots of connotations for people. I do understand that. The recent visiting restrictions at Tallaght University Hospital were associated with a significant uptick in the number of people with Covid. They were not necessarily in hospital because of Covid but they had Covid. They also had norovirus, which can be quite a dreadful infection if people who are sick or older people in particular catch it. It is just awful. We get outbreaks, and we did see an upsurge in outbreaks. Tallaght was not on its own in that.

Deputy John Lahart: However, it is the only one the HSE notes in its report.

Mr. Bernard Gloster: I am sorry; Sligo has had restrictions, as have Limerick and Galway. The most recent spike in respect of Covid-19, which was in June, was associated with the FLiRT variant. It did not necessarily cause an increase in severity of illness or admission to ICU, but it was still quite infectious and the numbers did go up. It is levelling off, but I think into July we will still see the numbers of cases for that. When we add that to any other type of infection control outbreak in a hospital, like I said, a vomiting bug such as norovirus, we will get elements of restriction.

The visiting restrictions being applied anywhere are being applied under antimicrobial resistance and infection control, AMRIC, guidelines, which means we do not go for full blanket of there being absolutely no visiting. We do sensitive management for any type of restriction for the least possible time. That is simply to reduce the spread of the infection. Infection comes from visitors, staff and patients and infection controls measures are very important. We seem to

be over the highest peak of that, I hope, but we will continue to see waves in the future. There is nothing particular to Tallaght hospital, to be fair to it. The hospital actually managed it very well. It is very hard to manage restriction in a hospital environment, but I think it actually did it exceptionally well.

Mr. O'Connell might comment on the primary care centre.

Mr. Brian O'Connell: I refer to the numbers we have delivered. There has been a lack of delivery due to the interest rates increasing at the same time that construction inflation increased, which would have all happened after it. We would have locked in our rental rate going forward on the 25 years, so that has paused-----

Deputy John Lahart: Interest rates are beginning to go the other way now.

Mr. Brian O'Connell: Yes, and that is why we are-----

Deputy John Lahart: The HSE is not designing a policy on the-----

Mr. Brian O'Connell: That is why we are only going out now.

Deputy John Lahart: Okay.

Mr. Brian O'Connell: There was a pause. We waited because the risk of construction inflation or the instability on the interest rates would have been cooked into any future figures had we gone out earlier. There is stabilisation both on the construction side and on the interest rates going forward, so that should make for a competitive market at the moment.

Mr. Bernard Gloster: The Deputy mentioned the Huntington's disease piece, and I thank him for his comments. He raised that issue with me. I went out to, and spent quite a bit of time in, Bloomfield Hospital. I met patients and families, staff and management. There is no question but that it provides an outstanding service. It was funded by multiple community health organisation, CHO, areas up to now and different CHOs paid for different patients. To make its planning more sustainable, I have now made it one single nationally funded service, which means all these guys have to chip in whether they have beds that are occupied or not. That approach gives more sustainability. It is one of the most expert responses that I have seen in a long time to a dreadful condition.

An Cathaoirleach: One of the reasons Tallaght hospital was included was that the community asked for a report. We were trying to get a sense of what was happening around the country. Tallaght hospital experienced both the winter vomiting bug and Covid-19 and that was the big challenge it faced. As the CEO said, that is also happening in other places.

I welcome the members of the Neurological Alliance of Ireland, NAI, to the Gallery. They came in to the audiovisual room in Leinster House a number of months ago. What impressed many of us was the number of organisations involved in the Neurological Alliance of Ireland. Its representatives spoke about the considerable numbers of Irish citizens who are impacted by neurological events. There were different people on the front table. For some, it was almost a cry for help. They were saying that, unlike in other sections of our health organisation, there was a plan in place. This was the point they were making. A plan was in place but the funding was not following through. When representatives of the NAI came before the committee, they made the point that funds committed to were not released under the HSE service plan. They asked why that was the case. They pointed to other services for which funding seemed to be

available. Neurology seemed to be the poor relation even though it has had a considerable impact. Nearly 1 million people have been impacted by a neurological event. Why has that funding not been released? Is there politics at play? Why is it the case? I do not know and could not answer.

Mr. Bernard Gloster: I hope the advocates would agree that it is not a prejudiced position towards neurology or the development of services in neurology. It just happens to be a service that competes with many demands for improvements and developments across a whole range of services, programmes and strategies. There is no prejudiced position towards it. We are not putting it into second place or setting it aside. That is not the case and I assure the committee of that.

An Cathaoirleach: Those representatives said there is a big gap in the community.

Mr. Bernard Gloster: There is, and we recognise that.

An Cathaoirleach: You have the event and are brought to hospital. The next step is to try to get you home, but if you do not have the support in the home, you are not able to make that transition. It is about that pathway. There are simple things, such as getting an occupational therapist, OT, to say that you might need a shower rail or a ramp going into the house. These are all simple things. In some areas, there is a good relationship with the local authority but in other places there is not. There seem to be gaps. That was one of the questions I was asking the discharge team in University Hospital Limerick. I asked is there a good relationship in place. I know that there is a good relationship in south Dublin but there is a long waiting list. Years ago, the council team would do it but councils do not have the staff now so it falls to private operators. Is Mr. Gloster finding that there is a gap? Is that an issue he has encountered?

Mr. Bernard Gloster: There is no doubt that the living and build environment people live in, whether they are suffering from a neurological condition or many other illnesses, is a contributing factor to whether they can successfully remain at home and recover and whether they can exploit their full potential. There is no question about that. Some of us have been around long enough to remember things such as housing aid for the elderly schemes and different things, insulating houses and so on. There is no doubt that it is a challenge. What we specialise in is not the building, although we do have good relationships with local authorities. We specialise in the equipment. There is certainly now far better provision of equipment to assist people at home. That includes everything from grab rails to raised toilet seats and various fall prevention equipment. There is a considerable amount of technology available in that regard and we are providing it.

The deficit and the gap on the rehabilitation and neurology side is in the specialist service. The general community services, such as OT, physiotherapy and many of the other supports that will help people to live in the community, are unrecognisable compared with what they were. They have substantially improved. There is evidence to demonstrate that in tens of thousands of cases. The specialist piece is where there is a significant deficit and the advocates would agree with that. Those are the community teams about which Mr. Canavan was talking right back up to specialist beds nationally.

An Cathaoirleach: That leads us to the gaps in services. There is a lack of community nurses to call to people in the community. All those ABCs are simple things but if they are not joined up, there is a gap. The impact on individuals is delayed recovery because they are not getting those supports. People have told me that the longer recovery takes, the more difficult

and challenging it will be. If someone has had a stroke, he or she might lose the use of an arm if those ABCs that are supposed to follow are not in place. That is the cry for help people have been making.

Mr. Gloster mentioned the report on pay and numbers. When are section 39 workers going to be paid? These are the workers who have been waiting for up to ten years for an increase. Is there any timescale in that regard?

Mr. Bernard Gloster: They achieved a percentage increase last year at the Workplace Relations Commission, WRC, which I fully endorse and welcome. Payments in that regard have substantially advanced. There are a couple of organisations that will find it difficult to provide sufficiently accurate information to ensure the probity of it. Discussions are currently ongoing, during these weeks, at the WRC about what the improvement would be for section 39 workers now that a new public sector agreement is in place. Discussions around a further percentage increase have been positive. Not to walk away from the situation, but the HSE is not the employer in those circumstances. We fund those organisations, as does Tusla and many other State bodies. The negotiations are led by the line Government Departments and by the Department of Public Expenditure, National Development Plan Delivery and Reform. My understanding is there is an attempt to give the sector a further pay award this year.

An Cathaoirleach: Going back to the group who was before the committee previously, they made the point that there is an overreliance on the voluntary and charity sector and it is not getting proper funding. People are being recruited to the public sector and so on. There is a big challenge within the system.

Mr. Bernard Gloster: There is.

An Cathaoirleach: Mr. Gloster said earlier that he did not want to look at every job in the context of the recruitment freeze. I want to look at one area. I am glad Senator Conway raised the issue of the recruitment freeze. There is almost a narrative that the HSE was recruiting staff willy-nilly. When public representatives ask questions about key personnel who are missing, we are told it is the result of the recruitment freeze. I will give the example of audiology services in my locality. The waiting list for audiology services for children has doubled and is now at approximately 5,800. That is over two years. The challenge is that there is a shortage of audiologists in the area. That is just one example. That is brought to the attention of the Minister and his attention is also drawn to the recruitment of other people and the importance of administrative staff. Consultants and junior doctors who came before the committee told us they do not have the teams around them. Administration staff are part of the team and if we do not have them, consultants and junior doctors cannot do their jobs. This willy-nilly thing needs to be responded to. Is that the way it operates? Did the HSE recruit anyone who was available?

Mr. Bernard Gloster: I would not go so far as to say that it is a willy-nilly thing. There was certainly an acceleration to try to recruit to as many disciplines as possible, particularly coming out of the pandemic and given the growth in services that was necessary. Generally, we are recruiting a multidisciplinary team in nearly every part of the health and social care sector and, therefore, we go out and look to get, for example, as many physios or OTs as we can. I would not use the term "willy-nilly", but it probably had that appearance because of the absence of a full-control environment.

Equally, I have never heard so many problems in the history of the health service being attributed to a recruitment pause that came in last October. Audiology has been a consistent

problem since my first management job in 2003. It will remain so for some time because of the volume versus the available skill set. People ask when the pause will end. What will be clear in the future, and I will be unequivocal about this, is that the funded workforce of the service will be X. That is not to say that is everything we need, but that is what it is. If the control operates within that, there will not be any need for these kinds of arbitrary decisions around pauses. Adding to it is a different decision, and those are matters for the Government later, but the workforce has never been bigger. There has been an explosion in the past four years. We have to see what it is we are getting from that to the benefit of the public, as well as just recruiting more.

An Cathaoirleach: People have been talking about local areas. There is no dietician in CHO 7 at the moment. I was dealing with a family with a newborn child, and the child is now one and a half years of age. To try to see a consultant, the pathway would normally be through the dietician, but the family cannot use that pathway as there is no dietician. The only other pathway is to try to get a skin-prick test to see what the child's allergies or other conditions are, but that costs €180 and not everyone is in that position. Because there is no dietitian, there is no official waiting list and people cannot get the skin-prick test locally because the public and private sectors are going through the same avenue. There is a big challenge in this regard. That child was losing weight. The mother was pulling her hair out wondering what she should do and thinking that all of those supports were there. She was basically just told there is no dietician so there is no pathway, and she had to find a pathway herself. She is still waiting to see a consultant and the child is now a year and a half old.

There is no good news for that family and other families who are stuck in that situation, unless Mr. Gloster has good news this morning. Again, that is just an example of one job, but I am sure that can be replicated across the service. The point I am making is that having key personnel missing across the service is impacting many people.

Mr. Bernard Gloster: The dietetic capacity in Ireland has very little to do with recruitment and is predominantly to do with the graduating supply and the available number of training places.

Deputy David Cullinane: I asked a question earlier in regard to spending being ahead of profile and Mr. Gloster said it was probably greater than the €500 million we were told about the last time he was before the committee. Will he provide the committee with a briefing on the following point, if possible? To much fanfare, the Minister announced the establishment of a group to look at achieving savings within the HSE, productivity and reining in spending, or perhaps greater accountability around spending is a better way to put it. I know Mr. Gloster raised a number of areas in regard to agency spend, management consultancy and recruitment. Will he set out for the committee what was the target that was set in regard to the overall savings that were to be achieved for 2024 to deal with the spend of money on healthcare, on the one hand, but also what has been achieved to date in regard to those savings and, more specifically, where spending is currently ahead of profile? I can understand that Mr. Gloster does not have that information at his fingertips now, but it would be helpful if it could be provided to the committee.

I am looking for clarity on the following matter. We had some discussion on the pay and numbers strategy, which still has not been published. A number of commitments were given by Mr. Gloster and by Ministers with regard to certain posts. I mentioned one of them, which is a business case to staff the cardiac service in Waterford to a seven-days-a-week service, which is a long-standing commitment. There was a bit of over-and-back between Mr. Gloster and me as to whether that has formally been approved. My question is whether Mr. Gloster has clarity on this, which is important for me. Have the management of the hospital been given the green

light to recruit the additional staff needed to move to a seven-days-a-week service or do they have to wait until they get clearance from the regional executive office, REO, once the HSE has allocated the staffing under the pay and numbers strategy?

Mr. Bernard Gloster: They do not have to wait on the pay and numbers strategy because they are part of the new-development allocation of 1,850, which I have said is protected. The notifications for this have been going out in the past couple of weeks, so Waterford either has got that or is just about to get it. Provision is being made for improved staffing. At the moment, the two cath labs are functional and one of them provides a STEMI on-call service, which is for the higher level of heart attack, from 8 a.m. to 8 p.m., Monday to Friday, excluding bank holidays. What it is receiving now will put it to a seven-day, 8 a.m. to 8 p.m. STEMI on-call service.

Deputy David Cullinane: To clarify, Mr. Gloster said there was correspondence that has gone or will go.

Mr. Bernard Gloster: If it is not there now, it is being typed. There are 1,850 notifications going out.

Deputy David Cullinane: Mr. Gloster might come back to me by email to clarify that they have got it. I will be asked by the public whether this has been approved and whether the hospital has been given this.

Mr. Bernard Gloster: I am saying to the Deputy that it is approved.

Deputy David Cullinane: It is approved and they have been given the green light. Whether they got that letter or not, they know that they can start recruiting.

Mr. Bernard Gloster: They will certainly be left in no doubt about that.

Deputy David Cullinane: Mr. Canavan might have the answer to a separate question. A number of my colleagues in Sligo were in contact with me recently about the pain management service in Sligo that has apparently ceased operating. Councillor Thomas Healy was one of those who was in contact with me. I know local representatives have been raising this with Mr. Canavan. I know, from my experience in the south east, that pain management delays and a lack of options or capacity for pain management can cause problems because pain management is very important for people who might be waiting for treatment or are post-treatment. What happened in Sligo? What led to the closure of pain management services or is that what has happened? Mr. Canavan might provide clarity.

Mr. Tony Canavan: I would not describe it as the closure of the service. The service in Sligo was being provided by two consultant anaesthetists and other staff, but led clinically by those two consultants. Both of those post-holders resigned, which left a gap in the service. We would not normally expect two people in the same service to go at the one time, but that is what happened and it left us with a gap. We have put interim arrangements in place to try to fill that gap and ensure that, insofar as possible, patients are seen. For example, we are engaging with the private hospital in Sligo to see if some patients can go there and we are also working through the NTPF to see if it can provide a source.

Deputy David Cullinane: It is a recruitment issue.

Mr. Tony Canavan: We have started the recruitment process to replace both of those posts

and we have gone out to recruit a locum. We would expect a locum consultant to start in July.

Deputy David Cullinane: I will come back to the issue of neurology services, which is a matter of frustration for us. I do not expect Mr. Gloster to micromanage every staff member who is recruited to the health service. However, when the Oireachtas health committee puts a particular focus on a major issue like neurology services, when we have had not one but several meetings where we discussed the roll-out of community neurological teams, and when the head of the HSE comes before the committee and gives certain commitments, we would expect that there will be follow-through. If there was a discrepancy or a problem in recruiting staff, that would be captured at that point in time. Obviously, Mr. Gloster referenced earlier that mistakes were made. Can he understand the frustration that here we are today, in July 2024, when commitments were given over a long number of years, and I still cannot tell people when those six teams will be fully operational? I will ask again before I finish, and I will leave my remaining minute to Mr. Gloster to answer the following question. Regarding the two teams that were funded recently, can Mr. Gloster give some sense of a timeline as to when they will be fully operational? Is it a case that the other two teams will need to be funded in the upcoming budget?

Mr. Bernard Gloster: I will not say it is my hope - because that is not a strategy - but my best estimate is that the four will be functional before the end of this year, and the two further teams will be funded in the Estimates for 2025. What the answer to that will be, I do not know. The one thing I will say is that the one limiting factor will be the availability of individual specialists. If they are not available, they are not available. Other than that, the answer is "Yes".

Deputy David Cullinane: I thank Mr. Gloster.

Deputy Róisín Shortall: Dr. Burke is going to send us details of the different CAMHS teams, the number of vacancies and what kinds of vacancies there are in each area. There is other information that we will also need. We have all been in touch with Families for Reform of CAMHS. The information they are feeding back to us regarding the experiences of families is quite shocking. The other piece of information that is very information is the details of waiting times and staffing with regard to primary care psychology services. Again, getting back to that principle of the importance of prevention and early intervention, CAMHS should be for moderate-to-severe cases but if we do not have the earlier interventions then clearly, there will be more people looking for the CAMHS services.

Councillor Liam Quaide, a colleague of mine, was in touch with me recently. He said that with regard to the Cork-Kerry area, he got figures recently which showed that in that area alone there are 5,000 children on waiting lists for primary care psychology services. Looking at the detail of that, 1,500 children in that area alone have been waiting in excess of two years. That is just a shocking figure. Is that standard across the country or are there particular problems in Cork and Kerry? When the HSE is preparing the information about CAMHS, will it provide the corresponding information for primary care psychological services? Groups like Jigsaw were mentioned. The position in this regard needs to be mapped because there are several areas in the country where Jigsaw is not available. What is the level of service provision? I am not asking for an answer now but if the HSE could prepare that full picture for us, it would be helpful.

On primary care centres, what is the status of the capital plan for this year?

Mr. Bernard Gloster: My understanding is that the updated version of the capital plan will be going live in the next two to three days.

Deputy Róisín Shortall: Has it been approved by Government?

Mr. Bernard Gloster: It has been approved by the Minister. It will possibly be going live today. If not today, then it will be live tomorrow.

Deputy Róisín Shortall: We are talking about the capital plan for 2024 coming out in the second half of the year, which is strange. We are into the second half of the year now.

Deputy Bernard J. Durkan: There are strong objections to the capital plan and the direction in which it is heading at present. I apologise for interrupting.

Deputy Róisín Shortall: It just seems incredible that it is July and we have not seen the capital plan yet.

Primary care centres are obviously a critical element of the roll-out of proper community services and a switch to the Sláintecare model. I have a fundamental problem with the approach the HSE is taking with regard to the different methods of procurement. If you look at highly disadvantaged areas, generally speaking, they are not very attractive for the private sector because they are not good money-spinners, to put it bluntly. Unless the HSE is stepping in and providing State-funded primary care centres in those areas of high disadvantage, we are going to continue to see disadvantaged areas losing out badly.

A case in point is Finglas in my constituency. Some 12 years ago, Finglas was the number one priority for a State-funded primary care centre. We are now just at the point of applying for planning permission. How many more years will it be before that is available?

The list that was drawn up was referred to. I assure Mr. Gloster that I am very familiar with the list that was drawn up in 2012. It was stated that it was amended and rejigged somehow. Does the HSE intend to publish that list? It should be available transparently to the public in order that we know what areas are being targeted for State investment and that we have an assurance that it is a proper priority system.

Mr. Bernard Gloster: On State funding, I know the general point the Deputy is making. I do not want to split hairs on it.

Deputy Róisín Shortall: I should probably have said State-provided.

Mr. Bernard Gloster: The Deputy means State-built. I understand that. In some areas of disadvantage, I am very familiar with the lease-option model. It has worked very well. I do not think it affects the developer in leasing to us where the actual location is.

On the list of primary care centres, quite frequently the Deputy will see the list of available advertised ones on eTenders. They also feature in the capital plan commitments every year or so. If there is a specific, full list that is not apparently visible to anybody, I have no difficulty publishing that.

Deputy Róisín Shortall: Does the HSE still have a priority list?

Mr. Brian O'Connell: Yes. We are still working off the bones of the 2012 list. What may have happened is that a larger number were originally identified. They are currently being progressed. That is down to the overall movement from back in 2012 whereby they have consolidated a number of centres together where it makes sense. One might pick slightly bigger centres and maybe utilise satellites from that in some of the areas. To give an example,

Ballyjamesduff would have been on it. It is now getting consolidated into a bigger centre in Virginia. That is the sort of approach we have very much targeted under the PPP model. Then on the capital plan we have targeted them in those areas of higher deprivation that would have got prioritised as one of the matrix. They would have been prioritised and the first call on the capital list would have worked from that prioritisation downwards.

To put a little bit of colour on the Finglas centre, permission was refused. We had a scheme developed-----

Deputy Róisín Shortall: I am familiar with that; I am just saying that-----

Mr. Brian O'Connell: It was refused-----

Deputy Róisín Shortall: -----the State has to step up to ensure there are facilities in disadvantaged areas.

Mr. Brian O'Connell: We are in Finglas, and my point-----

Deputy Róisín Shortall: I am sorry, it is 12 years later. I would like some detail on the State-funded aspect, by whatever method, whether PPP or direct build-----

Mr. Brian O'Connell: There was only one bundle of PPP projects, so that is the 14 sites. We have no intention to go back-----

Deputy Róisín Shortall: So maybe just over the past few years. The State-funded ones were referred to in the report but there are not any figures. For, say, the past ten years, Mr. O'Connell might provide some detail of what ones have been fully funded by the State.

Mr. Brian O'Connell: There are seven that have been delivered through the capital plan that would be brand-new builds. I would categorise them slightly different to ones like Roselawn, which have been extended. There were 20 refurbishments in addition to that.

Deputy Róisín Shortall: That information would be very helpful. I thank Mr. O'Connell.

An Cathaoirleach: I believe Deputy Durkan is heading off to another meeting.

Deputy Bernard J. Durkan: I want to come back again along the lines Deputy Shortall was mentioning there with regard to the primary centres. In my locality, we had to attend a public meeting in the context of the recent local and European elections. It was disclosed to us that we had changed the locations. There was no consultation with anybody that I am aware of, except we were told there was no suitable site available in, for instance, Maynooth. That is not true. The biggest building construction concentration in the country is in Maynooth. It has been for the past four or five years and is growing, and it has to grow in order to accommodate the population.

My concern, Deputy Shortall referred to this as well, is about who calls the shots. Is it going to be somebody who says, "I have a site available four or five miles down the road"? That site may suit some people, but it might not suit those who have to travel there. In addition, in the context of meeting the demands of a community that is going to grow rapidly, there may not be a suitable site available. I strongly contest the criteria used so far and object to them on the basis of the lack of consultation. That means that we need to upgrade the services in all towns and villages because in many cases, it has been 50 years since that has been done. In the meantime, there is a major growth in demand and this is going to continue in the next ten, 15 or 20 years.

We need to keep that in mind and we need to ensure that what we do is done in the interests of the provision of health facilities to the wider community in line with the growing demand and given the commitments. We cannot get into a situation whereby we make a commitment and have a pecking order, a priority list and so on, and just because something comes handy for somebody else somewhere, we change all that. We should not change that. We are in the business of the delivery of health services, not the delivery of sites for somebody. I emphasise that and put down a marker to the effect that this will not be an easy-go system. We will not be easily fobbed off on that one or any other one where a commitment is already made.

I will make a point about demand on the health services in general. It applies to almost all services now, in every area, whether health, sport, industrial investment, job creation or whatever it is. That is all increasing. The demand has to increase. Even though we are at a very high level and have improved considerably in the past ten years, and rightly so, the fact of the matter is that we have a bigger population. I heard somebody today mention in a report that we could have too many houses, the answer being to stop building houses, presumably, in the meantime. What a load of nonsense. That is like the situation that developed after the financial crash, when, as we will all recall, there were fellas running around saying, "We must demolish the houses that are built. We do not need them." What a load of nonsense. Where do people get these ideas? The fact of the matter is that when you have built something, you use it. When you have too many houses, you will know very quickly. The price in the market will indicate that to everybody. However, let us not start running against the tide and say that, in anticipation of the fact that we might have too many houses, in the event of the population going down, flood levels rising and so on - we need not and should not go there. We need to be very careful as to what we do and what we present.

The final point I will make on that is simply as follows. I notice that in several areas the intention is the continuous rise in house prices. That cannot happen. There has to be a levelling off. People say there is inflation. Yes, we know, and every contribution and every increase contribute more to that inflation. That is a fact, and we all know that. There is a time for us to re-evaluate more than where to locate the primary healthcare facilities. We need to do it now, otherwise it will be after the event.

Mr. Bernard Gloster: I assure the Deputy of something I mentioned to him at the break and said to him earlier. I cannot do much about the housing but, as regards the concern about the primary care centres in Kildare and their locations changing, I will arrange for the regional executive officer and the head of estates there to meet with the public representatives to hear the concern and to share any information it is possible to share. If that does not resolve the issue, I am quite happy to engage with the Deputy further on it.

An Cathaoirleach: I call Senator Conway.

Senator Martin Conway: I thank the Chairman for facilitating me in coming in again. I know this is not necessarily on the agenda but I know also that Mr. Gloster will not be surprised that I want to raise UHL. I feel duty-bound to do so every time the HSE comes before the committee and duty-bound for the people on trolleys there. Since we spoke last, the Minister announced that he would send down an expert team on 4 April. A month later, in reply to a Sinn Féin motion, he made further comments. Surprisingly, a week after that, on 9 May, he announced that this HIQA investigation would review emergency capacity. There seem to be a number of announcements, and we do not have the terms of reference for the HIQA review or, at least, I am not aware of them yet because we are told they are pending Frank Clark's report. My question for Mr. Gloster is what the story is now in respect of UHL. Is there any update?

Mr. Bernard Gloster: On the report, by way of making an intervention, first, our internal expert team of three people spent more than four weeks there. They reported to me in the past ten days or so. I have asked the regional executive officer in the hospital to respond to me with their view on report. The report is about a short-term intervention to de-escalate the hospital. That is the short term because we know what the medium- and long-term plans are. I expect that we will have a de-escalation plan, probably in the next week or so. That will operate throughout July and August. That is to try to take the discomfort out of this for everybody, but it is not a long-term solution. That is the first thing.

Senator Martin Conway: Can Mr. Gloster share with us any of the recommendations the expert group made?

Mr. Bernard Gloster: When you de-escalate a hospital, particularly one that is under significant or sustained pressure, you redirect the entire health service of the region to prioritise every person who is in the hospital, as opposed to anything else, to make sure there is literally not a minute lost, be it for a diagnostic, a discharge, a home support package or anything else for people moving through the system. That is it, in essence. The report of that team is very short. I will publish it as soon as I have had the hospital's response to it. That is the first thing.

The second-----

An Cathaoirleach: There was also a comprehensive report relating to UHL given to the health committee last week.

Senator Martin Conway: Yes, but this is since then. This is a new update.

Mr. Bernard Gloster: I will deal with that. The Minister's announcement relating to the review by HIQA of adequacy of unscheduled or emergency care provision, particularly emergency department provision in the mid-west, was a decision the Minister made. It was a sensible decision in light of the repeated questions as to why and why not and what is and is not the clinical advice. That will take its course. The Minister is right to say that duplication should be avoided if there is learning to be gleaned. The Senator will recall that, after Christmas, following the report I received into the dreadful death of Aoife Johnston, I commissioned Mr. Justice Clark to assist me with a very complex matter. His report is imminent; I expect it very shortly.

Senator Martin Conway: Will it be days or weeks?

Mr. Bernard Gloster: I will say it is very imminent. I do not want to commit the judge, to be fair to the very sensitive consideration he has given to this, but it will certainly not be beyond July. I will then take Mr. Justice Clark's report and do two things with it. First, I will put it with all the other reports and information I have from HIQA, the systems analysis review of Aoife's death and another report into an unrelated case. I will consider that in the totality of any decision I need to make as the CEO of the HSE regarding the hospital and how it operates. Then, separately, I will discuss that with the Minister and share it with him in a way that will help him to have his discussions with HIQA, because that is separate from me, all the time mindful that while all these reports and improvements are going on and they are very important, there are very good staff working in that hospital today. They have also been through a difficult time. First and foremost in my mind, however, in considering the report of Mr. Justice Clark, will be Aoife's family. Nobody could be indifferent to what we heard in the very publicised inquest.

Senator Martin Conway: I fully agree. I cannot disagree with that.

Mr. Bernard Gloster: I commissioned that report, I will have it and I will not delay in my consideration of it.

Senator Martin Conway: Would it be fair to say that assuming the report from Mr. Justice Clark arrives in the coming short period, there will be deliberations and Mr. Gloster will consider the report along with other reports and will then discuss them with the Minister? Regarding the terms of reference for HIQA, is it fair to say that we are looking at September at the earliest?

Mr. Bernard Gloster: I genuinely do not want to speak for the Chairman or CEO of HIQA or for the Minister in respect of that matter. I am not avoiding the question. Senator Conway knows the HSE's view of reconfiguration and other issues as well as I do. The Minister has asked HIQA to look at this cold, independent of all of the other views that have gone before and I think that is fair. I would imagine a reasonable timeline to finalise those terms of reference would be September.

Senator Martin Conway: In terms of the hospital group's response to the expert group's recommendations, has Mr. Gloster given them a timeline?

Mr. Bernard Gloster: Yes. In fact, Ms Sandra Broderick our regional executive officer spoke to me about this last week. Given that they are giving such detailed consideration to the options available to them as the 50 beds in Nenagh are about to come on stream, she asked if I could afford them another week to come up with a proper, detailed consideration of all of the moving parts. I have given her that so I expect to have that response this Friday or next Monday and then I will make a decision.

Senator Martin Conway: Will Mr. Gloster be publishing the response and the recommendations?

Mr. Bernard Gloster: Yes, completely because it will be a live action plan that the hospital will be doing so the public will need to be aware of it.

Senator Martin Conway: That is great. Thanks very much.

An Cathaoirleach: Again, I thank the representatives of the HSE for their engagement with the committee on these important matters. We appreciate the fact that they were able to move away from items on the agenda and respond to other questions from members. The committee continues to closely monitor progress in relation to the matters discussed this morning and looks forward to continued full engagement with the HSE. I thank everyone for their engagement.

The joint committee adjourned at 12.32 p.m. until 9.30 a.m. on Wednesday, 10 July 2024.